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Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Teleconference Meeting
October 22, 2020
9:00 AM – 1:00 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 October 22, 2020**.

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: October 22, 2020

TIME: 9:00 a.m. – 1:00 p.m.

ZOOM ACCESS:

Link: https://zoom.us/j/99214465268
Dial-in Number: 408-638-0968
Meeting ID: 992 1446 5268
Passcode: 495495

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 **Action**

1: Approve September 24, 2020 MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the September 24, 2020 teleconference meeting.

- Public Comment
- Vote

9:50 AM **Action**

2: Schools and Mental Health Project Report

Presenter:

- **Kai Dawn Stauffer LeMasson, Ph.D., Senior Researcher**

The Commission will consider adoption of the Schools and Mental Health Project Report.

- Public Comment
- Vote

10:30 AM **10 Minute Break**

10:40 AM **Action**

3: Election of the MHSOAC Chair and Vice-Chair for 2021

Facilitator:

- **Filomena Yeroshek, Chief Counsel**

Nominations for Chair and Vice-Chair for 2021 will be entertained and the Commission will vote on the nominations and elect the Chair and Vice-Chair.

- Public Comment
- Vote

11:10 AM **Action**

4: Contract Authorization

Presenter:

- **Brian R. Sala, Deputy Director for Evaluation and Chief Information Officer**

The Commission will consider authorizing the Executive Director to enter into one or more contracts not to exceed $125,000 to support the Commission in implementing best practices in Information Technology security including Federal Bureau of Investigation Criminal Justice Information Services security compliant practices.

- Public Comment
- Vote

11:40 AM **Action**

5: Statewide Virtual and Digital Strategy for Mental Health

Presenter:

- **Toby Ewing, Executive Director**

The Commission will consider working with the Administration to support a statewide virtual and digital strategy for mental health.

- Public comment
- Vote

12:30 PM **Information**

6: Staff Report

Presenters:

- **Toby Ewing, Executive Director**
- **Brian Sala, Ph.D.**

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

1:00 PM **Adjournment**

AGENDA ITEM 1

Action

October 22, 2020 Commission Meeting

Approve September 24, 2020 MHSOAC Teleconference Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the September 24, 2020 Commission teleconference meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None.

Enclosures (1): (1) September 24, 2020 Meeting Minutes

Handouts: None.

Proposed Motion: The Commission approves the September 24, 2020 meeting minutes.

Mental Health Services
Oversight and Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM
Governor

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Teleconference Meeting
September 24, 2020

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

408-638-0968; Code 658758

Members Participating:

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

Members Absent:

Senator Jim Beall
Assembly Member Wendy Carrillo
Tina Wooton

Staff Present:

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

CALL TO ORDER AND WELCOME

Chair Lynne Ashbeck called the teleconference meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 8:05 a.m. and welcomed everyone. Chair Ashbeck announced that the Commission

would move to Closed Session to discuss personnel matter and would return to open session approximately 9:05am.

CLOSED SESSION

- **Government Code Section 11126(A) related to personnel**

The Commission met in closed session as permitted by law related to personnel.

CLOSED SESSION REPORT OUT

Chair Ashbeck reconvened the meeting and stated the Commission took no reportable action in closed session.

ROLL CALL

Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

GENERAL PUBLIC COMMENT

Poshi Walker, LGBTQ Program Director, Cal Voices, and Co-Director, #Out4MentalHealth, stated public comment that was submitted prior to in-person meetings was provided to Commissioners and made available on the back table for meeting participants to read. The speaker stated the need to ensure that public comment sent to staff prior to teleconference meetings is forwarded to Commissioners and made available to the public.

Joel Baum, Senior Director, Gender Spectrum, stated Gender Spectrum was selected as one of 35 organizations as part of the California Reducing Disparities Project (CRDP), which was created to address historical inequities and disparities in health and wellbeing, particularly mental health, for five populations – African American, Latinx, Asian and Pacific Islander, Native American, and LGBTQ communities.

Joel Baum asked the Commission to encourage the Governor and Legislature to take leadership towards addressing historical disparities, which have surfaced more than ever during the COVID-19 pandemic, by investing $2 million in resources that have been identified and any other additional funding to address the intersecting crises of the COVID-19 pandemic and the legacy of structural racism that exists in the mental health system.

Joel Baum suggested that the $2 million be used to support a strategy to create systems change to address these larger cultural issues, while, at the same time, addressing disparities and leveraging the incredible work that the CRDP infrastructure and the 35 community-based providers have done on this issue and that are now significantly impacted by COVID-19.

Josefina Alvarado Mena stated the 35 community-based providers funded through the CRDP sent a letter to the Governor on June 24th urging action to leverage the CRDP infrastructure to meet the overwhelming mental health needs emerging from the COVID-19 pandemic and the historical disparities experienced by individuals of color and the LGBTQ community. The speaker stated there has been no response to the letter to date.

Josefina Alvarado Mena stated the CRDP sent a second letter on September 8th to the Commission articulating that, while the data consistently confirms the disproportionate impact of COVID-19 on communities, the public investment of resources fails to match the disturbing upward data trend. State leadership is urgently needed to mitigate the agonizing need and interrupt the widening of mental health disparities among the most vulnerable populations. The speaker urged the Commission to invest the $2 million in resources identified and any other additional funding to address the currently intersecting crises of COVID-19 and the legacy of structural racism in the mental health system and other public systems to support a strategy to create the long-term system changes that are needed to systemically reduce disparities.

Cynthia Foltz, Program Director, Health Education Council, stated the Health Education Council is one of the CRDP projects focused on serving and reaching the Latinx community and one of the 35 community driven CRDP projects throughout California. The speaker echoed the comments of previous speakers that the CRDP has been serving one of the hardest culturally hit communities, the Latinx community, especially with COVID-19 and the impact it can have within mental health.

Cynthia Foltz echoed what was shared about the CRDP letter specifically urging the Commission to use these funds to continue to support the success of the CRDP community driven projects.

Sonya Young Aadam, CEO, California Black Women's Health Project, echoed the comments of previous speakers. The speaker stated they hear of actions being taken but do not see actions taking place across communities. The speaker implored the state to be intentional and to quickly invest additional resources into the 35 community driven CRDP projects and other community-defined projects.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), spoke in support of the comments made by the CRDP partners. The speaker asked the Commission to consider, in addition to the $2 million identified, using the funds left over from the Early Psychosis Intervention Plus (EPI Plus) Program. These funds should be prioritized for the current battle against COVID-19 in underserved communities. The speaker stated there are no more deserving organizations than the CRDP partners.

Lilyane Glamben, ONTRACK Program Resources, stated ONTRACK Program Resources is a member of the CRDP community. The speaker echoed the comments of previous speakers. The speaker stated the hope that the CRDP letter sent to the Commission will be addressed since the content of the letter reflects the comments made during public comment today. The speaker shared concerns about recent social injustices and what it does to emotional, mental, and psychological wellbeing.

Lilyane Glamben stated concern about the funding that was wasted on the Technology Suite Collaborative Innovation (Tech Suite) Project and what could have been done to address the digital divide already in existence. The speaker asked the Commission to address the digital divide with intentional focus especially during the COVID-19 pandemic.

Thomas Mahany, Executive Director, Honor for ALL, stated the hope that their letter sent to the Commission was included in the meeting packet. The speaker asked the Commission to formally adopt and submit a Governor's Office Action Request (GOAR) to Governor Newsom requesting him to issue a proclamation designating June 27th as Post-Traumatic Stress Injury Awareness Day to reduce stigma and resulting suicides. One tactic that can combat stigma is the use of non-stigmatizing language.

ACTION

1: <u>Approve August 27, 2020, MHSOAC Meeting Minutes</u>

Chair Ashbeck stated the Commission will consider approval of the minutes from the August 27, 2020, teleconference meeting. She asked for a motion to approve the minutes.

Commissioner Boyd made a motion to approve the August 27, 2020, meeting minutes.

Commissioner Alvarez seconded.

Public Comment

No public comment.

Action: Commissioner Boyd made a motion, seconded by Commissioner Alvarez, that:

- *The Commission approves the August 27, 2020, Teleconference Meeting Minutes as presented.*

Motion carried 9 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Berrick, Boyd, Brown, Gordon, and Tamplen, Vice Chair Madrigal-Weiss and Chair Ashbeck.

The following Commissioners abstained: Commissioners Bunch and Mitchell.

ACTION

2: <u>San Mateo County Innovation Plan</u>

Presenter:

- Cynthia Chatterjee, M.D., M.A., FASAM, Deputy Medical Director at San Mateo County Behavioral Health and Recovery Service

Chair Ashbeck stated the Commission will consider approval of $663,125 in Innovation funding for San Mateo County's Addiction Medicine Fellowship in a County/Community Setting Innovation Project. She asked the county representative to present this agenda item.

Cynthia Chatterjee, M.D., M.A., FASAM, Deputy Medical Director at San Mateo County Behavioral Health and Recovery Service, provided an overview, with a slide presentation, of the need, proposed project to address the need, and budget of the proposed Addiction Medicine Fellowship in a County/Community Setting Innovation Project.

Commissioner Questions

Commissioner Danovitch stated his support for this important initiative but was personally conflicted due to his concern about the fit between this proposal and the funding mechanism. Innovation funding is not the right mechanism. He stated Innovation is designed to try things that have not been tested whereas the proposed strategies are known to work. He stated Workforce, Education, and Training (WET) is the right funding mechanism for the proposed project.

Commissioner Brown asked if participants in the proposed project make a commitment to continue to work in the field.

Dr. Chatterjee stated the fellows are not legally bound to work in any addiction medical field.

Commissioner Brown asked if a physician who is part of this fellowship and gains the funding and the training is committed to stay in San Mateo County.

Dr. Chatterjee stated there is no binding or requirement that they stay within San Mateo County but 50 percent of the psychiatry residency program graduates do stay with the county. She stated the hope that they would stay at least within California. She stated usually doctors who do a fellowship program do it at a reduced salary because they are interested in this subspecialty.

Chair Ashbeck asked how many fellows the proposed project will fund and what percentage of time the fellows provide service versus learning.

Dr. Chatterjee stated the fellows will work full-time for the county. The proposed project will fund one fellow per year for the next three years.

Chair Ashbeck asked Dr. Chatterjee to comment on Commissioner Danovitch's comment about WET funding.

Dr. Chatterjee stated the proposed project is innovative in that there are no other county-sponsored addiction medicine fellowship programs in the country.

Commissioner Danovitch stated county sponsorship is not an innovation. Sponsorship means who pays. An accredited training program is by definition not an Innovation but is a well-established and accredited mechanism to train individuals, which is valuable and needed. Many fellowships do get public sector experience. He stated WET funds are a more appropriate mechanism to support pipeline development and workforce training. Part of the issue is that Innovation funds are meant to fund something over a short period of time to establish whether that works and then, based on that, assumes that the project itself has the ability to be self-sustaining. He asked about the mechanism to support the proposed project.

Chair Ashbeck asked if the county has pursued obtaining WET funding. She stated there is a reference in the staff report that WET funds may not be available for the proposed project.

Doris Estremera, MHSA Coordinator, San Mateo County Behavioral Health and Recovery Service, stated WET funding goes through the same community planning processes and has been allocated. There is no WET funding to fund this project. She stated the legislation defines Innovation as being able to be used across programs such as Prevention and Early Intervention (PEI) and Community Services and Supports (CSS) programs. The intent is to try the proposed project using Innovation funding to build a case to be brought before the stakeholders for WET funding.

Commissioner Alvarez stated she is also conflicted because of the requirements for Innovation, the availability of other funds to support such an initiative, and knowing that these fellowship programs are proven and will make a difference. She stated more broadly that this is a recurring challenge that the Commission is seeing. Many counties are using Innovation funding because there does not seem to be a bucket of resources that allows them to be creative with solutions to meet needs in their communities.

Commissioner Alvarez stated this is not the first time that Commissioners have been conflicted on whether something is innovative enough to meet the definition. There is no flexibility in funds that allows county mental health leaders to be creative. She asked fellow Commissioners if the proposed project should be supported because it is what the county says they need to better meet the needs of their community versus not supported because it does not meet the definition.

Commissioner Berrick stated the county could not use WET funds because those funds are already committed. In response to Commissioner Alvarez's question and Commissioner Danovitch's comments, he stated, if Innovation funds are allowed to go entirely towards unmet needs in counties, then that should be done consciously as either a modification of the MHSA or a modification of the Commission's rules and procedures. This has not been the Commission's precedent. He stated this seems like a needed, important, and well-reasoned project but approving it makes the statement that community needs surpass Innovation requirements.

Commissioner Mitchell agreed with fellow Commissioners and stated she is also conflicted. She asked how the participants will be selected for the proposed fellowship program.

Commissioner Alvarez asked if the county has tried to move CSS funds to support this initiative.

Ms. Estremera stated the community selected this project as part of the community stakeholder process. The county can get CSS support once the county can show that the proposed project will work and that it will create a pipeline.

Commissioner Bunch stated there is a difference between need and innovation. She stated the Commission has been inconsistent and has approved other plans that have not been that innovative.

Dr. Chatterjee stated the county has been assured by the accrediting organization that the proposed project is the first addiction medicine program to be sponsored by a county health system. She noted that San Mateo County cannot attract graduates from surrounding academic programs.

Commissioner Berrick stated another issue is there is no clear sustainability strategy. He stated concern that after the pilot period the county will come back to the Commission asking to continue this project because it has been successful. He stated he will support this pilot one time provided, at the end of the pilot, the project demonstrates to other counties that they could use their WET funds to develop a better pipeline and that San Mateo County makes it a priority to move this to funding sources other than Innovation.

Commissioner Gordon reinforced Commissioner Berrick's comment. He stated he did not want to see the proposed project being used as a precedent. He stated he has difficulty finding school psychologists but, if he sponsored a fellowship program to help train school psychologists, that would help get them in the school system. This is not an Innovation; this is a way to create incentives for individuals to agree to work in difficult situations and is therefore more appropriate for WET funding.

Public Comment

Devin Aceret, resident, San Mateo County, spoke in support of the proposed San Mateo County Innovation Project.

Andrea Crook. Advocacy Director, ACCESS California, a program of Cal Voices, stated their two fundamental questions for Innovation projects are if there was a meaningful community planning process and if it meets the requirements. The proposed project is not an innovative plan. Regarding what was written about the community planning process, the speaker stated time, money, and resources are invested when something is valued. The spirit and philosophy of the MHSA does not come through the written materials. Nothing is written about clients and family members. The speaker suggested going back to the basics to look at how the community is driving the decisions and programs.

Tiffany Carter, Statewide Advocacy Liaison, ACCESS California, a program of Cal Voices, stated, while San Mateo County has identified the statutory requirements, the proposed project does not appear to have been birthed by a robust community planning process of consumers, family members, and community members or to include the general standards reflected throughout the planning and development. There are also no details regarding the usage of peers within this plan aside from what is referenced about fellows working in conjunction with peer case managers. The speaker stated there is no funding for peers in the budget. While this plan sounds like it would be beneficial for those with co-occurring disorders, it does not reflect the mission and vision of the MHSA or the intent of Innovation opportunities under the MHSA.

Hector Ramirez, consumer and advocate, commented on the issues of Innovation and precedent. As someone who participates at the state level in selecting some of the WET funding, the speaker stated they have never seen a substance use disorder issue, which makes the proposed project innovative in that respect. The speaker suggested that the Commission provide technical assistance and ask the county to revise their project and come back at the next meeting.

Hector Ramirez stated there seems to be a variation in the way deliberation and standards are applied for projects such as the Technology Suite Project, which was approved despite significant stakeholder opposition and concern. The speaker stated, at that time, it was brought up the fact that it was not innovative since apps are not new.

Hector Ramirez stated there is a lack of clarity and confusion in how counties can communicate and bring proposals to the Commission. It is important to see applicable standards that the Commission utilizes when critiquing the necessary components of proposals for clarity. The speaker asked that legal counsel and the executive director work with Commissioners to establish those standards.

Hector Ramirez spoke in support of the proposed San Mateo County Innovative Project. It is significantly needed, especially now when many consumers do not have access to service providers.

Steve Leoni, consumer and advocate, agreed with Commissioner Danovitch’s concerns and stated Commissioner Berrick may have found a compromise for this conflict. The idea that the county is doing this themselves versus someone else might be a wafer-thin justification for Innovation status. It is also dangerously close to supplantation since other funds are available for this kind of training.

Steve Leoni stated one of the problems is that the WET component of the MHSA has almost sunsetted. The speaker stated it ran out of funds due to a lack of foresight of those who helped frame the MHSA. Turning to WET funds for this type of training is difficult. The speaker invited the Commission to collaborate with the California Behavioral Health Planning Council (CBHPC) to reinforce and expand the scope of the WET component, which is much smaller than it used to be.

Steve Leoni stated, if the Commission approves the proposed project, he would ask for a friendly amendment to the training protocol, consistent with the standards in the MHSA and WET, that there be materials and voices from diverse clients and family members included in the training on mental health recovery, which is different than

substance use recovery. The speaker stated the MHSA emphasizes a team approach. Having the fellows acquainted with those principles and those voices should help them play as team members.

Stacie Hiramoto stated they were on the original Innovations task force and noted that there has not been clarity from the start. The speaker thanked Commissioner Danovitch for insisting that Innovation projects be innovative. Innovations have not been carried out in a consistent way due to a lack of clarity. The speaker stated the hope that the Innovations Subcommittee will address this.

Steve McNally, a parent of a child with serious mental illness, and a member of the Orange County Mental Health Board, shared the story of a family whose 38-year-old son has spent half his life in hospitals because, as soon as his mental illness clears, he is released and his substance abuse takes over and he is put back in the hospital.

Steve McNally liked the idea of using the proposed project to help the community. The speaker stated it is unfortunate that the trailer bill language for the MHSA did not go through, which would have freed up Innovation funds for individuals to use for direct services. The speaker agreed with Commissioner Alvarez that the Commission can either pass something today that is not a precedent but is recognized as needed during COVID-19, or it can look back at many Innovation plans that have gone through that were not innovative.

Steve McNally stated the Commission could approve something like this and not make it a precedent, but, either way, the Commission should tighten up the MHSA language between the Commission, behavioral health directors, the CBHPC, and the local mental health boards because the only individuals who are being hurt in this are consumers and family members who are left out of the conversation. This is not a surprise.

Steve McNally stated peer certification could be an Innovation plan in California. It would not meet the rules but it cannot be done any other way. The speaker spoke in support of the proposed project because it is needed. The speaker stated it is better to err on the side of supporting a community need and putting in whatever language is necessary to make it not a precedent.

Poshi Walker agreed with Commissioners Danovitch’s and Berrick’s comments regarding need versus honoring the purpose and spirit of Innovations. The speaker stated psychiatrists have the least touch with consumers. The disparities that San Mateo County talks about in terms of meeting the needs of the most vulnerable populations will not actually be addressed.

Poshi Walker stated psychiatrists are a purely medical model and are medication-focused. While there is a need for psychiatrists, the proposed project is not a community-defined practice as were the CRDP partners the Commission heard from today. Those practices and other practices would address the underlying minority stressors that lead to substance abuse. The proposed project would not do that. Also, this practice is proven and therefore is not innovative.

Poshi Walker stated they disagree with Steve Leoni in terms of WET funding. This should be funded by WET funds. Counties have the option to use WET funds even though the statewide funding has expired.

Poshi Walker suggested requiring that the participants in the proposed project remain in the county for at least two years post-training. A 50/50 chance that they will stay is not good enough.

Commissioner Discussion

Chair Ashbeck asked about the community planning process and how the proposed project emerged from that conversation.

Ms. Estremera stated the county takes the community planning process seriously. She agreed that the writeup is one paragraph but noted that there is also a five-page appendix detailing the thorough process. The county takes a collaborative approach for Innovations planning. Ideas on ways to meet a need are gathered and then a committee made up of clients, consumers, commissioners, and community members selects an idea to become an Innovation project. She stated, in this case, the committee selected the proposed project out of 35 ideas gathered from the community stakeholder process. The county then held workshops to refine the details of the proposed project presented today.

Ms. Estremera stated moving direct treatment money into WET funds requires stakeholder support. The way to gain stakeholder support is by building a case. She stated the proposed project will allow the county to build that case and show that it is successful and sustainable in order to gain stakeholder support.

Commissioner Berrick asked if the county would be willing to share the program with small counties so they would have access and if there is a technical assistance component to support other counties to develop regional programs.

Dr. Chatterjee answered yes to both of Commissioner Berrick's questions. She stated one of the most exciting things about the project is that the county can be a model to other counties throughout California.

Chair Ashbeck asked for a motion to approve San Mateo County's County Addiction Medicine Fellowship Innovation Project.

Commissioner Alvarez moved the staff recommendation with note of Commissioner feedback presented today.

Commissioner Bunch seconded.

Commissioner Mitchell offered a friendly amendment to require the fellows to commit to remain in the county for a certain length of time after training.

Commissioner Alvarez agreed with the friendly amendment and suggested a one-year commitment after training, which is consistent with federal and state programs.

Commissioner Bunch agreed with the friendly amendment.

Dr. Chatterjee stated she will verify approval of that requirement from the American Board of Preventive Medicine, which sponsors the addiction medicine fellowships.

Commissioner Danovitch cautioned against well-intentioned remedies when implications are not fully understood. It may hamper the ability to recruit the right candidates. If the Commission votes to support the proposed project, it should rely on the county to do what is right for the program and/or have a more thorough process.

Commissioner Berrick agreed.

Commissioner Alvarez stated it is not necessarily a requirement for the fellows to stay in the county but that they stay in the field of addiction. The fellows would not be tied to a geographic commitment but to serve in a community with these needs.

Dr. Chatterjee agreed and stated the county selects individuals who want to work in public health.

Commissioner Brown stated he also feels conflicted about this project. There is a need and it seems to be a good program, but he stated he shared Commissioner Danovitch's concerns and Commissioner Berrick's concern about precedent. The project does not meet the criteria of Innovation as it stands.

Commissioner Brown stated Commissioner Berrick's way of getting around setting a precedent by only approving this project once also sets a precedent that the Commission will approve projects once. He stated it would be more prudent for the Commission to not approve the proposed project as it stands or offer friendly amendments which perhaps change the nature of it and may not be legally viable. He suggested asking San Mateo County to rework the project and look at ways to bolster the innovative aspect of the program. Although it is a worthy project, it is not appropriate for Innovation funding.

Executive Director Ewing agreed that it would be better to either vote on the recommendation as is or to ask staff to work with the county to address concerns. The county and staff need more clarity on what the Commission's approval is. Another option is to table it, work with the county, and bring it back.

Chair Ashbeck stated the motion on the floor has amendments to support technical assistance to other counties and to require the fellows to commit to serve the community for one year after training.

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

The Commission approves San Mateo County's Innovation Plan, including supporting technical assistance to other counties and requiring the fellows to commit to serve in the public sector for one year after training, *as follows:*

Name: County Addiction Medicine Fellowship

Amount: Up to $663,125 in MHSA INN funds

Project Length: Four (4) Years

Motion failed 3 yes, 7 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Berrick, and Bunch.

The following Commissioners voted “No”: Commissioners Anthony, Brown, Danovitch, Gordon, and Mitchell, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

The following Commissioner abstained: Commissioner Tamplen.

Chair Ashbeck asked Commissioner Brown to restate his recommendation.

Commissioner Brown stated the Commission would be happy to see this project again if it was retooled with effort to bolster and emphasize the innovative aspect of it. It is a worthy project but does not fit as submitted in the category of Innovation. There is always more need than resources available in the public sector but this should not stop the county from looking at alternatives to use WET funds or other ways to do this if there is no way to bolster the innovative aspect of the program.

Executive Director Ewing stated staff will work with the county to bring the project back at a future meeting.

10 MINUTE BREAK

ACTION

3: <u>Suicide Prevention Funding Allocation</u>

Presenter:

- Ashley Mills, Research Supervisor

Chair Ashbeck stated the Commission will consider approving allocation of up to $2 million to implement suicide prevention action items consistent with Striving for Zero: California’s Strategic Plan for Suicide Prevention, 2020 – 2025. She asked staff to present this agenda item.

Ashley Mills, Research Supervisor, provided an overview, with a slide presentation, of the background, initiatives, and budgets of the suicide prevention funding allocation. She stated the proposed funding allocations are as follows:

- Advance Local Strategic Planning and Implementation – budget not to exceed $535,000
- Increase Lethal Means Safety – budget not to exceed $200,000
- Accelerate Standardized Suicide Risk Assessment and Management Training and Technology Support – budget not to exceed $215,000
- Deliver Standardized Suicide Risk Screening Training – budget not to exceed $150,000
- Create a Suicidal Behavior Research Agenda and Action Plan and Begin Implementation – budget not to exceed $500,000

Public Comment

Poshi Walker stated, while they support the suicide prevention work, they urge the Commission to require that any funding that is allotted be done on a competitive basis and not sole-sourced. It is important to fund local entities and to be transparent about the selection process. The speaker stated the Executive Director should not be able to enter into $2 million of contracts without Commissioner or public response. This precedent needs to change.

Stacie Hiramoto agreed with the previous speaker. The speaker stated there is a rule in the Commission's rules and procedures that does not allow for sole-source contracts in excess of $99,000. The speaker asked how to know that these allocations will affect or be utilized for individuals who serve underserved communities. In order to reduce disparities for racial and ethnic communities and LGBTQ communities, it must be done with intention.

Stacie Hiramoto stated Native American youth have consistently high rates of suicide – much higher than any other group – yet specific efforts were not directed at this group. At this point, the Latinx population is the largest in California, yet they are the least likely to have access to mental health care. She stated, unless strategies are targeted, these efforts will continue to serve non-Latinx white individuals, leaving the majority of Californians behind. The speaker said there are years of penetration data to confirm this statement.

Sonya Young Aadam stated the hope, as the distribution of funds is determined, that there will be an equity lens and that communities with inordinate impact would be elevated and considered for this funding. The speaker stated they were surprised to see $500,000 dedicated to the data. Giving 25 percent of the funding to data seems like a missed opportunity to address work that could be done on prevention and early intervention on this issue.

Sonya Young Aadam stated, while the adjusted rate of suicide in the black community is approximately half the overall rate in the United States, this data is not current given the COVID-19 pandemic, which has exacerbated stress, anxiety, and suicide rates. There is a significant disparity in black suicide rates among adolescents and young adults. The suicide rate of black men is more than three times that of black women, and a higher level of black youth have attempted suicide compared to the broader population. The speaker encouraged the Commission to prioritize disparities intervention in the distribution of funding.

Tiffany Carter echoed the comments of the previous speakers urging a competitive process, a focus on reducing disparities, and that California projects fully benefit Californians.

Lilyane Glamben echoed the comments of previous speakers. The speaker asked that whoever gets this contract or contracts be culturally sophisticated in how suicide is understood.

Hector Ramirez noted the new report by the Center for Disease Control (CDC) on frequent mental health distresses. The speaker stated the main finding of the report is

that adults with disabilities reported mental distress 4.6 times as often as adults without disabilities. Prior to COVID-19, the CDC estimated that the rate of disability in the general population was one-in-four. That rate of disability has significantly increased due to the COVID-19 pandemic, particularly for those individuals who are dealing with mental health crises.

Hector Ramirez admired the work of this Commission but emphasized the need to recognize the role that disabilities often play within the mental health community – not only to ensure that services and avenues are Americans with Disabilities Act (ADA) accessible, but also to consider that individuals with disabilities are a population in themselves since they deal with generational issues.

Commissioner Questions and Discussion

Chair Ashbeck asked if the funding can be shifted within the categories to accommodate the work.

Executive Director Ewing stated the $2 million to be spent over two years is structured with a cap in each of the categories. Amounts above the cap would need to be approved by the Commission. He stated Senator Ramos has a bill on the Governor's desk to establish a formal Office of Suicide Prevention that will then transition the Commission's efforts using the $2 million over to the California Department of Public Health (CDPH).

Chair Ashbeck asked for a motion to approve the suicide prevention funding allocation.

Commissioner Anthony moved the staff recommendation as presented.

Commissioner Danovitch seconded.

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

- *The MHSOAC allocates funding and authorizes the Executive Director to enter into contracts to support the five (5) initiatives with the key activities presented in aggregate not to exceed $2,000,000.*

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

The following Commissioners voted "Yes": Commissioners Anthony, Berrick, Brown, Bunch, Danovitch, Gordon, Mitchell, and Tamplen, and Chair Ashbeck.

ACTION

4: <u>Statewide Virtual and Digital Strategy for Mental Health</u>

Presenter:

- Toby Ewing, Ph.D., Executive Director

Chair Ashbeck asked Executive Director Ewing to introduce this item in the staff report and tabled the presentation and discussion of this item to the next meeting.

INFORMATION

5: Staff Report

Presenters:

- Toby Ewing, Ph.D., Executive Director, MHSOAC
- Dr. Dawnté Early, Chief of Research and Evaluation
- Ashley Mills, Research Supervisor

Chair Ashbeck stated staff will report out on projects underway, county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission. She asked staff to present this agenda item.

Executive Director Ewing presented his report as follows:

ADA Compliance

The remediated logo has been aligned with ADA color contrast compatibility and the gradient element was replaced with a non-gradient sun detail to ensure future usability of the logo across all applications.

The website revision for ADA accessibility continues with guidance from consultants and stakeholders.

Commissioners and Personnel

Vice Chair Madrigal-Weiss was reappointed to the Commission by the Superintendent of Public Instruction for a new three-year term.

Kayla Landry has been promoted to Health Program Specialist and will be working on a number of grant projects.

Sarah Turner has joined the staff and will be working on the Youth Drop-In grants work.

Committees

Scheduling challenges have postponed the next Client and Family Leadership Committee (CFLC) meeting.

County Innovation Plans

Staff is working with counties to determine an estimate of Innovation dollars that will revert in order for the Commission to have an opportunity to review them all by the end of the fiscal year.

Staff is following up on an Innovation that the Commission approved years ago in Solano County that focused on strengthening the community engagement process and tailoring resources for different demographic groups in those counties. Solano County focused on the Latino, Filipino, and LGBTQ communities. The county has outreached to 30 counties that are interested in exploring opportunities to replicate that work consistent with the Commission's comments that individual Innovations have the opportunity to go to scale.

COVID-19 Response

There were two anomalies this fiscal year: The Commission's ability to use $2 million to support suicide prevention and $2 million to support a response to the COVID-19 pandemic. Staff is sending out a survey to counties, providers, and stakeholders on opportunities to take best advantage of the funding. Staff is interviewing partners, including stakeholder grantees, for guidance on how to best use the funding with the intent to give the Commission opportunities to explore at the October meeting.

Data Briefs and Videos

The Commission is working with community partners to develop videos to be posted on the website about prevention issues.

A series of briefs will be developed on current issues following conversations the Commission has had over the past year about the value of that work. He asked Dr. Early to give the update on the brief series.

Dr. Dawnté Early, Chief of Research and Evaluation, stated staff has heard from Commissioners and stakeholders during data forums and when she presented the revised data dashboards to the County Behavioral Health Directors Association of California (CBHDA) and to the Cultural and Linguistic Competence Committee (CLCC), that, in addition to these dashboards, there is a need for context about what the Commission is learning and what the data means.

Dr. Early stated, in response to feedback, the Commission will be doing a series of data briefs on current issues. The data briefs are expected to come out in the coming months. They will include interpretations and understanding of what is being learned, which will help stakeholders and advocates to access and use this data. She added that data briefs and dashboards will also be created about what is being learned in regards to the Commission's policy work.

Outreach

Executive Director mentioned that staff supported and participated in a Native American Youth Mental Health Conference, the Breaking Barriers Conference, and the Human Service Interoperability webinar with community partners.

Project Updates

Workplace Mental Health

A community engagement opportunity was held on the Workplace Mental Health Project. Executive Director Ewing thanked Vice Chair Madrigal-Weiss and Commissioner Bunch for their efforts.

The Executive Director and the consulting psychologist met with an employment and training subcommittee established by the Department of Rehabilitation (DOR) involving DOR stakeholders.

Rules of Procedure

Executive Director Ewing stated, on September 14th, the Chair and Vice-Chair held a public meeting with stakeholders on the Commission's rules of procedure. Amendments to the rules of procedure, based on stakeholder input, will be presented at a future meeting.

Statewide Virtual and Digital Strategy for Mental Health

This proposal, which was tabled to the next meeting, was meant to recognize that the state has put opportunities in place during COVID-19 for providers to use digital and virtual mental health tools. Approximately 80 percent of mental health care has moved towards digital strategies. Outside of its emergency rules, the state has not adopted a strategy to support access to care through digital and virtual strategies including addressing digital divide issues.

The Commission would like to engage the administration, the Legislature, and communities to think strategically about, outside of the COVID-19 emergency, how a robust digital and virtual mental health strategy would look for California and how the lessons learned from the Technology Suite Project can be beneficial to be more strategic in how to support access to care through those tools when and where they are appropriate. This item will be put on the October meeting agenda for an in-depth discussion.

Public Comment

Hellan Roth Dowden, President and CEO, Teachers for Healthy Kids, stated, regarding the virtual and digital strategy, Teachers for Healthy Kids and the California Association of School Psychologists are requesting that, as part of the COVID-19 response funding, the Commission set aside funding for training school-based psychologists and mental health workers, who were not included in the Department of Health Care Services (DHCS) possibility of training grants since the county does not consider them to be providers.

Hellan Roth Dowden stated school psychologists have direct access to children who need mental health support. One of the big issues is a lack of hardware, but schools have given computers to children so there is a safe and effective way of providing the service. What is required now is additional training for these mental health workers at the school.

Stacie Hiramoto asked that materials be provided to the community prior to the engagement about the virtual and digital strategy. It is difficult for stakeholders to give meaningful public comment without the necessary information.

Stacie Hiramoto asked if the letter sent to the Commission from the CRDP partners is being handled by staff or is being sent to the CLCC. The speaker asked for confirmation that the Commission is taking the letter seriously.

Sally Zinman, Executive Director, California Association of Mental Health Peer-Run Organizations (CAMHPRO), suggested that, regarding the virtual and digital strategy, more than 50 percent of the plan should address the inability and lack of accessibility of

individuals in the public mental health system to communicate in this environment of virtual meetings. The speaker stated the disparity is glaringly exposed in this digital and virtual environment.

Sally Zinman stated many individuals in the public mental health system have huge barriers and challenges in communicating because of the virtual vehicles of communication. Also, training will be required for individuals who are new to this technology. The speaker noted that it is difficult to read agendas and meeting documents on a cell phone.

Chair Ashbeck asked Executive Director Ewing to comment on the Commission's response to the letter from the CRDP partners.

Executive Director Ewing stated staff has drafted a response to the letter that lays out some of the things that the Commission is doing and is working with the chair to finalize it. There is an issue in the letter about the Commission adding its voice to elevate the issues that are raised around disparities.

Executive Director Ewing stated his appreciation that the CRDP letter referenced the letter the Commission wrote to the Governor earlier this year highlighting some of those challenges. Staff has presented to the CLCC information on the broad array of strategies the Commission is deploying in order to address issues raised by not just disparities but the COVID-plus-disparities challenges and how the COVID-19 pandemic has made these challenges more difficult particularly in the context of racial justice and white supremacy.

Executive Director Ewing stated, as part of the $2 million COVID-19 response funding, the Commission is surveying the counties who are core partners in this and working with contract holders to better understand the best opportunities to leverage that funding.

Executive Director Ewing stated staff is doing additional work trying to understand the potential funding that is available in Innovation, for example, to avoid the crunch in terms of the workload at the end of the fiscal year, but also to talk about helping to shape the opportunities that counties see in terms of how they use Innovation dollars.

Executive Director Ewing stated part of the delay in providing a response to the letter from the CRDP partners is so much of that work is underway and the discussion was to send a response to the letter while the work is being done or to wait to report the outcomes of that work. The bottom line is that there is a draft letter that staff is working with the chair to finalize. He stated a response to the letter will be sent out as soon as possible.

Executive Director Ewing stated it is not just about sending a response letter. It is also about how the Commission, as evidenced by some of the earlier conversation today, has engaged a nationally-recognized consultant on racial equity to work with staff to look at the Commission's internal and external practices. Staff is still assessing, with the leadership of Commissioner Mitchell through the CLCC, where the Commission is part of the problem, how that can be addressed, and how the Commission can be a better part of the solution. A response letter plus all of the other strategies that can be brought

to bear to address the dual issues of COVID and disparities will soon be provided to the CRDP partners.

ADJOURNMENT

There being no further business, the meeting was adjourned at 12:26 p.m.

AGENDA ITEM 2

Action

October 22, 2020 Commission Meeting

Schools and Mental Health Project Report

Summary: The Mental Health Services Oversight and Accountability Commission will consider adopting "Every Young Heart and Mind: Schools as Centers of Wellness."

Background:
The Schools and Mental Health Project began in late 2016 to explore how school settings can be better used to meet the mental health and wellness needs of children, youth, and families. Since then, the Commission has examined promising models and conducted extensive outreach through public hearings, community forums, meetings, school site visits, and focus groups. The Commission has spoken to youth, educators, school administrators, school and community mental health providers, cultural brokers, and community leaders. This engagement strategy was designed to connect to the racial-ethnic diversity of California's K-12 students, as highlighted in the policy brief "Diverse Community-Defined Solutions to Promote the Wellbeing of Students."

Over the course of this project, the Commission seized emerging opportunities to advance a school mental health agenda. In 2017, the Commission allocated SB 82 Triage grants to incentivize school-county partnerships to provide a continuum of services and supports on school campuses. More recently, the 2019-20 budget established the Mental Health Student Services Act (MHSSA) to fund partnerships between education and county mental health departments through a competitive grant program.

The culmination of the project was a draft report released for public comment on July 17, 2020. The subcommittee met virtually on July 27, 2020 to hear feedback and consider input on the draft report. The subcommittee directed staff to make revisions as directed by the Project Chair, and the subcommittee voted unanimously to submit a revised draft report to the Commission to consider for adoption.

Subcommittee members:

- Commissioners Dave Gordon (Chair), Gladys Mitchell, Mara Madrigal-Weiss, and Ken Berrick.

Presenter:

- Kai LeMasson, Senior Researcher and Project Staff Lead

Enclosures(3): (1) Report "Every Young Heart and Mind: Schools as Centers of Wellness," (2) Policy Brief "Diverse Community-Defined Solutions to Promote the Wellbeing of Students," and (3) Written public comment.

Handout: None.

Proposed Motion: The MHSOAC adopts “Every Young Heart and Mind: Schools as Centers of Wellness.”

DRAFT REPORT

EVERY YOUNG HEART AND MIND: SCHOOLS AS CENTERS OF WELLNESS

OCTOBER 2020

About the Commission

The Mental Health Services Oversight and Accountability Commission is an independent state agency created in 2004 by voter-approved Proposition 63, the Mental Health Services Act. The 16-member Commission is composed of one Senator, one Assemblymember, the State Attorney General, the State Superintendent of Public Instruction, and 12 public members appointed by the Governor. By law, the gubernatorial appointees represent different sectors of society, including individuals with mental health needs, their family members, law enforcement, education, labor, business, and the mental health profession.

COMMISSIONERS:

LYNNE ASHBECK, *Chair; Senior Vice President of Community Engagement and Population Wellness, Valley Children's Healthcare*
MARA MADRIGAL-WEISS, *Vice Chair;* ***Schools and Mental Health Subcommittee Member****; Director of Wellness and Student Achievement, Student Services and Programs Division, San Diego County Office of Education*
MAYRA E. ALVAREZ; *President, Children's Partnership*
RENEETA ANTHONY; *Executive Director, A3 Concepts LLC*
JIM BEALL; *California State Senator, District 15*
KEN BERRICK; **Schools and Mental Health Subcommittee Member**, *Chief Executive Officer, Seneca Family of Agencies*
JOHN BOYD*, Psy.D.; Chief Executive Officer of Mental Health Services, Sutter Health Care*
BILL BROWN; *Sheriff, County of Santa Barbara*
KEYONDRIA BUNCH, Ph.D.; *Clinical Psychologist, Emergency Outreach Bureau, Los Angeles County Department of Mental Health*
WENDY CARRILLO; *Assemblymember, District 51*
ITAI DANOVITCH, M.D.; *Chair, Department of Psychiatry and Behavioral Neurosciences, Cedars Sinai Medical Center*
DAVID GORDON; ***Chair of the Schools and Mental Health Subcommittee****, Superintendent, Sacramento County Office of Education*
GLADYS MITCHELL; **Schools and Mental Health Subcommittee Member**, *Former Staff Services Manager, California Department of Health Care Services and California Department of Alcohol and Drug Programs*
KHATERA TAMPLEN; *Consumer Empowerment Manager, Alameda County Behavioral Health Care Services*
TINA WOOTON; *Consumer Empowerment Manager, Santa Barbara County Department of Behavioral Wellness*

TOBY EWING, Ph.D.; Executive Director
BRIAN SALA, Ph.D.; Deputy Director of Evaluation and Program Operations
DAWNTÉ R. EARLY, Ph.D., M.S.; Chief of Research and Evaluation
KAI LEMASSON, Ph.D.; Senior Researcher and Schools and Mental Health Project Lead

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

October 7, 2020

Dear Governor Newsom and members of the Legislature, county and school officials, and the people of California,

The Commission in 2016 began to explore the mental health needs of California's K-12 students, with the knowledge that mental health is integral to academic success and lifelong prosperity and wellbeing. We discovered both a growing need and a growing response from professionals and community members. During this time, the State also responded, in part due to this very public process, by investing in partnerships between schools and county behavioral health departments, which is the essential infrastructure for durable and effective strategies.

As the Commission was finalizing this report, the COVID-19 pandemic hit, then the economic recession, and then the series of events that elevated for everyone the tragically enduring inequities in our communities.

The pre-existing student mental health crisis has grown deeper and more widespread – and at the same time less visible to schools and communities. Remote learning and social distancing have increased isolation and reduced student access to peer and adult support. Unemployment and economic uncertainty are straining families and raising concerns about an unseen surge of domestic violence and child abuse.

These impacts are compounded for children of color and their families, for whom long-standing inequities worsened as COVID-19 and the job losses hit them harder, and conflicts with police and other racial injustices inflicted more stress, trauma and anxiety.

Amid this multitude of crises, the wellbeing and resilience of students and their families are more important than ever. The Commission's report *Every Young Heart and Mind: Schools as Centers of Wellness* proposes a way to bring healing to our students, families, and schools in 2021 and beyond.

Now is the time to build upon the many local collaborations between health and education agencies to establish schools as centers of wellness and healing – where social and emotional learning is a core mission; youth are engaged as mental health champions and leaders; and families, including younger children, have access to mental health supports.

To achieve this vision the Commission offers the following recommendations:

- The State should establish collaborative leadership among its agencies, local governments, and local educational agencies to develop a statewide strategy for making schools centers of wellness and healing, with a clear focus on prevention and intervention as early as possible for those birth to five years old.
- The State should make a multi-year foundational investment that increases services while also building the necessary infrastructure of programming, data management, workforce and sustainable funding models so all schools are centers of wellness and healing regardless of the economic cycle.
- The State should provide technical assistance to schools, health agencies, and other community partners to strengthen capacity to integrate local resources and service systems, adapt proven practices and drive continuous improvement.

While the State has many urgent needs, the mental health crisis, if unaddressed, will have implications for a generation. The consequences – trauma and anxiety, diminished health and wellbeing, lost wages and economic security, and higher demands on social and health care systems – will continue and could even grow long after a vaccine vanquishes COVID-19 and the economy recovers.

In these times, meeting the mental health needs of children and families is not a discretionary act, but rather an essential one. At the same time, we know what to do. Emerging local models, partnerships, and entrepreneurial community leaders are showing us the way. If we find the courage and the commitment as a State, we will find the resources.

The Commission will do all it can, in partnership with others, to advance the vision, principles and recommendations in this report.

Sincerely,

David W. Gordon
Superintendent of the Sacramento (CA) County Office of Education & Commissioner
Chair, MHSOAC Subcommittee on School Mental Health

Acknowledgements

The Commissions expresses gratitude to all the stakeholders who contributed their professional knowledge and experiential wisdom to this report. We sincerely thank the students and parents who courageously shared their personal stories and lived experiences with the Commission. We also thank those individuals—teachers, staff, counselors, psychologists, social workers, school administrators, community mental health providers and leaders—who shared with the Commission their challenges as well as successes in providing a continuum of mental health services to students.

This report represents a culmination of this collective effort. Special acknowledgements are given to the Commission's Subcommittee, leadership and staff, and specifically to Anna Naify, Katherine Elliot, and Melissa Huerta for their contributions to this report. A special acknowledgement is also given to Jim Mayer, Chief of Innovation Incubation, who provided expert guidance and was instrumental in editing and bringing this report to fruition.

We thank the many state and local leaders who supported this work, with special thanks to Hellan Dowden, Elizabeth Estes, Michael Lombardo, Brent Malicote, and Monica Nepomuceno for their generous support.

This report is dedicated to every student whose trauma and mental health needs have been unmet, misunderstood, stigmatized or punished. We lift them up with the hope that this ongoing work will bring healing to their lives, families, schools, and communities.

TABLE OF CONTENTS

Executive Summary

The wellbeing of California's children is vital to the future of the state. Yet across California's schools and communities, a sobering crisis burdens the young. Trauma and adversity are undermining the ability of many students to learn.[1] Bullying and harassment are common.[2] Anxiety, depression, and suicidal behavior are on the rise.[3]

Student Wellness in California

Depression Symptoms

> 1 in 3 high school students report feeling chronically sad and hopeless.

> More than half of all LGBT students report feeling chronically sad and hopeless.

Suicide Ideation

> 1 in 6 high school students report having considered suicide in the past year.

> 1 in 3 LGBT students report having considered suicide in the past year.

Amid this crisis, there is cause for hope, even confidence. School districts and counties are working together to promote awareness, provide training, increase staffing, and leverage community partnerships. Social-emotional learning is being elevated as key to academic success. Youth are courageously stepping up to guide mental health programming and provide support to their peers. The State has buoyed this optimism with additional financial investments before COVID hit.

But the pandemic has increased the risk factors, the recession is shrinking revenues, and the spotlight on racial inequities and social justice has amplified the urgency.

The State must act decisively to establish the leadership structure to support these local efforts and provide the technical assistance required to make schools "centers of wellness and healing." This school-based approach will allow communities to connect to families with mental health needs, reach younger children at home before they start school, and further empower youth to develop the resiliency required in these times. This strategic state support also is needed to build financially sustainable local partnerships designed to become more effective over time.

The Mental Health Services Oversight and Accountability Commission reached these conclusions after more than three years of engagement with parents, youth, teachers, providers and community members, which produced a deep understanding of the mental health needs of students, and the promising efforts already underway in schools and communities. The Commission was inspired by the tireless efforts of professionals and community members who recognize the needs of the "whole child" and realize that mental, social, and emotional health are integral to school success.

To advance this shared vision – and in recognition that communities throughout California are entrepreneurially working to meet these needs – the Commission developed principles to inform and align the actions of everyone working to develop healthy children. The Commission also developed specific recommendations, detailed below, for how the State can exercise its leadership obligations to develop a coherent and durable infrastructure for school mental health.

A comprehensive look at an unfolding tragedy – and a concern for all Californians

Mental health needs can begin long before children enter school. Early exposure to trauma and chronic stress derails healthy development, and without proper intervention can lead to lifelong learning and mental health struggles.[4]

Students of color are at heightened risk. They disproportionately carry to school the burden of poverty, racism and discrimination, parental incarceration, exposure to violence and intergenerational trauma.[5]

Nationwide incidents of hate, racial injustice, and religious intolerance are deepening that burden. Federal immigration policies have spread fear of deportation among immigrant families and created ongoing anxiety for the one-in-eight students with an undocumented parent.[6,7]

Students are manifesting symptoms in ways that can be misunderstood by adults—distraction, disobedience, and disengagement. Exclusionary discipline practices disproportionately affect African American and Native American students, and students in foster care who are being pushed out of school at alarming rates for behavior that often reflects underlying trauma and mental health needs.[8]

These unmet mental health needs are a major barrier for learning for many of California's 6.2 million K-12 students.

These considerations elevate the importance of schools as a prime venue for promoting healthy development through prevention and early intervention to achieve equity. Schools are central to the lives of children – not just their education, but their lives – and central to promoting wellness, and accurately identifying and quickly responding to trauma and emerging mental health needs.

Schools also are the bedrock of the community and the place where children spend most of their time outside of their homes. And families look to educators to be role models for their children and provide nurturing care, guidance and support. But teachers and other school staff can only do so in the context of family trust, strong partnerships and adequate training and support.

School-based mental health professionals—school psychologists, counselors, social workers and nurses—provide that training and support, and are the bedrock of the school mental health team. But there are not enough of these professionals to respond to the student mental health crisis.

The needs are great and require collaboration across sectors, engaging the health care system and community providers. Through collaboration schools can become centers of wellness and healing where more mental health services can be provided on school campuses and where families can be empowered through continued learning and support. Schools can also become safe spaces where children can thrive and reach their full potential, a vision that youth and families strongly urged the Commission to support.

The Governor and the Legislature have incentivized stronger partnerships between local education agencies and county behavioral health departments.[9] Trainings and workshops on student mental health and wellness are widespread, and thousands gather for annual state conferences to learn and share information.[10,11] At the local level, schools and community partners have created integrated solutions to local challenges.

Momentum is building for involving youth leadership in designing youth-centered programs and systems.[12,13] This energy, excitement and momentum can be harnessed by schools and communities, provided youth engagement is based on active participation and decision-making.

These impressive efforts should be focused on a common, overarching goal – **to promote the wellbeing and success of every child, regardless of where they start**.

This goal prioritizes the imperative to reduce disparities and to explicitly address the implicit bias in institutions, policies and practices that have limited the potential of some Californians generation upon generation.

The following recommendations, detailed in Chapter VII, are essential to achieving this overarching goal. All Californians can contribute to their advancement—lawmakers, educators, mental health providers, youth, parents, and concerned citizens.

Recommendations

1. State Leadership

The Governor and the Legislature should establish a leadership structure dedicated to the development of schools as centers for wellness and healing. The Governor's office should lead this effort, in partnership with the State Board of Education and Superintendent of Public Instruction, with operational leadership from the Department of Health Care Services, the California Department of Education and other agencies that can make a contribution. The leadership structure should work closely with the K-12 Statewide System of Support.[14] The operational leadership should have dedicated staff charged with developing and implementing a state-level strategy to support community-level partnerships.

2. State Investment

The State should make a significant investment to establish schools as centers for wellness and healing. This foundational investment will require a multi-year commitment to developing the model programs, the data and management systems and the workforce. It will require allocating more funding for services, and developing a sustainable funding strategy that links and leverages related funding and existing services, as described below.

3. State-supported Capacity Building

The state leadership structure must help counties and school districts develop the capacities required to integrate resources, adapt evidence-based practices and manage for continuous improvement. The capacity building efforts should include these elements:

a. Model / program development. The K-12 System of Support should be expanded and funded to provide this technical expertise to schools, and find ways to enhance preventive support to early learning programs that serve children ages birth to five.

b. Data and management. The K-12 System of Support should facilitate the local capacity for data and cross-system management with education and mental health systems, and facilitate ongoing policy evaluation at the state level.

c. Workforce. OSHPD should be directed to work with county behavioral health and the K-12 System of Support to identify specific school-based workforce needs and allocate future fiscal year funding to students and educational providers.

Design Criteria

The system should be engineered to meet the following criteria:

- Sustainability
- Outcome-oriented
- Continuous improvement

d. Sustainability. The Governor and the Legislature should make a multi-year funding commitment for services, while also investing in system capacity and system sustainability. Among the considerations:

- Structure one-time funds to ramp up spending and then be reduced as ongoing funds are incorporated or created.
- The State and K-12 System of Support should work together to develop and test options for braiding existing funds. The State and communities must share the objective of achieving financial sustainability and pursue opportunities to create more flexibility from existing funds or to develop new funding sources.

Guiding Principles

To guide the system-level changes that are underway – and need to be accelerated – the Commission developed principles that distill the knowledge, wisdom and experience that are needed to fortify school mental health. These guiding principles are intended to inspire and inform the myriad of decisions being made by state and community leaders.

Guiding Principle 1. Each Child Should be Emotionally and Intellectually Nourished
A commitment to equity and reducing disparities is central to a school mental health strategy.

Guiding Principle 2. Schools Should Be Centers of Wellness and Healing
Students feel safe, valued, and respected, and have positive, healthy relationships with adults and students.

Guiding Principle 3. Health and Education Must Join Together
School-community-health system collaboration is essential to support student and family wellness.

Guiding Principle 4. Prevention and Early Intervention Must Be Prioritized
Healthy mental, emotional, and behavioral development in early childhood is foundational for school readiness and success.

Guiding Principle 5. All Youth and Families Must Be Engaged and Have Ownership
Youth and families have leadership roles at all levels of decision-making and service delivery.

Guiding Principle 6. Sustainable Funding, Continuity and Collaborative Leadership
State leaders are responsible for aligning policies, funding, training and technical assistance to local communities and schools.

I. The Journey: "Our Children Live Crisis-Filled Lives"

The Mental Health Services Act (MHSA), through its Prevention and Early Intervention (PEI) component, promotes strategies to reduce the negative outcomes that may result from untreated mental health needs—suicide, unemployment, incarceration, homelessness, school failure or dropout, removal of children from their homes, and prolonged suffering. The Act also calls for the Commission to support the positive educational outcomes that can result from tailored mental health interventions.

In response to this charge, the Commission embarked on the Schools and Mental Health Project with the recognition that mental wellness is necessary for children to succeed in school. The project is directed by a subcommittee chaired by Commissioner and Sacramento County Schools Superintendent Dave Gordon. Through this project, the Commission set out to promote student wellness, encourage early identification, and support access to a continuum of school-based mental health services and supports.

The project began with a subcommittee meeting in December 2016 hosted by the Greater Sacramento Urban League in a neighborhood where approximately 28 percent of residents live in poverty and more than 50 percent speak a language other than English at home. The Commission chose this location to better understand the challenges of raising and educating children in communities struggling with poverty, unemployment, and other societal problems. A diverse group of parents and educators came together to discuss children's mental health and how schools can better support wellness and school success in their neighborhood. Participants emphasized the importance of engaging families and supporting students, especially in low-income, diverse communities – through education and empowerment, destigmatizing mental health, building family-school partnerships, and providing family advocates to assist families in need. Stakeholders specifically spoke to the "vulnerability of children of color" and poor mental health outcomes as a result of school disciplinary practices, cultural insensitivity and a host of environmental factors that place these children at risk.

On the same day, the Commission visited a neighborhood elementary school that was responding to the mental health needs of young students with a dedicated school social worker and a school climate initiative. Many of the students were exposed to poverty, housing and food instability, neighborhood and family violence. They often arrived at school unable or unprepared to learn. Laura Lystrup, an educator and executive director of a Special Education Local Plan Area (SELPA), observed that an increasing number of children in her district were struggling and appear to have been exposed to trauma. "Our children live crisis-filled lives," she said.

Faced with significant adversity, children may disengage or act out in the classroom. However, Lystrup noted, children who are academically on target do not qualify for state-funded Educationally Related Mental Health Services (ERMHS) through Special Education. Therefore, schools are less able and likely to intervene.

Following that first meeting and school visit, the Commission conducted extensive outreach through public hearings, meetings, site visits, and focus groups. (Appendix A inventories these

activities.) The Commission made a concerted effort to reach as many constituencies as possible and deliberately sought different perspectives to understand how school settings can be better used to meet the mental health and wellness needs of children, youth and families.

Listening to Families and Community Members

The Commission talked to youth, educators, school administrators, school and community mental health providers, cultural brokers, and community leaders. The engagement strategy was designed to connect to the racial-ethnic diversity of California's K-12 students. Thus, the Commission hosted several parent meetings in Spanish. Two of these meetings were near California's southern border and were facilitated by Commissioner and Subcommittee Member Mara Madrigal-Weiss to understand the unique challenges of families living in immigrant communities.

The Commission concentrated attention on student groups that were more likely to have poor educational outcomes. Community forums and focus groups explored the needs of African American, Asian American, and gender diverse students. Commission staff also worked closely with cultural brokers in the Native American community, who generously shared the results of their engagement with Native families regarding children's mental health. This project also tapped the expertise of a diverse group of youth who comprise the Commission's Youth Innovation Project Planning Committee. The committee members represent 12 counties and are developing youth-led solutions to the mental health challenges facing their peers.

Seizing Opportunities

In the course of this journey, the Commission seized emerging opportunities to advance a school mental health agenda. In 2013, the Legislature enacted SB 82 and entrusted the Commission to administer Triage grants.[15] The Commission allocated the grants to incentivize school-county partnerships to provide a continuum of services and supports on school campuses. More recently, the 2019-20 budget established the Mental Health Student Services Act (MHSSA) to fund partnerships between education and county mental health departments through a competitive grant program.[16] The Commission also partnered with the California Department of Education (CDE) to promote school mental health activities. That partnership is developing a school mental health toolkit and a statewide learning community to encourage its use.

In addition, the Commission's project has been informed by other statewide entities providing leadership in school mental health training, technical assistance and policy. These entities include the California Department of Education's Student Mental Health Policy Workgroup, Breaking Barriers, the California County Superintendents Educational Services Association (CCSESA), the California School-Based Health Alliance (CSBHA), the California PBIS Coalition Network, the Sacramento County Social and Emotional Learning Community of Practice, and CalMHSA to name a few. Many others such as the California Children's Trust are working on children's mental health policy to bring about systems change.

The Collective Wisdom

The bedrock for this report is the lived experience of children, youth and families; their teachers, health and mental health providers; and, other practitioners and community leaders seeking to reduce risk and increase resiliency for vulnerable Californians. From their thoughtful insight and candid guidance, six themes emerged:

1. Childhood Adversity Clouds the Future of Many Young Californians

Across stakeholder groups, Californians were concerned about the pervasiveness of adversity in their communities, and its impact on child wellbeing and the increased risk of mental health needs. This concern is understandably strongest in communities of color dealing with disproportionate poverty, violence, housing and food instability, and intergenerational and immigration-related trauma, including deprivation or violence during migration or border crossings and the fear of family separation.

Here's how one mother described her experience at an African American Community Forum in February 2019:

"My son had severe trauma and many transitions. An absent father, instability in the home, homeless from ages 1 to 6…moving frequently, house to house, city to city. He would cry a lot. He lacked social skills and did not understand his peers. What calmed him down was one teacher that took the time to understand my son. And she would hug him when he needed it."

The impact on child wellbeing is evident to educators who described being overwhelmed by student behavior in the classroom – including impulsivity and acting out, and their limited ability to effectively respond given the lack of time, resources and support. As one educator said, "It feels like we are putting a Band-Aid on students and not getting to the core issues."

2. It is Never Too Early to Intervene

The Commission frequently heard that the signs and symptoms of mental health needs were evident early in development and expressed by children in different ways, such as acting out, impulsivity, emotional dysregulation ("meltdowns"), or difficulty getting along with peers. However, these behaviors were not always recognized as an expression of an underlying mental health need or appropriately addressed. As Commissioner Gordon noted, too often schools operate under a "fail first paradigm," in which "children must get worse before they can get better."

The education system in California has no mandates or incentives to provide universal mental health/wellness supports to all children through a comprehensive strategy. The default in this "fail first" approach is a referral for special education services. In the mental health system, children can be required to meet "medical necessity" to be eligible for services. In other words, they must exhibit signs and symptoms and meet criteria for a mental health diagnosis to receive help. In both education and health care, mental health service delivery traditionally has been individually focused and deficit-based.

Parents and family members told personal accounts of how their children's mental health needs did not receive enough attention until worsening symptoms led to a crisis. One mother shared her agonizing experience of receiving a call from her 7-year-old son's elementary school telling her that police were taking him to the hospital to be placed on suicide watch. Another mother said her child had been "hauled out" of their house by police in the middle of a violent fit to be taken to the hospital. This mother described the incident as a horribly traumatic experience, but also beneficial. "It opened a lot of doors (to services)," she said. "But why did it get to this point before those doors were open?"

Some stories were less dramatic but had serious implications for a child's future success, including failing grades, disengagement from school, being suspended or expelled, and eventually dropping out of school – all of which could have been mitigated with access to comprehensive school mental health services.

Stakeholders from different backgrounds and professions all agreed on one aspect – the need for greater prevention and early intervention services, before children enter formal schooling and during their K-12 education. Stakeholders also were clear that services needed to physically meet children and families where they are, which is more often in schools and communities rather than offices. Community members wanted a greater focus on wellness, rather than diagnosis, through prevention and early intervention efforts.

A mental health professional at a December 2016 subcommittee said children are often diagnosed later than they should be, which delays treatment: "You don't want it to get to that point. You want to help them early."

3. Common Barriers Block Efforts to Support Healthy Development

Stakeholders identified common barriers to promoting student wellness and addressing the signs and symptoms of mental health needs when they first arise, including the following:

- The education system's priority focus on learning and academic achievement can overshadow other contributing factors to student success. Although the education system has evolved to address the "whole child" and support social and emotional learning, the focus on academic achievement continues to dominate school policy and resource allocation.
- Schools lack on-campus resources, including sufficient numbers of school-based mental health professionals to evaluate the needs of students and provide services and supports. Educators find it challenging to recognize and respond appropriately to children's mental health needs, particularly in the absence of school-based mental health professionals.
- The complexity of family needs challenge schools and counties to engage families as equal partners to support children's mental health.
- Mental health services and supports for children and their families are often poorly organized across systems – education, county behavioral health, child welfare, and juvenile justice.

- Stigma and shame about mental health needs are pervasive in families and communities.

4. Trust Needs to be Built with Families

Stakeholders emphasized the importance of building trust and working in close partnership with families, especially those from unserved and underserved communities. Focus groups and community forums revealed a disconnection and cultural divide between families and institutions, including education and county behavioral health. At an African American community forum, participants talked about a general fear and distrust of social institutions because of the removal of African American children from their homes by Child Protective Services. An African American community stakeholder, said:

"I believe it all boils down to trust. It's very difficult to establish trust. We grew up seeing it – kids getting split up. It's difficult to place the trust in people at school."

This mistrust extended to relationships with educators and school employees, especially if these individuals were not from the communities they served and held implicit biases about those communities.

This disconnection was heightened in communities where programs and services did not match the language, cultural beliefs and practices regarding mental health, especially regarding stigma and shame. For example, during the Asian and Pacific Islander Community forum held in Fresno, a Southeast Asian community provider shared that families in her community will rarely seek clinic-based services and open-up to a stranger. She spent a considerable amount of time getting to know families in their homes and building trust by washing dishes and helping around the house before offering services.

Across racial and ethnic groups, parents wanted greater communication and better, more trusting relationships with their children's schools and teachers. They wanted more information about mental health, parenting, and the availability of services for their children. They also wanted the opportunity to participate in mental health trainings and workshops with teachers so that they were "all on the same page" in rearing and educating their children.

5. Educators Need Support

Educators and school staff are on the frontlines of mental health for children and youth. And yet, they may not receive the training and support to work with children with mental health needs in their classrooms. Participants emphasized the importance of building mental health literacy across school campuses by training all school staff, including bus drivers and food services workers. Communities of color wanted schools to train staff to be trauma-informed and recognize that acting out behavior can stem from exposure to stressful and adverse events that require empathy and support rather than punishment. These communities also wanted to see more training and support for gender and cultural sensitivity, competence, and humility in schools.

Stakeholders also advocated for greater attention to educator wellbeing due to high levels of stress, burnout, and attrition.

As one stakeholder said, “If educators are not well, then students are not well.”

6. Siloed Services Need to be Connected

A parent at a Commission public hearing in January 2017 described the system this way:

“There is definitely a lot of finger pointing of whose job it is…you go to the medical community and (they say) those are supports that the school should be providing. And you go to the school and they say we don’t provide those supports. So, you just end up with medication, but no one wants to handle the support that goes with that.”

Parents and other stakeholders highlighted the disconnections between school and mental health programs, services, systems and professionals – and the negative impact those disconnections have on children and families. Parents and family members feel alone and frustrated when they try to navigate systems with diffused responsibility and little or no communication or coordination across schools and mental health providers. The Commission learned through focus groups with educators and families that a variety of barriers (e.g., parental consent, referrals, transportation, appointment wait times, privacy concerns, etc.) can deter successful linkages.

A school social worker described her efforts to refer an elementary student to community mental health services because of the severity of his condition, only to face an arduous six-month process of getting services for the child and family. She felt there was an implicit distrust between the schools and county behavioral health departments, which was augmented by a lack of structure and clear process for client referrals and data sharing that resulted in long delays in children receiving treatment.

Stakeholders advocated for greater connection and collaboration between school districts and community mental health providers to provide a comprehensive array of services in school.

The Commission’s inquiry revealed the imperative of building a sustainable, cross-system infrastructure, which prompted the Commission to explore the complexity of leveraging different systems and funding mechanisms to support school readiness and success – and informed the Commission’s principles for advancing comprehensive school mental health in California.

II. The Imperative of Prevention and Early Intervention

Mental health needs among children are stunningly common. The science is providing increasing clarity that the early years of life and the social conditions that children grow up in are foundational to their mental wellness. For many young Californians, however, childhood is filled with trauma and toxic stress. Proactive efforts to address and respond to mental health needs can improve outcomes. The MHSA requires investments in prevention and early intervention programs, and several counties target early childhood.[17] But a systems approach to these systemic issues is lacking in most communities.

Mental Health Needs are Common

Mental health needs are the most common and disabling medical conditions impacting children. Up to one out of every five children have a diagnosable mental health disorder.[18] Among the 9.6 million children in California, roughly 1.8 million could be in need of mental health services and supports.

Certain groups of children experience mental health needs at higher rates than the general population, including those living in low-income families, those involved with the child welfare or juvenile justice systems, and those who experience family rejection, abuse and neglect.[19,20,21]

Common mental health needs in children are attention-deficit hyperactivity disorder (ADHD), anxiety disorders, and depression.[22] These disorders often co-occur, increasing symptom severity and disease burden.[23] Mental health needs negatively impact every aspect of a child's life; changing the way they learn, behave, and manage emotion. If left unaddressed, mental health needs disrupt a child's development and ability to reach their full potential in life.[24]

Half of all lifetime mental health needs emerge before the age 14 and three-quarters before age 24.[25] The mental health needs that have the earliest onset are impulse control and anxiety disorders, which usually begin in childhood or early adolescence.[26] Mood disorders (including depression) generally begin later, with rates rising in early adolescence and increasing in linear fashion into middle adulthood.[27]

Mental health needs in youth have increased in recent years. Emotional distress, major depression, and suicide ideation are on the rise among youth.[28] Suicide is the second leading cause of death for youth.[29]

Many children suffer without help. Approximately half to three-quarters do not receive mental health treatment or services.[30,31] For children living in low-income households with limited English proficiency, unmet mental health needs are even greater.[32]

The gap between need and care is both a major public health crisis and has serious implications for the future of California. As baby boomers age, younger generations bear a larger economic and social burden.[33] Public health experts and economists are finding common cause in the importance of all children growing up to be healthy and productive.

The Early Years and Social Conditions Are Determinants

In 1963, President John Kennedy said, "Children are the world's most valuable resources and its best hope for the future."[34] Unmet mental health needs erode that future and result in human suffering, lost human capital, and staggering economic losses.

The mental health of children is impacted by many different factors – genes and biology, as well conditions in the family, neighborhood, social, economic, and physical environments.

The early years of development provide the foundation for mental health and wellness.[35] From birth to five, the brain develops at a rapid pace. During this time, connections are being made between brain cells and networks that provide the architecture of the brain. Ninety percent of the brain is developed by the age of 5.

Early experiences with caregivers and the environment shape the developing brain. Exposure to adverse events and toxic stress changes brain architecture and put children at risk for problems with self-regulation and learning, and later mental and physical health challenges.[36] This is primarily due to the overactivation of prolonged exposure to stress hormones.

Results from a California statewide maternal health survey suggest that many women are giving birth under stressful conditions.[37] A majority of Hispanic/Latina and African American mothers were unmarried and living in high poverty neighborhoods. One in 10 mothers were victims of intimate partner violence.[38] In addition, one in three mothers had experienced multiple hardships as children. Maternal stress heightens the risk for depression before and after birth.[39] Maternal depression can impair the mother-infant bond and be predictive of later learning and mental health needs for the child.[40]

Just as community members expressed, the conditions in which children are born, live, learn and play – known as the social determinants of health – have a direct impact on health and mental health risks and outcomes.[41] Healthy environments produce healthy children. Unhealthy environmental conditions such as poverty, food insecurity, racism and discrimination, housing instability or low-quality housing, neighborhood crime and violence, and lack of access to health care are associated with poorer health. Children living in poverty are more likely to experience multiple adverse events (witness violence, experience homelessness, etc.), which can lead to higher arousal and chronic stress accumulating over time and contributing to the development of chronic disease including mental health needs.[42]

Trauma and Toxic Stress Impact Mental Health

Jordan is a kindergartner who is struggling to learn and behave appropriately in the classroom. He has been inattentive, hyperactive, and acts aggressively toward others. His teacher is unable to manage or redirect his behavior and often resorts to sending him to the school office. He has recently been referred for a Special Education assessment. Since birth, Jordan has experienced multiple adverse events. His family lived in poverty and experienced housing instability. Jordan's mother suffered from postpartum depression soon after his birth, which impaired their attachment bond. By the age of 3, Jordan had been exposed to domestic violence, witnessed his father being arrested by police, and had been expelled from preschool.[43]

Some may ask, "What is wrong with Jordan? Is it ADHD, a conduct disorder, or some other developmental problem?" These questions can obscure the cause of Jordan's behavior. A different question to ask, "What has happened to Jordan?"[44]

Jordan's story illustrates the vulnerability of being exposed to adversity early in life. Science reveals that infants and young children are not built to handle chronic stress.[45] And yet, trauma –

a perceived threat to self or others – is pervasive in the early years when children are most vulnerable to stress.[46] This is particularly true for those children living in low-income neighborhoods who are being exposed to high rates of family stress and community violence.[47]

Children experiencing trauma also experience a cascade of physiological responses. In the absence of safe and nurturing environments, they can get stuck in survival-based responses, including fight, flight, and freeze. Psychological responses and coping behaviors to trauma can be misunderstood by adults, parents, and teachers, and at times elicit punishment. These behaviors include ADHD-type behavior, hyper-arousal, anxiety, avoidance, dissociation, and numbing.

Sadly, trauma teaches children powerful lifelong lessons about themselves and the world – that the world is unsafe, other people cannot be trusted, and that they are unlovable.[48] Lessons rooted in trauma disturb the internal world of children and their ability to regulate emotions, control their behavior, and feel safe in their own bodies.[49] Thus, Jordan was unable to learn or thrive in a classroom setting until his basic needs for safety and security could be addressed.

Without early screening and appropriate intervention, many children who have been exposed to trauma will not be prepared to meet the expectations of formal schooling and kindergarten.[50,51] They may begin school with few school readiness skills, which will decrease their likelihood of later school success.

Proactive Efforts Can Improve Outcomes

Mental health prevention and promotion can reduce risk and build protective factors to improve mental health and educational outcomes. Figure 1 identifies strategies and programs for supporting healthy development from birth to young adulthood.[52] Since the early years are foundational for mental health and school readiness, investments to increase access to prenatal care, home visitation programs, and early childhood interventions such as parenting and social-emotional learning programs can yield substantial economic and societal benefits.[53]

Prevention and Early Intervention from Prenatal Development to Young Adulthood

Prenatal	Infancy	Early Childhood	Childhood	Early Adolescence	Adolescence	Young Adulthood
Foundation for mental health and school readiness						
Prenatal care						
Home visitation programs						
Early childhood intervention/SEL						
School climate & mental health literacy						
⟵ Enhancing family strengths and parenting support ⟶						
⟵ Developmental/BH Screening ⟶						

Local planning and coordination
Training, technical assistance, data & policy

Figure 1. A local whole child agenda should coordinate interventions at each developmental stage. Adapted from *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* (2009) by the National Academy of Sciences, Washington, DC.

Community prevention efforts can build protective factors – attributes that are external (such as safety, family support, positive adult role models and healthy school climate) and internal to the child such as social-emotional competence, self-esteem, and achievement motivation. Strengthening families is foundational in building protective factors in children.[54] Increasing parental resilience, social connectedness, support, and knowledge of good parenting practices can reduce the likelihood of abuse and neglect and buffer the effects of adversity and trauma.[55]

The Primary School: An Innovative Model for Beginning Early & Integrating Services[56]

The Primary School expands the boundaries of traditional education to include health care and family support in an integrated, service delivery model. Located in East Palo Alto, the school enrolls families at or before birth and commits to providing services and supports that engage high-need families and support healthy child development as the foundation for school achievement and success in life. Key features of the school include:

- Coordination across caring adults and systems. The school partners with health care providers to coordinate timely pediatric exams and developmental screenings to ensure that children are healthy and able to successfully participate in school.
- Children begin formal schooling at age 3 and are provided with a seamless educational experience from preschool to middle school.
- Families are engaged as partners and supported through group-based coaching to expand their social network and help them achieve personal goals.

The Primary School is creating a new and replicable system of care for serving California's children and families.

MHSA Requires Prevention and Early Intervention Investments

The Mental Health Services Act provides dedicated funding for prevention and early intervention (PEI) programs in county mental health systems to promote mental health and reduce the risk of individuals developing serious mental health needs.[57] Approximately 20 percent of MHSA revenues received by counties must be spent on PEI strategies. Approximately $350 million to $400 million dollars are available for PEI each year; 51 percent of these funds to be used to serve individuals from birth to 25 year of age.

The intention of the PEI component is to move the mental health system toward a "help first" rather than a "fail first" system. PEI strategies can target a range of activities and services from reducing risk and building protective factors (prevention) to enhancing outcomes and recovery early in the course of mental illness (early intervention), or a combination of the two. These

efforts are most often successful when partnerships are linked across systems including education, mental health, social services and criminal justice, which is encouraged by the requirement that county PEI programs engage with underserved communities and work to reduce stigma.

The act directs PEI strategies to address the negative outcomes associated with untreated mental health needs, including school failure. From a strengths-based perspective, PEI funds can be used to support and enhance school success. School success can be defined many ways and includes learning, student achievement, school engagement, and eventually graduation from high school and college, to name a few. However, the proverbial saying that "school success begins at home" provides context for understanding the student experience. A student's success is embedded in loving and supportive families, and safe, healthy schools and communities.

The research literature suggests that a child's readiness for kindergarten plays an important role in later school success.[58] Thus, efforts to bolster school success can begin as early as infancy and include parents, families, and educators in different community settings. Some county MHSA programs address the early building blocks of school success (See Appendix A). These programs strengthen early relationships, build social and emotional competence in young children, and include developmental screenings, including screening for trauma, social and emotional functioning.

But a Broad, Systems Approach is Lacking

While counties use MHSA to fund programs for young children and their families, most programs do not focus on children younger than 8-years-old or address early trauma as a precursor to mental illness. In addition, programs that are focused on specific ages or circumstances usually operate as independent "add-ons" and may only reach a small number of individuals.

Stakeholders said too often county PEI programs are tied to Medi-Cal, which requires a mental health diagnosis for the provision of services. These stakeholders felt that using PEI dollars as the Medi-Cal match was a "fail first" approach – not in the spirit of PEI, of addressing problems early so that a child does need a diagnosis or continuation of traditional mental health services.

Generally speaking, most counties do not have a strategic plan for enhancing school success and student mental wellness through prevention and early intervention beginning at birth. Many different agencies and organizations serve families with young children and students with little coordination of services and/or leveraging of resources across various service systems. Some county First 5 commissions and school districts report being unaware of or left out of the community planning process required in the development of MHSA programs. These entities would like to see more robust community engagement and a stronger commitment to assessing the needs of young children and families.

III. Schools as Centers for Wellness

Schools are essential partners in supporting the mental health and wellness of children and youth, and several partnerships are working across systems to meet the diverse needs of California's students to improve outcomes through comprehensive school mental health.

Children cannot grow, learn, and thrive if they are unable to pay attention and self-regulate due to a mental health condition. Thus, improving school performance must also focus on supporting student mental, emotional and behavioral health.

Schools also are central to family and community life and can increase access to mental health services and reduce stigma. Children spend almost one-third of their lives at school (approximately 180 days a year). And by extension, parents and younger siblings also are connected to the schools, allowing practitioners to provide additional education and referrals.

Schools are often termed the de facto mental health provider,[59] although many students with mental health needs do not receive services. Those who do receive mental health services typically receive them in schools rather than community clinics and offices. Schools can be the first line of defense in identifying and addressing mental health needs before they become severe and disabling.

To address the needs, and especially the disparities, California educators are cultivating a positive school climate and incorporating social emotional learning into curricula.[60,61,62] School-community partnerships are forming, and strong models are emerging. Experience is proving to be a good teacher in how to work better together – and one lesson is empowering youth to help them address their needs and increase resiliency.

California Students Have Disparate Experiences and Outcomes

California has 6.2 million students enrolled in K-12 schools. California's students are among the most diverse in the country.[63] Approximately 51 percent of students are Latino/Latinx, 27 percent are white, 11 percent are Asian American, and 5 percent are African American.[64]

Based on national and state prevalence rates, between 620,000 and 1,240,000 students are estimated to have a mental health condition. Surveys of California high school students paint a sobering picture of student disconnection, victimization and mental health symptomology:

- Only 48 percent of high school students feel connected to their school.
- One in five report being harassed or bullied.
- Approximately 1 in 3 feel chronically sad and hopeless.
- Almost 1 in 5 have seriously considered suicide in the past year.[65]

Certain groups of students are at higher risk. LGBTQ experience alarmingly high rates of bullying, harassment, and victimization and as a result report feeling less safe at school than their non-LGBTQ peers.[66] Between 50 to 70 percent of LGBTQ students in California report experiencing verbal harassment and bullying.[67] LBGTQ students in California are also two times

more likely to report depression symptomology (i.e., chronic sadness) and three times more likely to report suicidal ideation than non-LGBTQ peers.[68]

Other student groups such as Muslim students experience victimization at school that can have a negative impact on their wellbeing.[69] Muslim students can experience offensive remarks and discrimination at school due to their religion and are two times more likely to be bullied than their non-Muslim peers.[70]

The vast majority of students will not receive the services and supports they need.[71] Unmet trauma and mental health needs are strongly associated with barriers to learning such as disengagement, chronic absenteeism, suspension and expulsion (and by extension, the school-to-prison pipeline), and school dropout.[72,73,74]

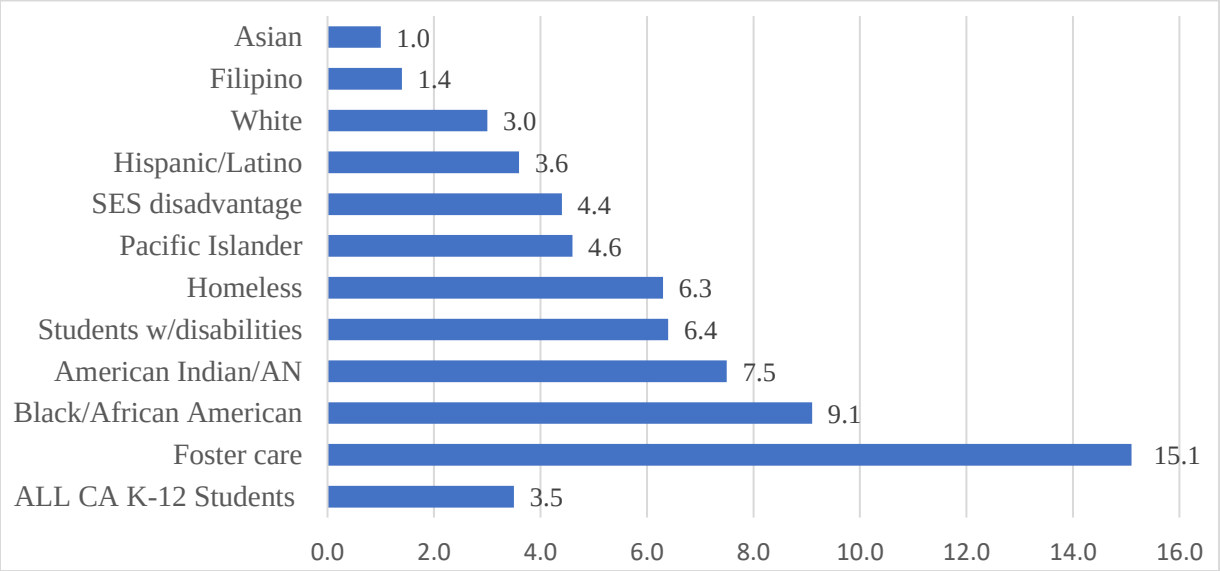
More than 75 percent of school principals in California indicate that students' emotional and mental health were a moderate or severe problem at their school.[75] Furthermore, two-thirds of teachers report they are unequipped to address their students' mental health needs.[76]

California school climate data show disparities in student outcomes that may be associated with unmet mental health needs:

1. Disparities in Chronic Absenteeism
    - African American, Native American, and Pacific Islander students are more than twice as likely to be chronically absent (missing greater than 10 percent of school days during the academic year) than their white peers.[77]
    - Approximately 1 in 5 African American, Native American, and Pacific Islander students are chronically absent, compared to 1 in 10 white students.[78]
    - Chronic absenteeism is highest among students in foster care (28 percent) and students who are homeless (25 percent).[79] Within these student groups, disparities exist. Among students who are homeless, 42 percent of African American students and 40 percent of Native American students miss more than 10 percent of academic instruction during the school year, compared to 29 percent of white students.[80]
2. Disparities in Suspension and Expulsion
    - Students in foster care, African American students, and Native American students, are more likely to be suspended or expelled than other groups of students.[81]
    - The highest disparities exist for African American boys K-3, who are 5.6 times more likely to be suspended or expelled than the statewide average.[82]
    - African American males in the foster care system are more likely to be suspended than all other groups of students: 27 percent of African American male students in the foster care system were suspended.[83]

- The highest rates of suspension for African American students classified as foster youth occurred in middle school. Forty-one percent of African American males in grades 7 and 8 and in the foster care system were suspended.[84]

Figure 1. California 2018-19 Suspension Rates by Student Group



The figure above provides suspension rates for different groups of students.[85] Students in the foster care system are almost five times more likely to be suspended than the statewide average.[86] The most common reasons for suspension – violent incident (no injury) and willful defiance – suggest that these students may be targets of implicit bias and/or experience challenges with interpreting the intention of others, communication, resolving conflict, and self-regulation (all of which are common among children who have experienced trauma).[87,88,89,90]

In 2015-16, 2,525 California students were arrested and 24,897 were referrals to police.[91] African American students were four times more likely to be arrested at school than white students.[92] An analysis of school incident reports between 2011 and 2019 in the Los Angeles County Unified School District showed a precipitous rise in counseling-related incidents (e.g., suicidal behavior) for whom the best responders would be school mental health personnel rather than school police.[93]

School-based mental health services can enhance school response to crises and reduce disciplinary measures.[94]

Spotlight on Oakland, California and Racial-Ethnic Disparities

"This data represents real children in our communities – children impacted by poverty, racism, isolation, violence and lack of opportunity and access to quality preschool education and other critical health, mental health and human services" – Curtiss Sarikey, Chief of Staff, Oakland Unified School District.[95]

- 29 percent of African American and Latinx boys are kindergarten ready, compared to 82 percent of non-Latinx, white boys.
- 11 percent of African American boys and 13 percent of Latinx boys are reading proficiently by the end of 3rd grade, compared to 65 percent non-Latinx, white boys.
- African American students are 6.8 times more likely to be identified as emotionally disturbed than non-Latinx, white students.
- More than half of African American 5th grade students have had friends or family members die by violence.[96]

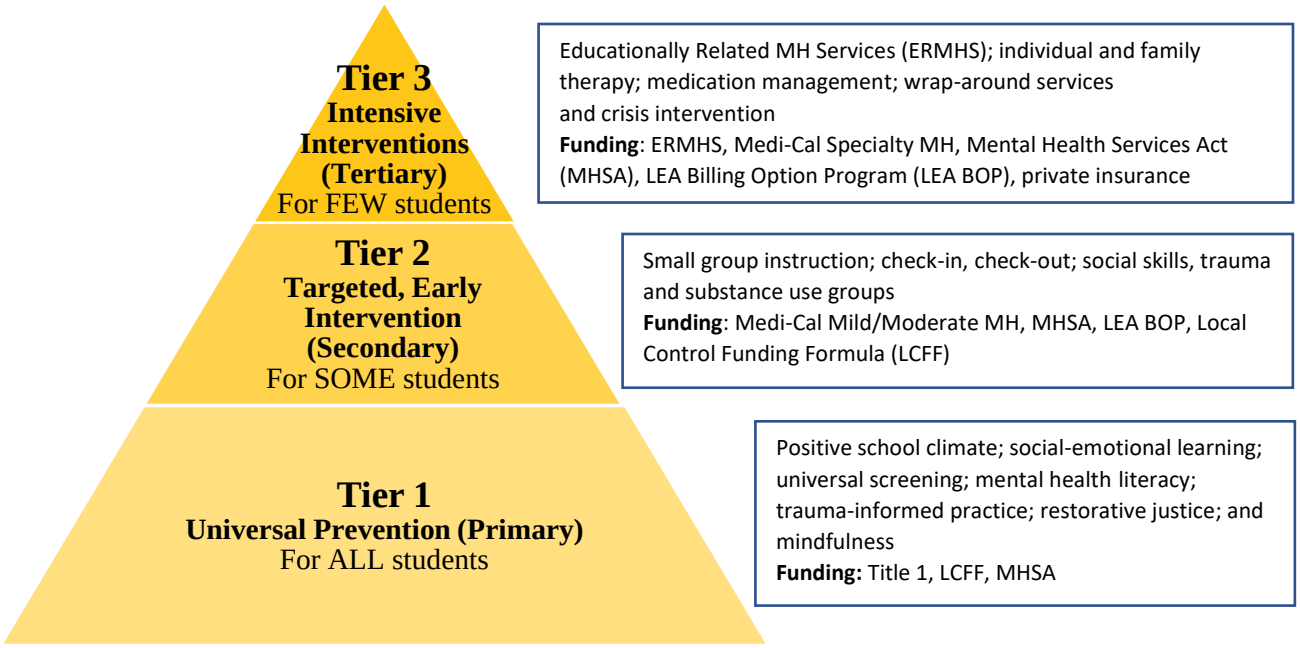
Solutions in the Oakland Unified School District included implementation of:

- **Full-Service Community Schools** to create a cradle-to-career approach to educating and developing the whole child to close achievement and opportunity gaps. These efforts aligned around partnerships around a common agenda and goals, strong family-school partnerships, and developing networks of support based on the local needs.
- **Social and Emotional Learning (SEL) standards** for Pre-K through adult. SEL provides the foundation for prevention – addressing issues of implicit bias and creating trauma/healing-informed environments.

Addressing Mental Health Can Enhance Learning and Wellness

Many terms are used to describe the provision of mental health services in schools – school mental health, school-based mental health services, and the expanded school mental health framework. These terms refer to school and staff efforts to respond to nonacademic barriers to learning, including social, emotional, and behavioral challenges. Recently, the term comprehensive school mental health has been used to emphasize the importance of providing a full array of mental health services to students based on their strengths, needs, and developmental status.[97] School mental health systems based on a multi-tiered system of supports (MTSS) model provide a continuum of services and supports across tiers of intervention:

- Tier 1: Universal, prevention services for all students to promote wellness and a healthy school climate.
- Tier 2: Targeted (selective) services for some children at risk and/or showing signs and symptoms of developing mental health needs; and
- Tier 3: Intensive (indicative) services for few students with greater mental health needs.[98]



Like MTSS, Positive Behavioral Interventions and Supports (PBIS) and the Integrated Systems Framework (ISF) are multi-tiered frameworks used to deliver a continuum of services and supports in schools that support student behavior and academic outcomes. PBIS is a proactive approach for supporting healthy and appropriate student behavior and establishing a positive school climate.[99] PBIS is structured to meet individual student needs, using evidence-based approaches at each of the three tiers of services and supports. PBIS operates in over 3,000 California schools and is an evidence-based approach to reducing the use of punitive school discipline.[100,101]ISF builds upon PBIS, integrating it into a multi-tiered system of support that includes school mental health, community mental health, and families.[102]

Research clearly links the provision of school mental health services to many positive school and student outcomes. School mental health is associated with improved academic performance, increased school engagement, reduction in disciplinary measures, decreased need for Special Education, and increased graduation rates.[103,104,105]

Within a multi-tiered system of support, between 15 and 20 percent of students are estimated to need support beyond Tier I, universal interventions. However, as stakeholders noted, the MTSS pyramid is often "inverted" in disadvantaged communities. This results in school staff feeling overwhelmed by "crisis management" and the large number of students who need more intensive interventions beyond Tier I. Some stakeholders expressed concern that Tier I interventions were not fully established. Thus, schools responded to student needs when problems became "acute and recognizable."

Strengthening and coordinating an array of Tier I universal evidence-based programs is critically important to the wellbeing of students and foundational to a comprehensive school mental health system. It is also in line with what stakeholders, including parents and caregivers, want more of in schools – prevention and early intervention activities. These activities can include a positive

school climate, social-emotional learning, universal screening, mental health literacy, trauma-informed practices, restorative justice, and mindfulness practices to name a few. (A list of evidence-based practices is provided in Appendix C). These activities require ongoing training and support for school staff who are on the front lines of student mental health and should be tailored to the age and developmental status of students.

Advancing Tier 1: Universal Prevention for All Students

A Positive School Climate is Essential

In addition to academic curriculum, schools can support healthy development by providing safe, supportive spaces for children to grow, learn and thrive. A positive school climate is a major factor in student experiences and success.[106] School climate is multifaceted and includes the physical conditions of buildings and classrooms; the social conditions, such as the quality of relationships and equitable and fair treatment; and, academic conditions, such as too much pressure and homework.[107] These conditions represent the quality and character of school life and influence the feelings the schools invoke, such as whether students feel safe, supported, and connected.[108]

Four aspects of school climate are associated with mental health and wellbeing: 1) positive social connections and relationships; 2) school safety; 3) school connectedness; and, 4) academic environment.[109] Students who feel that their schools have these characteristics report better psychosocial wellbeing, more positive and pro-social behaviors, fewer mental health issues, and fewer delinquent or risk behaviors.[110,111]

A positive school climate benefits all students, especially those at risk.[112]

Trauma-informed or "trauma-sensitive" schools recognize that many children have had traumatic experiences – a universal theme expressed during the community outreach efforts for this project. Trauma-sensitive schools help children feel safe – in the classroom, hallways, cafeteria, playground and on the school bus – so that they can learn.[113] Core features include a holistic approach to student learning, creating positive relationships with teachers and peers, connecting students to the school community (rather than pulling them out of class and away from others), and staff working together and assuming shared responsibility for all students.[114]

LGBTQ and Gender Inclusive Schools

"Trauma, shame, and rejection in children are the trajectory into mental health needs and suicide ideation in transgender and non-binary youth. It starts young" (LGBTQ leader, September 7, 2018 Education Forum). Transgender and gender diverse youth face more hostile school climates and are 3 to 10 times more likely to be diagnosed with a mental health need.[115] As part of comprehensive school mental health, school environments should be healthy, safe, and affirming and inclusive, and include:[116,117]

- Curriculum that explores human diversity.
- Education and training for parents and educators in LGBTQ cultural competency and how to support LGBTQ children and youth.

- Engaging LGBTQ students and their families in school mental health policy and planning.
- Policies that explicitly protect students from bullying, harassment, and discrimination on the basis of sexual orientation, gender identity or gender expression.
- Strengthening student-led clubs such as the Gay-Straight Alliance and provide adult support.
- School compliance with AB 1266 requiring students "be permitted to participate in sex-segregated school programs, activities, and use facilities consistent with their gender identity."[118]

Social and Emotional Skills are Among the New Basics

Schools can also promote healthy development and positive mental health among students, especially those impacted by trauma, by fostering social and emotional learning (SEL). According to the Collaborative for Academic, Social, and Emotional Learning (CASEL), social-emotional learning "is the process through which children and adults understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions."[119]

The positive benefits of SEL programs are well documented. Children who experience SEL programs have higher school achievement, better coping skills and resiliency, and fewer conduct problems. SEL programming also has reduced the school readiness gap and increased academic success for children from disadvantaged backgrounds.[120]

SEL programs have a positive return on investments. On average, every $1 spent on SEL programming produces an economic return of $11.[121] Providing children with early social and emotional skills is linked with positive adult outcomes, as well, including educational attainment, employment, civic engagement, positive mental health, and healthy relationships later in life.[122]

Five Core Competencies of Social and Emotional Learning and Acquired Skills[123]

Social and Emotional Competencies	Skills
Self-awareness	Recognizing feelings, self-confidence and self-efficacy
Self-regulation	Regulating emotions, thoughts, and behaviors; controlling impulses, working towards goals
Social awareness	Understanding different perspectives, empathy, respect for others
Relationship skills	Communicating effectively, establishing and maintaining relationships with others
Responsible decision-making	Problem-solving, understanding the consequences of actions

Educator Wellness is Integral to Student Wellness

In addressing student mental health and wellness, policies and programming should attend to the wellbeing of adults in a child's life. Parents, caregivers, educators, and other adults provide proximal contexts for children's development.[124] Adult who struggle with stress, past/present trauma, and mental health and substance abuse concerns are less able to provide safe, consistent, and loving environments for the children.[125]

Teachers and school staff are on the frontlines of student mental health. They are not immune to the stress and trauma in the lives of their students. Data on adverse childhood events (ACEs) suggest that educators are exposed to many children who have experienced trauma, and that puts them at risk.[126]

High levels of stress and burnout are common in the teaching profession,[127] which coupled with large numbers of students with trauma suggests the importance of better understanding the mental health needs of educators. For teachers and staff in low-income schools – who are less likely than their counterparts in high-income schools to be mentored and supported (known as the "support gap") – stress and burnout may be especially common and complicated by compassion fatigue and secondary trauma.[128]

Trauma-informed programs can address both teacher wellbeing and the classroom/school environment. A core feature of trauma-informed schools is to combat burnout, compassion fatigue, and secondary trauma by helping teachers create greater self-awareness around physical, emotional, and cognitive reactions in the classroom.[129]

Wellness Challenges Confronting Educators

Burnout – Chronic stress that arises when workers feel exhausted, dissatisfied, powerless and/or overwhelmed at work. (Burnout has many causes and is not necessarily trauma related.)

Compassion Fatigue – Profound stress and exhaustion that arises from caregiving and repeatedly hearing/witnessing trauma and suffering, which leads to an inability to care or feel empathy for others ("having nothing left to give").

Secondary Traumatic Stress – The development of PTSD-like symptoms as a result of working with or being close to people experiencing trauma and suffering. STS is also known as vicarious trauma and represents the fundamental changes in a person's worldview and sense of self as a result of working with traumatized individuals.

The above concepts often overlap. For example, unaddressed secondary traumatic stress can lead to compassion fatigue.

An MHSA PEI program in Orange County provides teachers with stress management and mindfulness training.[130] The training is part of the Resilient Mindful Learner Project at the Orange County Department of Education. K-12 teachers learn how to manage classroom stress and develop resiliency. Through the training, teachers:

- Learn about the biology of trauma and toxic stress, and its impact on student behavior and learning.
- Develop self-awareness around their own sources and levels of stress, and learn how to manage stress in healthier ways.
- Learn to recognize the signs of stress in their students and implement self-regulation strategies, such as mindfulness into the day-to-day classroom environment.

To successfully implement and sustain these practices, teachers receive in-class coaching and support from an ongoing learning/training cohort. Preliminary evaluation of the program suggests that after the training, teachers have a greater sense of competence and use less disciplinary means in their classroom.[131]

MHSA Funds are Supporting Prevention and Early Intervention in Schools

More than 100 MHSA PEI programs provide student mental health and wellness services.[132] Many of these programs support school-based interventions, including:

- Social-emotional learning and resilience building
- Positive Behavior Intervention Strategies (PBIS)
- Bullying and violence prevention

Some counties – including El Dorado, Los Angeles, and Monterey – use PEI funds to provide professional and paraprofessional mental health staff on school campuses. A smaller number of counties have blended PEI and other funds to build continuums of care within schools. For example, the San Francisco Department of Public Health-Behavioral Health Services collaborated with community-based organizations and San Francisco Unified School District to establish Wellness Centers.

Schools serve as hubs for a range of services and supports to students who have difficulties in school due to trauma, immigration stress, poverty, and family dysfunction. Services are prevention and/or resiliency-focused and are provided during and after school hours. Mental health consultation is also provided for teachers, administrators, and staff, particularly those who are experiencing challenges with student behavior and emerging mental health needs.

An Opportunity: County behavioral health departments can address school failure, which is one of the negative outcomes in the MHSA, by aligning PEI plans with a school district's local control and accountability plan (LCAP) to improve student outcomes.

Tier 2: Targeted Early Intervention for At-Risk Students

Targeted early intervention (Tier 2) is critical in preventing mental health needs from becoming chronic and severe and requiring more intensive services. Tier 2 services and supports are designed for students who are at risk, or who may be exhibiting problem behaviors, mild distress

or functional impairment and require more focused interventions than provided at Tier 1. Students are identified through screening, assessment, referral, or other teaming processes; and interventions are matched to individual student needs and generally geared toward skill development and/or building protective factors. Evidence-based interventions may include brief, individualized interventions (e.g., motivational interviewing) small group instruction, support groups, mentoring, or classroom-based supports such as daily check-ins with a teacher.

Tier 3: Intensive Intervention for Students with More Serious Needs

Students who have emotional and behavioral challenges or a mental health diagnosis may require more individualized, intensive services and supports (Tier 3). These interventions are tailored to the unique needs of student through an individualized plan of treatment that is implemented and monitored by a team of educators and mental health professionals in collaboration with parents and caregivers. Supports at Tier 3 may include individual, family, or group therapy, wrap-around service planning, and case management.

Mental Health Professionals Working Together is Essential

Mental health professionals from different disciplines need to collaborate in schools and with community agencies to meet the needs of students and families.

Schools-based mental health professionals (also known as specialized instructional support personnel) include school counselors, school psychologists, school social workers, and school nurses. These professionals bring specific skills to help students overcome barriers to learning.

In 2018-19, California employed 10,426 school counselors, 6,329 school psychologists, 885 school social workers, and 2,720 school nurses.

These numbers are well below what would be required to meet the recommended ratio of 1 school-based mental health professional for every 250-500 students. On average, California's K-12 schools have one counselor for every 626 students, one school psychologist for every 1,041 students, and one school social worker for every 7,308 students.

Given school budget constraints and professional shortages, integration of the school system with community-based mental health services and supports is vital. Community-based mental health professionals play an important role in delivering school mental health services in coordination with their school-based counterparts.

IV. Strong School-based Collaborations are Emerging

Across California, schools and local agencies are responding to student mental health needs in creative and innovative ways through partnership and collaboration. Communities are breaking down traditionally siloed systems to build comprehensive and integrated responses. Leadership is emerging from county offices of education, behavioral health departments, and community-based organizations working in close collaboration with other community partners.

At the state level, the California Department of Education has led through Project Cal-Well and the guidance of the Student Mental Health Policy Workgroup.[133] A list of models and partnerships are provided in Appendix B.

Key Elements of Mental Health Collaboratives

Collaboration between school and community partners is required to identify needs, align resources, and implement services and support. These partnerships range from modest relationships where schools and community agencies communicate and cooperate to more sophisticated collaborations with integration of services and supports through formal agreements, shared goals and joint decision-making.[134] According to the National Center for School Mental Health, best practices in comprehensive school mental health include:

- Strong and effective partnerships between schools, families, and community agencies based on shared vision and goals.
- Needs assessment and resource mapping to identify school and community needs and resource availability.
- Strong and effective implementation and alignment of universal interventions, including a healthy school climate and culture.
- Integrated, multi-disciplinary teams at all administrative levels to implement and monitor services and supports.
- Data-driven, quality improvement practices.
- Educator and staff wellness, support, and professional development.
- Sustainability of services through blending and braiding multiple funding streams.[135]

Collaborations involve considerable administrative time, planning, and creativity to make programs/services sustainable long after grants have ended.

Continuum of Collaboration[136]

Communication	Cooperation	Coordination	Coalition	Integration

Low Level Collaboration		High Level Collaboration
Limited or no formal agreement		Formal agreements
Work toward different goals and outcomes		Work toward shared goals and outcomes
Agencies remain in control of resources and funding		Agencies share responsibility for resources and funding
Staff managed by agency		Staff managed by partnership
Decision making by agency		Joint decision-making
Affiliation to agency		Affiliation to partnership
Accountable to agency		Accountable to partnership
Agency-Focused		**Collaboration-Focused**

Lessons Learned: Patience and Persistence are Essential

Collaborative partnership models are designed to respond to the unique needs of students and families in their community, as there is no "one size fits all" approach. Educators and mental health providers shared with the Commission the lessons learned in forging partnerships and building collaborative processes across systems. The following provides a brief summary of identified challenges and opportunities.

Partners noted that collaboratives can be especially challenging to build and sustain since each entity has different missions and goals, organizational structures, professional cultures, confidentiality and dating sharing regulations and funding mechanisms. State legislation has inadvertently made it difficult to break down silos by specifying which students are eligible for mental health services and how those services are delivered. For example, Assembly Bill (AB) 114 transferred responsibility for educationally related mental health services (ERMHS) from county behavioral health departments back to schools.[137] Under AB 114, school districts are responsible for providing mental health services only to those students with Individualized Education Programs (IEPs) who have mental health challenges that impair their learning and ability to access school curriculum.

In addition, California lacks enough mental health professionals employed in school settings to provide a comprehensive range of services and supports. California lags behind many other states in the ratio of mental health professionals to students.[138,139, 140, 141]

Community partners have learned many lessons. First and foremost, integration is hard work. As Kasey Rodenbush, behavioral health services manager at Monterey County, said: "Patience and persistence are essential. Mental health integration demands a shift in how system cultures work together, which takes time and commitment." All stakeholders, she said, must be at the table to identify the needs of students in the community, develop a plan, and carefully implement.

Second, bridging different professional cultures and languages requires interdisciplinary training so that all partners speak the same language and have a common set of goals.

Third, data must guide planning and decision-making at all levels of the governance structure – county, school districts and schools.

Fourth, schools must have a strong foundation of Tier I universal services and supports for all students to build upon. Universal services and supports are critical for establishing the positive school culture and social and emotional learning that forms the basis for comprehensive school mental health.

Lastly, schools and counties need technical assistance to align resources and maximize service delivery. Often, services and supports are in place, but are not efficiently coordinated.

V. The Importance of Youth Engagement and Leadership

Youth-driven movements to support youth mental health and wellness are rising across California and the nation. California's youth leaders are stepping up to educate their peers about mental health in schools, shape school-community mental health programs, and create

accountability for youth-driven mental health systems. These movements are bringing young people together to be advocates for greater mental health awareness and to become leaders in designing services in their schools and communities. Youth involvement in mental health programming leads to better quality services that are responsive to the needs of youth.[142,143] Since stigma is a primary barrier to youth seeking mental health services or helping a friend in crisis, youth can play an important role in reducing stigma among their peers through outreach and engagement, education and support.[144]

On school campuses across California, youth leaders are countering stigma and creating safe spaces for youth to open up, share their stories, and get connected to services. The National Alliance of Mental Health (NAMI) Campus High School (NCHS) Clubs are one example of a mechanism to support youth leadership and advocacy within schools and communities.[145] Some 70 student-led NCHS clubs in partnership with local NAMI Affiliates in California are promoting mental health awareness, learning ways to support friends or family members with mental illness, educating the school community about mental wellness, and supporting and connecting students to services.[146]

The California Health Occupations Students of America (Cal-HOSA): Future Health Professionals is another student-led effort to address mental health on school campuses, often partnering with NAMI clubs. Cal-HOSA chapters are comprised of students interested in the health and mental health professions; more than 200 middle and high schools in California have chapters.[147] Cal-HOSA has implemented the Mental Health Prevention and Early Intervention Consortium in schools to increase awareness of the risk factors associated with mental health needs, early detection, and treatment.[148] At one of the consortium schools, a high school in Madera County, youth serve as mental health ambassadors and facilitate peer-to-peer sessions and support networks around mental health for students.[149] These youth conduct mental health outreach to parents in their community, many of whom are farmworkers.

Other grassroots efforts are springing up on high school campuses. For example, Dublin High School students came together after a fellow student died by suicide to create a youth-led movement to address mental health in their school.[150] The Elephant in the Room Project enables students to connect with other students and share their personal stories in a safe environment. The project uses the hashtag campaign #YouCanTalkToMe to advertise events, connect students, and provide support.

Youth also have played leadership roles at the county level. For example, the Humboldt County Transition Age Youth Collaboration is a unit within the Transition Age Youth Division of the Department of Health and Human Services.[151] The collaborative includes two partner organizations to build youth-responsive and youth-informed systems of care. The collaborative includes a Youth Advisory Board comprised of 16- to 26-year-olds who have experience with foster care, mental health, juvenile justice or homelessness. The advisory board is predicated on the belief that youth are experts in the systems that serve them and are vitally important in transforming the system to respond to the needs of youth. Advisory board members are paid for their time and expertise, participate in local meetings about youth, drive youth-led local projects

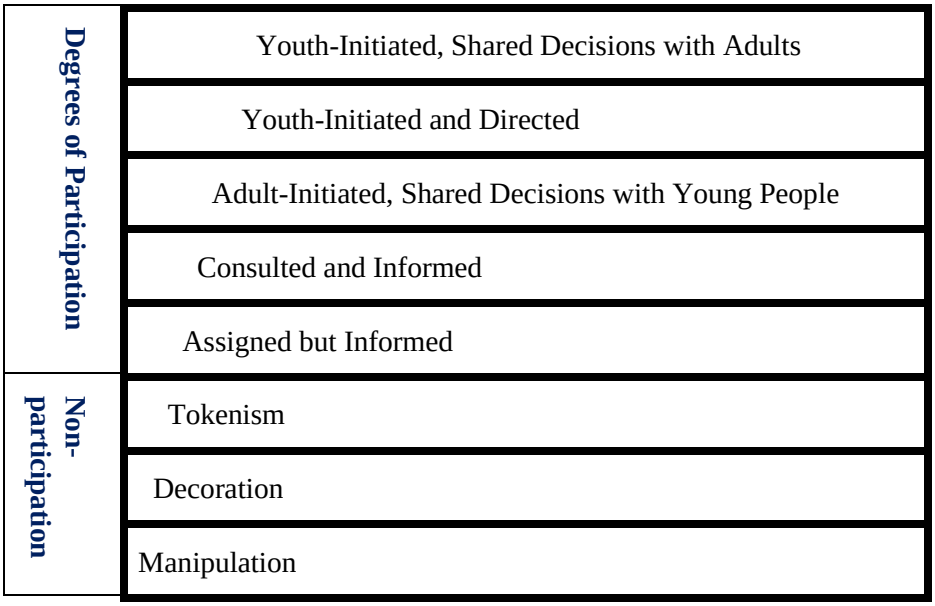
and initiatives, and provide training to other partners on engaging youth and developing youth informed approaches to service provision.

Eight out of 58 counties have children or youth advisory committees.[152] This represents an unrealized opportunity to engage youth in the MHSA community planning process, tap into their expertise, and support youth leadership.

Momentum is building for involving youth leadership in designing youth-centered programs and systems.[153,154] This energy, excitement and momentum can be harnessed by schools and communities, provided youth engagement is based on active participation and decision-making rather than "decoration" and "tokenism."

Hart's framework of children and youth participation can help schools and communities understand the different degrees of participation and engagement in program development, and support young people in initiating programs and sharing decision-making with adults through youth-led activism and youth-adult partnerships.[155]

Hart's Ladder of Youth Participation[156]



Providing youth with opportunities to make meaningful contributions to their schools and communities through participation and leadership in various settings contributes to positive youth development.[157] These activities can help youth strengthen connections to others, be caring and compassionate, develop character, and allow for a greater sense of self-confidence and competence (known as the 5 C's of Positive Youth Development).

VI. The Commission's Portfolio and Role in Transforming Schools into Centers of Wellness and Healing

Under its broad authority to advance the goals of the Mental Health Services Act, the Commission has prioritized children's mental health and has elevated the importance of schools as a point of access for services and a core partner in promoting mental wellbeing. The Commission has fostered public discussions in hearings and community forums. It has supported innovation projects involving school-based partnerships. It has partnered with other state agencies and advised the Governor and the Legislature on ways to incentivize and strengthen community collaborations. This section summarizes the Commission's efforts to catalyze school-based mental health partnerships.

SB 82/SB 833 Triage Grant Program

The Commission administers the investment in Mental Health Wellness Act (SB 82 of 2013),[158] which funds community-based mental health crisis services. Most programs funded under the first round of grants targeted adults. Based on concerns raised by children's advocates, the act was amended (SB 833 in 2016) to authorize Triage grants for a continuum of crisis intervention services and supports for children and youth 21-years-old and under.[159] In response, the Commission allocated 50 percent of Triage grants in a second round of funding to children's programs.

In addition, the Commission designated part of the funds as incentives for school-county collaborations. In 2018, funds were awarded to four entities: the California Association of Health and Education Linked Professions JPA (CAHELP in San Bernardino County) Humboldt County, Placer County, and the Tulare County Office of Education.

These collaborations are: 1) building and strengthening partnerships between education and community mental health, 2) supporting school-based and community-based strategies to improve access to care, and 3) enhancing crisis services that are responsive to the needs of children and youth.

In addition, the Commission awarded Triage contracts to four local agencies that are operating school-based Triage programs: the counties of Humboldt, Riverside, Sacramento, and San Luis Obispo.

A statewide evaluation of these programs will be conducted to understand the link between implementation and outcomes, as well as the lessons learned in developing a roadmap for other communities to follow. Opportunities for training and technical assistance can be leveraged with Triage grants to build learning communities statewide.

Triage School-Collaboration Grantees

CAHELP, San Bernardino County

- Leveraged 20 years of collaborative relationships, including partnerships with 15 school districts, 141 schools, 10 state preschools, and county agencies and community-based organizations.
- Hired mental health professionals who provide multi-tiered system of prevention, intervention, and triage supports including preventative supports, early identification, crisis interventions, crisis stabilization, mobile crisis support, intensive case management and linkages to service.

Humboldt County

- Leveraged 27 years of collaborative relationships, including partnerships with 31 school districts, as well as the 0-8 Mental Health Collaborative, and the Humboldt Del Norte SELPA.
- Hired mental health professionals who work alongside other school personnel to identify students in need of support, determine and provide treatment.

Placer County

- Leveraged 30 years of collaborative relationships between nine local entities and a robust governance group called the System Management Advocacy Resource Team (SMART).
- Hired school social workers and family/youth/community liaisons who form a team, along with existing school-based mental health professionals to create five school-based Wellness Centers.

Tulare County Office of Education

- Leveraged 24 years of collaborative relationships with 41 partners and an established Governance Group.
- Created the Mental Wellness Services program within the Tulare County Office of Education, in active collaboration with the Tulare County Health and Human Services, Mental Health Department and respective partners to hire school mental health professionals.

Mental Health Student Services Act (MHSSA)

Due to widespread interest in school-county partnerships, the 2019-20 state budget included the Mental Health Student Services Act (MHSSA), which provides $40 million one-time and $10 million ongoing funding for additional mental health partnerships between county behavioral health departments and school districts, charter schools, and county offices of education.[160]

The act specifies that partnering agencies should emphasize the prevention of health needs from becoming severe and disabling, timely access to services, the reduction of stigma, and outreach to families and service professionals to recognize early signs.

In the fall of 2019, the Commission conducted statewide listening sessions to allow stakeholders to shape how funds should be allocated. The Commission in November 2019 adopted criteria for the allocation of funds. In 2020, two rounds of grants were awarded to 18 counties: 10 to established school-county partnerships and eight to new and emerging school-county partnerships. The enthusiasm and interest in these grants, as indicated by the 38 out of 58

counties and their school partners submitting grant proposals, must be built upon and sustained if the State is to ensure that each child is intellectually and emotional nourished.

Partnership with the California Department of Education

The Commission has partnered with the Department of Education on several projects. First, the Commission consults with the State Superintendent of Public Instruction to ensure the MHSSA grants are aligned with the goals of the educational community. Second, the Commission contracted with the Department of Education to build and enhance school-county partnerships through the development of a toolkit and statewide learning collaborative. Stakeholders have indicated a need for more resources, including training and technical assistance to begin and sustain this work.

The Commission also is working with CDE to link educational and mental health data. Data matching has the potential to yield important information on the impact of mental wellness on educational outcomes, the needs for services and the effectiveness of interventions. A data forum will be held to engage stakeholders on key data-related issues and to strengthen partnerships that can link data for improving the quality of services and outcomes.

Youth Innovation Project

The Commission in 2018 launched the Youth Innovation Project and established a Youth Innovation Project Planning Committee, comprised of 14 youth from 12 counties to guide the project.[161] Led by Commission Chair Khatera Tamplen, the Committee is working to identify and develop concepts for youth-centered county innovation projects with the potential for significantly improving treatment and outcomes for youth. The Commission contracted with three youth serving organizations to provide support, training and capacity building for the committee.

The committee reviewed the mental health literature, results from a statewide survey on youth mental wellness, and findings from four focus groups of youth held in different parts of the state. The committee identified mental health promotion and prevention in schools and colleges as a key opportunity for exploring innovative solutions. The committee also recommended that research-informed tools and strategies such as positive youth development and youth-led action research be incorporated into projects.

The Commission is working with county leaders to partner with the committee and local youth to host regional idea labs that explore innovations to increase preventive mental health services in schools.

The Commission has also funded youth-led organizations such as the California Youth and Empowerment Network (CAYEN) and the California Youth Connection (CYC) to facilitate transition-age youth (TAY) engagement with California's mental health system. CAYEN has a statewide TAY board comprised of those who have been "touched by" the mental health, juvenile justice, or foster care systems.[162] CAYEN empowers TAY leaders to "create positive change" in the mental health system through involvement in decision-making and bridging

multiple systems to improve outcomes for youth. CYC is led by current and former youth in the foster care system who have been instrumental in transforming the foster care system through youth-led outreach, training, organizing, and advocacy.[163] CYC operates a youth-led project – No Stigma, No Barriers – which is designed to improve mental health outcomes for youth. A key finding from this outreach is that youth want services and supports that are strengths-based, peer-led, and wellness-oriented.

The Commission also has supported innovation projects that center on youth voice and leadership. In 2018, the Commission approved $15 million to open one-stop, youth mental health clinics in Santa Clara County.[164] These clinics were inspired by a model in Australia called headspace. The Santa Clara County allcove innovation is a partnership between Santa Clara County Behavioral Services and Stanford University Center for Youth Mental Health and Wellbeing. A Youth Advisory Committee was established to ensure that youth voice and experiences inform the development of allcove centers and their services. The allcove centers provide youth with access to holistic services, including onsite mental health and substance abuse counseling, physical health care services, and linkages to education, housing, employment, as well as intensive treatment options.

Suicide Prevention

The Commission in November 2019 adopted Striving for Zero, the State's suicide prevention plan for 2020-2025.[165] Young people disproportionately attempt suicide and young people of color are particularly at risk. Striving for Zero provides four specific actions the State and communities can take to advance a public health approach to suicide prevention: 1) Develop a networked infrastructure of organizations, resources and information; 2) reduce risk by promoting safe environments, resiliency and connectedness; 3) increase early identification and connection to services; and, 4) improve suicide-related services and supports.[166]

The plan was prepared at the direction of AB 114 (Chapter 38, Statutes of 2017).[167] The Commission conducted extensive public outreach and deep consultation with subject matter experts. The plan includes detailed recommendations and an action plan to reduce suicide, minimize harm to families and communities, and improve outcomes for survivors – including actions to address the risks to students and youth in general. The Commission was provided direction and resources in the 2020-21 budget act to begin implementing the plan.

Prevention and Early Intervention Project

Senate Bill 1004 (Chapter 843, Statutes of 2018) directed the Commission to establish priorities and a statewide strategy for prevention and early intervention services.[168] This project is exploring opportunities to promote mental health and reduce factors that may prevent people with mental health needs from thriving. The goals of this exploration are to equip people, families, and communities and systems with information to expand effective prevention and early intervention strategies. Children and youth are prioritized in the legislation, with a focus on childhood trauma, youth outreach and engagement, early psychosis and mood disorder detection, and suicide prevention. This project is scheduled to be completed in early 2021.

Supporting Transformational Change

The Mental Health Services Act was crafted to support transformational change in mental health care and the Mental Health Services Oversight and Accountability Commission was given the authorities and the responsibilities to drive that change.

The principles outlined below indicate the need for transformational change in school mental health and the imperative – morally, socially and economically – to meet the needs of every child. New spending and programs alone will not produce the required improvements.

As a whole, the principles call for a reordering of priorities, the development of new and stronger partnerships, as well as the integration of resources, including facilities and funding, but most importantly professional staffs. Concerted effort is required to develop more strategic knowledge, rapidly transfer that knowledge into practice, iterate on services and interventions, and evaluate for continuous improvement.

An essential element of this transformation is the deep collaboration among community-scale governments and equal collaboration among state agencies that support and guide their efforts. All partner agencies need to develop new capacities to innovate, execute, evaluate and improve strategies, programs and services.

Toward these ends, the Commission can use its authorities and capacities in the following ways:

1) **Oversight and accountability**. The "Transparency Suite" on the Commission's website will continually be improved so that policymakers, administrators, practitioners and parents can get information on how MHSA funds are being spent to prevent, intervene and treat mental health needs in children, and through schools in particular. Over time, more details on the programs and outcomes will be added.
2) **Program review and data collection**. The Commission will proactively review county Three-year MHSA, Innovation, and Prevention and Early Intervention plans for information and insights on the attributes, extent and impact of programs, and explore with counties and other partners how to accelerate the pace and scale of progress.
3) **Strategic projects**. The Commission's development of the Prevention and Early Intervention strategies and priorities directed by SB 1004 will incorporate the information and insights in this report. The Commission also will assess how to better align its program review and accountabilities functions to the goals of improving school mental health and children's mental health more broadly.
4) **Grant programs**. The Commission will work with recipients of the Mental Health Wellness Act (Triage) grants and the Mental Health Student Services Act grants to determine how future investments can improve outcomes by building stronger partnerships, integrating services, braiding funds and evaluating programs for continuous improvements.

The Commission also will continue to deploy its overall charge to advance mental wellbeing – and specifically the wellbeing of children and families – with the following activities:

- The Commission will convene mental health and education policymakers, experts and practitioners to understand and resolve issues that prevent progress. The Commission also will engage private and civic sector leaders, including researchers, health care providers, employers and community leaders to develop understanding and encourage innovation.
- The Commission will identify and resolve conflicts among policies, regulations, funding streams and cultures that slow or thwart efforts to develop human-centered services that cost-effectively meet the needs of individuals, families and communities.
- The Commission will support and evaluate service-level collaboratives striving to improve outcomes and learning collaboratives among enterprising counties and their partners.

VII. Principles for Advancing Student Mental Health

To guide the system-level changes that are underway – and need to be accelerated – the Commission developed principles that distill the knowledge, wisdom and experience that are known and needed to fortify school mental health. These guiding principles are intended to inspire and inform the myriad of decisions being made by leaders in communities and at the state. Several next steps and opportunities also are defined, and the Commission forecasts the authorities and capacities that can be deployed to support a well-functioning system approach.

Guiding Principle 1. Each Child Should be Emotionally and Intellectually Nourished

A commitment to equity and reducing disparities is central to a school mental health strategy. Disparities in student disciplinary action, chronic absenteeism, and other negative outcomes must be eliminated. To address disparities, schools must confront and counter racism and implicit bias, and engage with students and families in discussions about race, racial justice, and LGBTQ issues.

- ✓ Establish a continuum of culturally, linguistically, and LGBTQ-responsive mental health services and supports across tiers of intervention.
- ✓ Adopt trauma- and healing-informed practices to mitigate trauma and toxic stress in students.
- ✓ Implement positive discipline strategies such as restorative justice to reduce suspensions and expulsions.
- ✓ Establish educator preparation and training programs to support student wellness, and to raise awareness about bias and stereotypes.

Guiding Principle 2. Schools Should Be Centers of Wellness and Healing

Schools, youth, families, and health systems must work together to promote student wellness. Through these efforts, all students should feel safe, valued, respected, and supported at school. In addition, the wellbeing of educators and school staff needs to be prioritized and supported along with training and preparation. To establish schools as centers of wellness and healing:

- ✓ Ensure each student has at least one adult at school they can trust and turn to for support.
- ✓ Prioritize social and emotional skill development and establish social and emotional learning standards.[169]
- ✓ Review policies and practices that may hinder the mental wellness of students, particularly those that have a disproportionate negative impact on students of color, LGBTQ students, students in foster care, and other student groups.
- ✓ Provide students with daily opportunities to strengthen wellness and resiliency skills.
- ✓ Provide students with access to "safe spaces" during times of stress and need.
- ✓ Develop workplace policies and encourage private-public partnerships to support school employee wellness.

Guiding Principle 3. Health and Education Must Join Together

School-health system collaborations are essential to support student and family wellness. School and county health services should be integrated into a comprehensive and seamless continuum of support that is easily accessible to students and families. In this system, workforce capacity must be addressed for collaborations to be successful. Mental health personnel should be located on school campuses to enhance prevention and early intervention efforts, coordinate school-community collaboration, support teachers and staff, and connect students and families to additional community services when needed. To strengthen and deepen collaboration:

- ✓ Incentivize community collaboration.
- ✓ Leverage existing centers and networks to provide training and technical assistance to local communities to disseminate best practices and build sustainability.
- ✓ Address workforce shortages of mental health practitioners, particularly those from underserved communities.
- ✓ Improve ratios of school-based mental health professionals-to-students.

Guiding Principle 4. Prevention and Early Intervention Must Be Prioritized

Healthy mental, emotional, and behavioral development in early childhood is foundational for school readiness and success**.** Poverty, trauma, and other social determinants of health undermine healthy child and family development. Strengthening mental health promotion, prevention, and early intervention can build family resilience, promote healing, and reduce the prevalence and severity of mental health needs in society. Early and regular screenings are essential to a

prevention and early intervention strategy. To enhance children's healthy development and reduce the risk of developing a mental health need:

- ✓ Increase access to prenatal and postpartum care, screen for maternal mood disorders, and provide linkage to services and supports.
- ✓ Provide home-visitation to families at risk.
- ✓ Increase early childhood screening and mental health consultation.
- ✓ Expand access to affordable housing, bolster food security, and increase transportation support.
- ✓ Increase family knowledge of parenting and healthy development.
- ✓ Give concrete support to families in times of need, expand social networks and deepen community connections.
- ✓ Expand school entry health exam requirements to include mental health, trauma, and social determinants of health.
- ✓ Screen K-12 students regularly and at times of transition.

Guiding Principle 5. Youth and Families Must Be Engaged and Have Ownership

Student wellbeing is inseparable from family wellbeing. Programming and interventions with students should include their families. Schools should engage with families, build and strengthen trust, and provide access to resources to strengthen family wellbeing. Youth and families should have leadership roles at all levels of decision-making and service delivery. Responsive and respectful services should be designed to promote equity and reduce disparities, support best practice models and community-defined strategies, and are rooted in cultural, linguistic, and LGBTQ competence. To put youth and families at the center of school wellness:

- ✓ Establish youth and family wellness councils to guide school planning and policy.
- ✓ Engage youth and parents in training and teaming for school mental health and wellness.
- ✓ Engage with communities to develop positive discipline policies.
- ✓ Establish whole-family supports and services.
- ✓ Promote cultural understanding and humility, and provide culturally relevant community-wellness practices.

Guiding Principle 6. Sustainable Funding, Continuity and Collaborative Leadership are Critical to Making Schools Centers of Wellness and Healing

State leadership is needed to align policies, funding, training and technical assistance to local communities and schools in developing sustainably funded, comprehensive school mental health services that prioritize prevention and early intervention. Community leadership should identify local needs, coordinate community strategic planning processes, and align resources, funding, and quality improvement efforts. Data collection, evaluation and clear system-wide metrics are

required for effective planning, decision-making, service delivery, communication, and quality improvement efforts. To institutionalize and sustain schools as centers of wellness and healing:

- ✓ Establish a leadership body of state agencies to develop a statewide action agenda in collaboration with local communities for advancing comprehensive school mental health and wellness systems.
- ✓ Support local and regional training, technical assistance, innovation, and sustainability.
- ✓ Establish local cross-system partnerships to support school readiness, student wellness, and academic success.
- ✓ Align MHSA Community Program Planning with Local Control and Accountability Plans (LCAPs) to improve student outcomes.
- ✓ Develop an integrated data system, linking education and mental health data to identify, develop, and monitor indicators of student mental health and wellness.
- ✓ Facilitate research and evaluation to inform decision-making at the state and local level.

VIII. The State's Role in Transforming Schools into Centers for Wellness and Healing

The evidence is overwhelming that collaborative state and local leadership coupled with a significant investment in school mental health will advantage the next generation of Californians as they navigate a socially and economically dynamic world. The State's investment must provide additional services and build the adaptive and sustainable systems required to provide effective services.

California's initial investment in school mental health has revealed the need and the ambition of community stewards to address this need. Educators, health professionals and children's advocates are acting out of a sense of urgency to respond to the physical, emotional and developmental needs of children, which cannot be met with academic curriculum or teaching techniques alone. They are cobbling together the financial and professional resources, and applying and adapting emerging programs to stabilize children and families and to make learning possible. The response to the Commission's Triage and Mental Health Student Services Act grants have been several times the available resources.

The State's investments also have revealed the need to take a systemic approach. Schools, county behavioral health departments and other partners are developing programs based on their existing relationships, available knowledge and funding, and political will. Each is discovering and developing programs and services. Their efforts – and the return on the State's investment – would be significantly enhanced by peer-based learning and the development of comprehensive research-based models that are sustainable, impactful and adaptive from design.

Successful school and health system partnerships have common key elements:

1. Shared governance structures and accountability at all levels of decision-making.
2. Needs assessment and resource mapping to identify school and community needs and resource availability.
3. Strategic financing models to braid diverse funding streams and draw down federal entitlement dollars.
4. Integrated data systems that enable better service delivery, evaluation and continuing improvement while complying with privacy rules.
5. Strong and effective implementation and alignment of universal interventions, such as school climate, PBIS, social and emotional learning, universal screening, trauma-sensitive practices and restorative justice.
6. Integrated, multi-disciplinary teams at all administrative levels to implement and monitor services and supports.
7. A professional workforce equipped with the knowledge, preparation, training, and wellness to respond to student mental health needs.

The System of Support for K-12 education provides the infrastructure for developing models and professional skills.[170] California educators have created a structure to help all schools close the achievement gap, with tiered and specialized support for schools with additional needs. The structure includes the State Board of Education, State Superintendent of Public Instruction, Department of Education, County Offices of Education, and the California Collaborative for Educational Excellence. Select county offices of education serve as regional leads to supports other COEs and districts. And other county offices and districts serve as subject-matter leads, including community engagement, equity, special education, English learners and math.

Recommendations

1. **State Leadership**

The Governor and the Legislature should establish a leadership structure dedicated to the development of schools as centers for wellness and healing. The Governor's office should lead this effort, in partnership with the State Board of Education and Superintendent of Public Instruction, with operational leadership from the Department of Health Care Services, the California Department of Education and other agencies that can make a contribution. The leadership structure should work closely with the K-12 Statewide System of Support. The operational leadership should have dedicated staff charged with developing and implementing a state-level strategy to support community-level partnerships.

2. **State Investment**

The State should make a significant investment to establish schools as centers for wellness and healing. This foundational investment will require a multi-year commitment to developing the

model programs, the data and management systems and the workforce. It will require allocating more funding for services, and developing a sustainable funding strategy that links and leverages related funding and existing services, as described below.

3. State-supported Capacity Building

Funding alone – particularly "one-time funding" that initiates projects with no plan for sustainability – will not be enough to address the social-emotional needs of children. The state-level leadership structure must help counties and school districts develop the system-level capacities required to integrated resources, adapt evidence-based practices and manage for continuous improvement. The capacity building efforts should include these elements:

a. Model / program development. Successful models have common attributes based on research, experience and evaluation. The governance, management and programs are adapted to the needs, characteristics and cultures of communities. The significant diversity in communities and capacities requires a comprehensive effort to help all communities apply what is already known and develop the capacities required for effective services. The K-12 System of Support should be expanded and funded to provide this technical expertise to schools, and find ways to enhance preventive support to early learning programs that serve children ages birth to five.

b. Data and management. Effective data and management systems are needed at both the community and the state level to provide quality services and to align policies and funding to enable communities to be efficient and effective. The K-12 System of Support should facilitate the local capacity for data and cross-system management with education and mental health systems, and facilitate ongoing policy evaluation at the state level.

Design Criteria

The system should be engineered to meet the following criteria:

Sustainability. The mental health needs of schoolchildren cannot effectively be met with time-limited grants provided only when state revenue exceeds the previous year's budget. The evidence is overwhelming that mental health is integral to education itself. One-time funds can be used as start-up funds, to develop service systems, engineer ways to better tap into and align existing funds, including federal Medicaid funds, and develop proposals for ongoing funds.

Outcome oriented. Communities should be provided with expert assistance in designing well-functioning partnerships that deliver the intended results. The assistance should help local agencies develop effective school mental health systems and coordinate state actions to align funding and provide regulatory clarity.

Continuous improvement. Partnerships should be developed to adapt, replicate and scale proven practices, as well as to evaluate and incorporate new scientific knowledge and experiential insights. State actions should be aligned to support these abilities.

c. **Workforce**. The Budget Act of 2019-20 allocated to the Office of Statewide Health Planning more than $100 million in General Fund and funding from the MHSA Workforce Education and Training Program. OSHPD should be directed to work with county behavioral health and the K-12 System of Support to identify specific school-based workforce needs and allocate future fiscal year funding to students and educational providers.

d. **Funding.** The State needs to expeditiously spend available funds to initiate this effort and develop a sustainable funding system that will allow services to be provided in good and bad economic periods. The Governor and the Legislature should make a multi-year funding commitment for services, while also investing in system capacity and system sustainability. Among the considerations:

- Structure one-time funds to ramp up spending and then be reduced as ongoing funds are incorporated or created. Communities often are required to ramp up spending before they have developed programs, hired staff and developed management systems. Grant funds often run out when the programs are beginning to show impact. Spending should be coordinated and paced with capacity building activities.

- The State and K-12 System of Support should work together to develop and test options for braiding existing funds – including MHSA, Medi-Cal, LEA BOP, SMAA, ERMHS, LCFF, private insurance, and other funds including First 5 funds for younger siblings of children being served through schools. The State and communities must share the objective of achieving financial sustainability and pursue opportunities to create more flexibility from existing funds or to develop new funding sources.

Concluding Thoughts

Although this project began with a focus on student mental health, it expanded to include early childhood mental health and trauma. What happens to children prior to entering formal schooling matters. Children's social and emotional health and ability to self-regulate are critical to school readiness and later school success.

Children come to school bearing the burden of societal ills such as poverty, racism and discrimination, and intergenerational trauma. Strengthening local coordination of prevention and early identification can reduce the risk of trauma exposure, identify emerging mental health issues, and ensure timely intervention when needed.

Establishing schools as centers for wellness and healing through partnerships with health systems and robust family engagement can effectively support the needs of all children and prepare them "to live, work and thrive." With proper leadership, planning, collaboration, training and technical assistance, California has the opportunity to become a national leader in school mental health with an innovative whole-child agenda, ensuring our state's next generation is prepared for success.

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Appendix A: Examples of Early Childhood MHSA Programs

Shasta County Adverse Childhood Experiences (ACES)

Shasta County has leveraged PEI funds to support Shasta Strengthening Families, a local effort involving 30 agencies to strategically and collaboratively address adverse experiences. Shasta County residents have higher rates of adverse childhood experiences than the state's average. Forty percent of Shasta County adults report four or more experiences compared to 17 percent of adults statewide. The collaborative fosters greater partnerships and seamless service delivery across family-service agencies and medical providers. To raise awareness about trauma in different communities, the collaborative has hosted annual ACEs town halls.

Yolo County's Early Access and Screening Program

Yolo County's Early Access and Screening Program provides universal, developmental and behavioral health screening to parents and their children, birth to 5. Less than a third of California's children receive timely developmental, behavioral, and other health screenings from a health care provider; ranking California 30th in the nation. Screening rates are even lower for children of color. According to First 5 California, the screenings that are completed typically do not include a formal, structured assessment of a child's trauma history, mental health, or social and emotional functioning.

The Yolo program represents the first time that services for children, birth to 5 were included in the county's MHSA three-year plan. The program is a partnership with First 5 Yolo, which matches every PEI dollar to implement Help Me Grow (HMG). HMG aligns community resources to identify young children at risk, links families to services, and empowers families to support their child's development. HMG educates and encourages health care providers to conduct systematic screening of young children, and provides a centralized access point for providers, families and others to obtain information, support, and referrals.

Marin County's Early Childhood Programs

In Marin County, MHSA PEI funds are used to support Early Childhood Mental Health Consultation (ECMHC) in subsidized preschools and childcare sites in the region. ECMH is a prevention-based service to build the capacity of families and early care providers to support the social and emotional health of infants and young children and reduce challenging behaviors early before intervention is needed. A mental health consultant provides training, coaching, and consultation in different settings where children grow and learn – childcare, preschool, or in their home. Marin County also uses PEI dollars to support the implementation of an evidence-based positive parenting and family support system (Triple P) through training and technical assistance across settings and providers (mental health, primary care, schools, and family advocates). Triple P is designed to prevent and treat emotional and behavioral needs in children fostering healthy and positive family environments that help children realize their potential.

Imperial County's Innovation Program

Imperial County's Behavioral Health System Innovation Plan provides services in school settings to children ages 4 to 6 who are at risk for social and emotional needs. This partnership is based on implementation of First Steps to Success, an evidence-based intervention designed to help children improve their social and emotional skills at school and home. First Steps to Success has traditionally been implemented by school staff. Imperial's Innovation Plan embeds mental health staff in kindergarten and transitional kindergarten classrooms to coach students and provide ongoing consultation and support to teachers. This arrangement builds relationships across separate systems, and also provides children and family with links to community resources when needed.

Appendix B: School Mental Health and Wellness Models

Project Cal-Well: Federal Funds Support State Leadership and Awareness

California was one of 20 states awarded a five-year federal grant in 2014 to support expansion of school mental health. The grant – Advancing Wellness and Resilience in State Educational Agency (AWARE) – is funded under SAMHSA's Now is the Time Project. Project Cal-Well is led by the Department of Education in partnership with ABC Unified School District in Los Angeles County, Garden Grove School District in Orange County, and San Diego County Office of Education.

Project Cal-Well is working to increase mental health awareness in schools and communities, promote a positive school climate, and increase access to mental health services and supports in schools and communities through partnerships and system collaboration. Schools in Project Cal-Well have implemented schoolwide activities for all students that include positive behavioral interventions and support (PBIS), restorative justice, and social-emotional learning. They also have provided professional development training to educators and community members so they can recognize and support students who show signs and symptoms of mental health needs.

Since implementation of Project Cal-Well, schools have been able to hire additional specialized instructional support personnel and have markedly increased student utilization of mental health services and supports on school campuses. Schools also have increased school connectedness among students (feeling safe, close to people, and happy at school) and decreased suicide ideation, drug and alcohol use, and suspensions and expulsions.

Unconditional Education Model: Implementing a Multi-tiered System

Another approach is Seneca's Unconditional Education model. Seneca provides statewide educational, behavioral and mental health services to children and families. The Unconditional Education model arose out Seneca's long history working with children in foster care and group homes settings and the belief that children do not fail, but systems fail children.

Unconditional Education represents a paradigm shift from a traditional model of service delivery in which students must be referred to special education or mental health services, and those services are delivered by specialists in different settings. In the Unconditional Education model, integrated and coordinated services are available to all students. Love, compassion and respect are at the heart of the model. The belief that each student has the potential to succeed if adults and professionals take the time to understand both their past and current needs, and tailor, individualized services in response.

The Commission visited an elementary school in Contra Costa County where the Unconditional Education model had been implemented. Grant Elementary serves over 500 students in Kindergarten through 6th grade; the majority of whom are English Language Learners and live in families with incomes below the federal poverty level. Principal Farnaz Heydari said prior to implementation of the model, parents were not involved with school activities and some had even been banned from the school campus. She said that teachers were given limited support and

often took on the trauma of their students. School suspensions and expulsions were commonplace.

Seneca assigned a full-time site coach to the school to implement a tiered intervention strategy using a PBIS framework. The site coach worked with the school to establish and facilitate teams including a community partnership team to improve the coordination of services between school staff and community providers. Principal Heydari emphasized that community partnerships are a core component for transformational change at her school. The teams established a common understanding of student mental health needs and goals for the both the school and the students, monitored student progress and outcomes, and linked students to appropriate services. Data cards were created for school staff with information about each student; color-coding note those students in need of more intensive support or services. This and other information were used by a multi-disciplinary team of professionals to make decisions about which students might benefit from targeted or intensive services. After the first year of implementation, school suspensions were down, and teachers reported improvement in student behavior.

Hathaway-Sycamores School Based Mental Health Model

Hathaway-Sycamores Child and Family Services is a mental health and welfare agency providing services in Southern California. Hathaway-Sycamores has partnered with school districts since 1997 to provide school based mental health services throughout Los Angeles County including the Los Angeles Unified School District. In the Hathaway-Sycamores School Based Mental Health model, full-time therapists and community wellness specialists are embedded on school campuses. These professionals are fully integrated into the school community and work closely with educators to facilitate a safe and supportive learning environment that facilitates learning and supports healthy student social and emotional development. Under this model, a full provision of mental health services is provided including individual therapy, family, and group therapy; medication support; rehabilitation services; and co-occurring services for students with substance use disorders. Targeted services are also provided to students who are at risk and need additional support to be successful in school (e.g., life skills, social skills, coping skills and anger management). Students and their families have access to services year-round, even when school is not in session. School principals have reported declines in school disciplinary referrals since the inception of the model.

Other Recognized Leaders in School-County Partnerships

Several communities in California are making great strides in working together to support the mental health and wellbeing of children and families. These efforts began simply through relationships – conversations, dialogue building trust, and making commitment to work together. Positive working relationship are at the heart of successful partnerships. The following provide a brief summary of such efforts:

- **Fresno County** is among a growing number of counties leveraging the strength of local partnerships to collectively respond to student challenges. All 4 Youth is a $110 million campaign involving the Fresno County Behavioral Health Department, the Fresno

County Office of Education, and local school districts and schools. The goal is to increase access to mental health services for all children regardless of Medi-Cal eligibility and insurance coverage, and to provide flexible, family-driven mental health services in the school, community, or home. Mental health clinicians are being phased into every school in the county over five years.

- In **Monterey County**, the County Office of Education and the Behavioral Health Department established a team of leaders from school districts, community providers, public health, child welfare, probation and a local university as a way to connect the systems that touch children and families and provide a county-wide continuum of mental health services. County mental health clinicians are embedded in schools and can provide mental health training, coaching, consultation and direct services. The school-based clinicians are connected through the collaborative to every part of the system of care in the community to provide seamless, coordinated services and supports.

- **Placer County** has a long history of bringing agencies together as part of a multidisciplinary team of professionals to form a children's system of care. Recently, Placer County Health and Human Services and Placer County Office of Education have recently established school-based Wellness Centers similar to models in San Francisco and Napa Valley unified school districts. The Wellness Centers are intended to deepen the existing county-wide education, mental health, child welfare, probation, and community partnerships to provide a full continuum of mental health services to students and families. Each Wellness Center is staffed by a school social worker, family/youth/community liaison, and other school staff including school counselors, school psychologists, and nurses to meet mental health needs of students and families inside and outside of school. The Wellness Centers also serve as a resource hub for the community and are open before and after-school hours to serve working families.

- In **San Bernardino County**, the children's mental health system is shaped by the characteristics of the region – a large rural area with high rates of poverty. The Desert/Mountain Special Education Local Plan Area (SELPA) is a consortium of school districts and charters schools formed to provide mental health services to children at school because of the difficulty in transporting children to county mental health and child welfare offices. Desert Mountain SELPA was able to expand services in schools by entering into a contract with the San Bernardino County Department of Mental Health to provide school-based Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) mental health services for children eligible for Medi-Cal. Hence, the Desert/Mountain Children's Center was established under the administrative umbrella of the Office of San Bernardino County Superintendent of Schools. Other programs followed including the first screening, assessment, referral, and treatment (SART) clinic in the county that was funded primarily through EPSDT funds from the county with a local match from First 5.

Appendix C: School Mental Health and Wellness Evidence-Based Practices

Tier 1 **Universal Supports and Interventions**	Positive Behavioral Interventions and Supports (PBIS) Collaborative for Academic, Social, and Emotional Learning Safe & Sound Guide (CASEL) Mental Health First Aid Restorative practices Caring School Community Program Second Step Program Project ACHIEVE: Stop & Think Social Skills Project for School REACH (Relationships, Effort, Aspirations, Cognition, and Heart) Search Institute's Developmental Assets® Mindfulness practices
Tier 2 **Targeted Supports and Interventions**	Check In Check Out (CICO) Behavior contracts Mentor-based support Self-monitoring First Steps to Success (Kindergarten and 1st grade) Small group social-emotional learning Small group social skills training
Tier 3 **Targeted Supports and Interventions**	Cognitive-Behavior Therapy (CBT) Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) Dialectical Behavior Therapy (DBT) for Youth Wraparound Service Coordination Functional Family Therapy (FFT) Multidimensional Family Therapy (MDFT) Multisystemic Therapy (MST) for Youth

Note: Interventions should be age and developmentally appropriate.

Diverse Community-defined Solutions to Promote the Wellbeing of Students

POLICY BRIEF

MHSOAC
Mental Health Services
Oversight & Accountability Commission

The MHSOAC's Schools and Mental Health Project is designed to identify challenges and opportunities to improve educational and mental health outcomes for children in California. The MHSOAC held public hearings and community forums, visited schools across the state, and organized focus groups representing students, parents, educators, and mental health providers to gain a better understanding of the issues relevant to student mental health. As part of these efforts, the Commission conducted targeted events with communities of color to ensure that the perspectives and experiences of these communities were foundational to the project.

This brief provides a summary of themes brought forth by African American, Native American, Latino, and Asian/Pacific Islander (API) community members who participated in Commission-sponsored school mental health project events. Outreach efforts for this project yielded rich and varied perspectives on the concerns of diverse communities and resulted in key community-defined solutions for improving California's response to student mental health needs.

Although these events predated COVID-19 and school closures, they have even greater relevance today as communities of color grapple with disproportionate infections and deaths due to the coronavirus, unemployment, food insecurity and homelessness.[1-3] Racial-ethnic inequality has deepened, and coupled with social isolation and uncertainty about the future, will have a lasting impact on the wellbeing of students, particularly students of color. The second pandemic will be a mental health crisis and schools will be ground zero for mobilizing a compassionate and effective response.

THE PERVASIVENESS OF TRAUMA AND ADVERSITY FOR COMMUNITIES OF COLOR WAS A CENTRAL THEME ACROSS OUTREACH EVENTS.

Introduction

California's student population is among the most diverse in the country: 51 percent of children identify as Latino, 27 percent as non-Latino white, 11 percent as Asian American, and 5 percent as African American[4]. Ethnic and racial minority children often experience higher exposure to adverse events. Homelessness, foster care placement, school dropout, and school disciplinary enforcement disproportionately affect minority communities.[5,6] Given the prior exposure to risk and the negative consequences associated with those exposures, understanding the experiences and perspectives of children and families of color is even more critical to developing and implementing effective interventions in the wake of COVID-19.

Community Concerns

The following concerns were highlighted across diverse communities. These concerns are deeply intertwined. For example, stakeholders emphasized that trauma was common among students of color and too often resulted in punishment rather than culturally responsive mental health services which were lacking in unserved or underserved schools and communities.

Exposure to Trauma and Adversity is Not Being Recognized

The pervasiveness of trauma and adversity for communities of color was a central theme across outreach events. Parents, school personnel, providers, and community leaders who attended the engagement events reported that many of the children in their communities had experienced trauma, including violence in the home or in the community, removal from home and placement in foster care, immigration trauma (deprivation or violence experienced in migration or border crossing), and bullying. Participants suggested that exposure to these events lead children to react with anxiety, disruptive behaviors, difficulties with attention, and impulse control problems which affect their ability to learn.

COMMUNITY CONCERNS:

- Exposure to Trauma and Adversity is Not Being Recognized
- Punitive Disciplinary Practices Harm Traumatized Children
- Not Enough Mental Health Services in Schools
- Cultural Awareness and Understanding is Lacking
- Mistrust of Institutions Including Education

"MY SON HAS HAD SEVERE TRAUMA. AN ABSENT FATHER, INSTABILITY IN THE HOME, HOMELESS FROM AGE 1-6. HE WOULD CRY A LOT, HE LACKED SOCIAL SKILLS AND DIDN'T UNDERSTAND HIS PEERS. WHAT CALMED HIM DOWN WAS ONE TEACHER THAT TOOK THE TIME TO UNDERSTAND MY SON. AND SHE WOULD HUG HIM WHEN HE NEEDED IT."

Stakeholder Participant

In addition to traumatic events, participants brought up the disproportionate exposure to adverse circumstances and intergenerational trauma. Food insecurity, homelessness, family instability, caregiver incarceration, unemployment, substance abuse or mental illness may place considerable day-to-day stress on children and have a profound impact on their ability to engage effectively in the classroom. In addition, for communities that have experienced exposure to war and forced separation of families (such as through Native American boarding school policies, deportation, slavery and mass incarceration) intergenerational trauma is common.

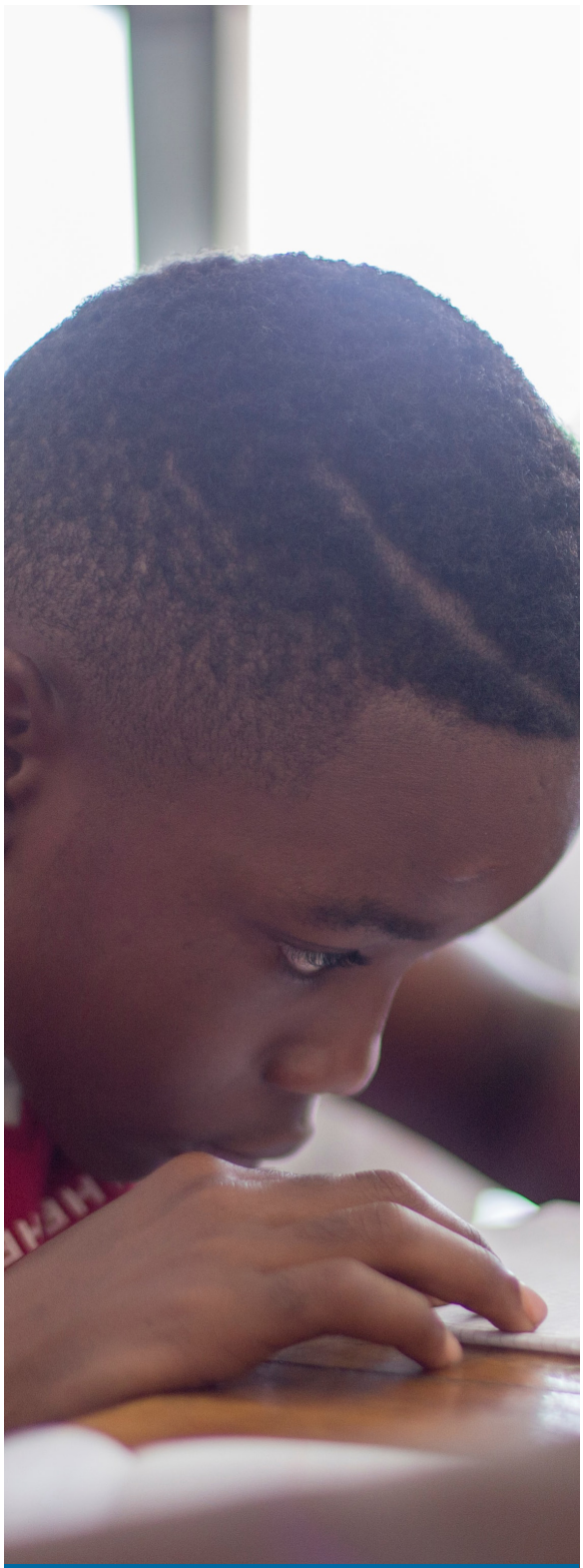
Intergenerational trauma requires a two-generation approach. Parents and caregivers who have trauma histories may also experience mental health symptoms or mental illness. These parents need services to heal and recover. They may also need parenting support and guidance to help their child develop the social and emotional competence required to function effectively in the classroom.

Punitive Disciplinary Practices Harm Traumatized Children

Many participants reported that when their children experienced emotional problems, they received disciplinary action. For example, one parent reported that after experiencing homelessness for the first six years of his life as well as sexual abuse, her child had difficulty sitting still in the classroom, was aggressive, disruptive, and disobedient. He was repeatedly suspended for this behavior. Participants reported that this tendency to discipline children of color for behaviors that most likely stem from early experiences of trauma is common. The frequent disciplinary actions are a source of stress for parents who are struggling to maintain employment and housing and must leave work to respond to calls from schools. For African American families, the use of police intervention was widely criticized.

"IF YOU COME FROM TRAUMA, YOU DO NOT WANT TO BE SEEN "

Stakeholder Participant



MANY PARTICIPANTS REPORTED THAT WHEN THEIR CHILDREN EXPERIENCED EMOTIONAL PROBLEMS THEY WERE DISCIPLINED INSTEAD.

ONE MEETING PARTICIPANT DESCRIBED A SITUATION IN WHICH HER SEVEN-YEAR-OLD SON WAS DETAINED BY POLICE OFFICERS AFTER MAKING SUICIDAL THREATS ON THE PLAYGROUND. INSTEAD OF ADDRESSING THE EMOTIONS THAT LED TO HIS BEHAVIOR, THIS INTERVENTION WAS BOTH PUNITIVE AND TRAUMATIZING FOR THE BOY, WHO WAS VERY FEARFUL OF THE POLICE.

Participants also noted that the excessive use of disciplinary actions and police interventions perpetuates the school-to-prison pipeline, in which youth of color experience increasing marginalization from educational opportunities and are pushed toward criminal justice involvement.

Not Enough Mental Health Services in Schools

Stakeholders perceived that educators are sometimes unaware of the trauma and hardships experienced by children and the effects of these experiences on their behavior and emotions. Caregivers reported that they only received help when behaviors became severe, suggesting that children had to "fail first" before receiving appropriate interventions. Caregivers often described feeling isolated and helpless, not knowing where to turn for help and experiencing a "long road" to getting help.

Stakeholders also suggested that schools lack the resources to adequately address mental health needs that arise in the school setting. As one stakeholder said, "That is what they always tell us: There are no funds, no funds, and no funds...Then, what do we do?"

Teachers are often unaware of the trauma and hardships experienced by children and the effects of these experiences on the children's behavior and emotions. Even when teachers are aware of children's trauma experiences, they may be unable to address children's emotional reactions given a lack of time or training. In large classrooms comprised of students with trauma and challenging behaviors, addressing their mental health needs is often not feasible for teachers. Teachers may be overwhelmed with the task of managing classroom behavior or may experience burnout resulting from the emotional burden of caring for children with multiple challenges. Furthermore, schools lack other supportive services, such as counselors, classroom aids, playground supervisors and other school personnel trained to manage behavioral and emotional difficulties.

Cultural Awareness and Understanding is Lacking

Across groups, participants suggested that school personnel and other providers often lack familiarity or awareness of cultural differences. Many African American participants suggested that

"I BELIEVE IT ALL BOILS DOWN TO TRUST. IT'S VERY DIFFICULT TO ESTABLISH TRUST. WE GREW UP SEEING IT – KIDS GETTING SPLIT UP. IT'S DIFFICULT TO PLACE THE TRUST IN PEOPLE AT SCHOOL"

Stakeholder Participant

teachers do not understand the way their families communicate, their experiences, or the history of oppression and discrimination that continues to affect African American families. Similarly, Native American participants suggested that schools lack an awareness of intergenerational trauma and the importance of cultural connections for Native youth.

Latino and API participants suggested that language barriers and cultural differences often prevent caregivers from forging relationships with teachers, participating actively in their children's education, and feeling a sense of connectedness and community in the school environment. In sum, participants across groups reported that school personnel and providers' lack of awareness of history, culture, discrimination, and racism and the effects of these on families and children creates a significant barrier to building collaborative relationships and addressing children's mental health needs.

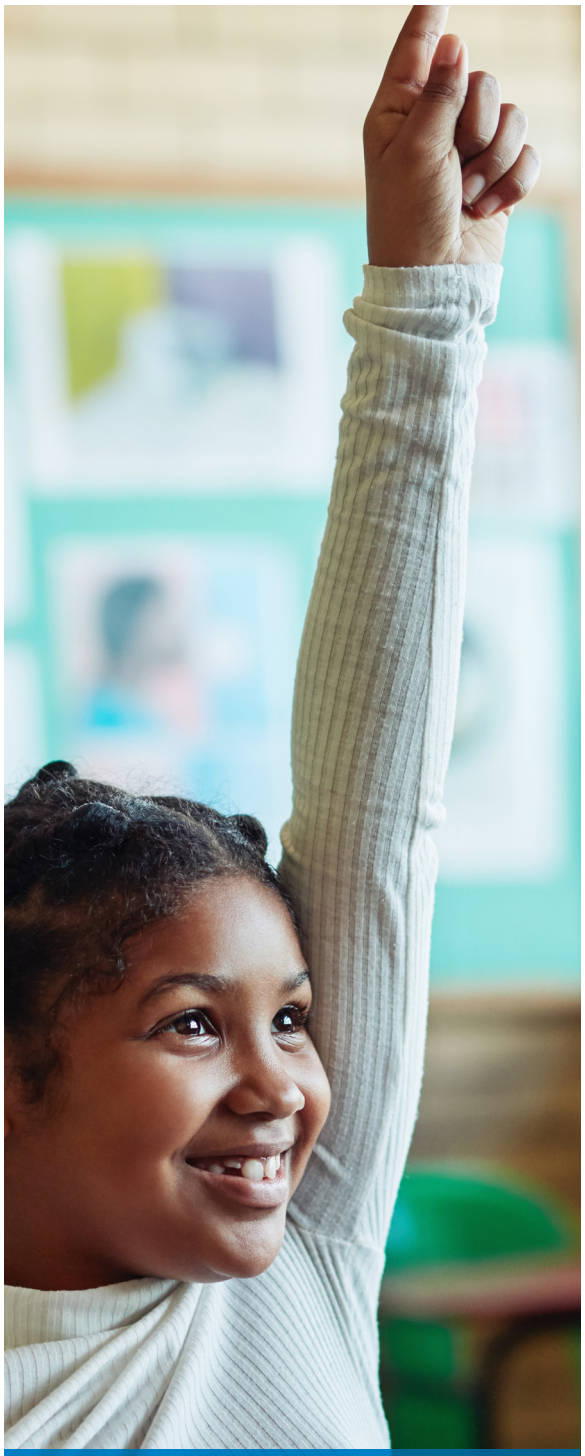
Mistrust of Institutions Including Education

Community forum discussions also focused on the lack of trust between communities and government/educational institutions. For many communities, the experiences of family separation (due to current practices of deportation, mass incarceration, and CPS intervention, as well as histories of forced family separation due to slavery and forced removal to boarding schools) have resulted in a profound sense of mistrust. Many communities of color fear government intervention as historically this intervention has led to the most deeply traumatic and damaging experiences.

Latino participants further pointed to the current political climate in which deportation and family separations are a constant threat and discrimination and racism against Latino families continues to be on the rise. For API participants, stigma was a significant barrier affecting caregivers' willingness to engage with schools. Specifically, participants in the API forum suggested that many API families are reluctant to divulge personal family information to others outside the home. Further, mental illness may be viewed as shameful, particularly in a culture in which pressures to succeed academically are high. In sum, within a context of mistrust, forging collaborative relationships to effectively address child mental health problems is vital.

COMMUNITY DRIVEN SOLUTIONS:

- Recognize and Address Trauma and Adversity
- Build Relationships with Communities
- Foster Cultural Awareness and Humility
- Increase access to Prevention and Mental Health Services



"CREATE MEANINGFUL RELATIONSHIPS - THEY CALL US DAUGHTERS AND COUSINS. THEY TELL OTHER PEOPLE ABOUT OUR SERVICES. THERE IS NO CLEAR WAY OF DOING THIS, TRY NEW THINGS"

COMMUNITY PROVIDER

COMMUNITY-DEFINED SOLUTIONS

Across diverse groups, there were four primary solutions proposed to meet community concerns. These solutions emphasize and elevate the importance of relationships—developing understanding, empathy and trust—as the foundation for supporting student mental health and wellness.

Effectively Respond to Trauma and Adversity

Across outreach events, the most common recommendation for improving the mental health of school-age children was to recognize and address trauma and adversity. As noted above, participants across groups viewed adverse experiences as responsible for causing the bulk of social and emotional difficulties manifested in school-age children. Accordingly, participants recommended that school personnel and providers be trained to recognize when children have experienced a trauma or are experiencing ongoing distress due to difficult life circumstances. This may require building awareness of the kinds of stressors experienced by students including food and housing insecurity, violence in the home, community, and school, immigration and refugee stress, racism and discrimination, bullying, and the effects of these experiences on students' behavior in the classroom. Instead of punishing children, approaching disruptive behaviors as manifestations of distress and trauma and incorporating opportunities for socioemotional learning may be an effective approach for eliminating or reducing these behaviors.

At the same time, participants recognized the enormity of this task and suggested that schools invest in services and supports to enhance capacity to address student's social and emotional needs. These services and supports may include additional classroom aids trained in behavioral interventions as well as school-based counselors and even brick-and-mortar facilities that could serve as safe spaces for children in crisis.

Build Trusting and Meaningful Relationships with Communities

To more effectively address the mental health needs of students, collaborative relationships between schools and communities must be fostered. To establish positive and collaborative relationships with families, schools may need to prioritize relationship-building, reframing these efforts as critical to the success of students. This will require the investment of time and resources in activities to promote communication and participation in school activities.

Immersion in communities through involvement in community events and promotion of home-visiting may also be instrumental in improving relationships. Further, schools may need to ensure that outreach activities and school events provide a welcoming environment and interpreter services when needed.

Foster Cultural Awareness and Humility

Cultural humility is critical to building positive relationships with families. Many participants suggested that teachers did not have an understanding of their cultural norms and values and therefore missed opportunities to connect with families. Teachers and other school personnel may bridge gaps and enhance relationships with families by approaching families with cultural humility and by learning more about the families with whom they work. To enhance students' social and emotional adjustment, teachers may provide opportunities to showcase and celebrate the diverse cultures of students in their classrooms.

In addition, attention to histories of discrimination is critical in building relationships with communities of color. To begin to repair the damage done by historical oppression, schools may need to invest effort into regaining the trust of communities. This can be done through open and transparent communication, increased awareness of the histories of oppression and discrimination, and recognition of the fears and challenges faced by parents.

Cultural humility is the "ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]."[7]

"WHEN YOU TRY TO REACH THE AFRICAN AMERICAN COMMUNITY, WHAT YOU SEE IS BOUNDARIES FROM WESTERN PHILOSOPHY - THAT HAS TO GO OUT THE DOOR. THEY MUST SEE THAT IN YOU FIRST. I CANNOT BE COLOR BLIND...I NEED YOU TO BE WHITE CONSPIRATORS, NOT ALLIES. YOU ARE STANDING WITH THE PEOPLE OF COLOR "

Stakeholder Participant

CULTURAL HUMILITY IS CRITICAL TO BUILDING POSITIVE RELATIONSHIPS WITH FAMILIES.

THROUGH THE WORK OF THIS PROJECT, THE VOICES OF COMMUNITIES OF COLOR WILL BE ELEVATED AND THE PERSPECTIVES EXPRESSED WILL INFORM POLICY MOVING FORWARD.

Increase Access to a Continuum of Mental Health Services

Participants recommended improving access to a broad spectrum of mental health and wellness services and programs. To promote wellness, schools may implement affordable recreational programs that provide support and opportunities for social and emotional learning for students. These programs may include arts, dance, theater, athletic programs, and music. For students who experience trauma, avoiding a "fail first" approach is critical. Instead, early identification of children struggling with emotional challenges and timely intervention may prevent the escalation of behavioral and emotional problems. Finally, for students with emotional or behavioral challenges, schools may facilitate access to mental health services, either by providing mental health services on site, or providing a warm hand-off to community-based clinics. To ensure the success of these programs, enhanced coordination among systems is critical. Schools, mental health providers, community-based organizations, social services, juvenile justice, and developmental services must collaborate to form integrated and coordinated care plans.

Conclusion

The Schools and Mental Health Project convened stakeholders from across various disciplines representing a wide variety of perspectives. Amongst all participants was a shared sense of purpose and a willingness to work together to develop strategies that would improve the well-being of children. As a result, meetings were energetic and dynamic, relationships were forged, and partnerships developed that will likely lead to further action and change on behalf of students suffering from trauma and mental health conditions. The Commission hopes that through this project, the voices of communities of color will be elevated and the perspectives expressed will inform policy as schools move forward under COVID-19.

SUGGESTED CITATION: Elliott, K., LeMasson, K. D., and Early, D. R. (2020). *Diverse-community defined solutions to promote the wellbeing of students.* Mental Health Services Oversight and Accountability Commission.

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Select Project Events	Location
School Site Visits	
1. Bell Avenue Elementary School	Sacramento, CA
2. Grant Elementary School	Richmond, CA
3. Monterey Park Elementary School	Salinas, CA
Community Meetings	
1. Enhancing the Mental Health of API Children in San Joaquin Valley Schools	Fresno, CA
2. Transitioning Back to School: Gender, Mental Health, and Education Summit	Oakland, CA
3. Schools, Mental Health, and Well-Being in the African American Community	Stockton, CA
Small Group Meetings/Focus Groups	
1. African American Parent Focus Groups	Sacramento, CA
2. Latino Parent Focus Group (Spanish)	San Mateo, CA
3. Latino Parent Meetings (2) (Spanish	Chula Vista, CA
4. Teachers & School Professionals	Sacramento, CA
5. Teachers & School Professionals	Los Angeles, CA

August 14, 2020

To: Toby Ewing, Executive Director
Dave Gordan, Commissioner
Kai Dawn Stauffer LeMasson, Senior Researcher

SUBJECT: CBHDA Comments regarding the MHSOAC Schools as Centers of Wellness Daft Report

The County Behavioral Health Directors Association of California (CBHDA), which represents the public mental health and substance use disorder program authorities in counties throughout California, was pleased to read the report outlined by the Commission to strengthen coordination across the county behavioral health and education systems to support vulnerable children and youth. CBHDA was especially pleased to find that the MHSOAC highlighted many of the innovative county behavioral health and education partnerships that have been developed to provide both supportive and intensive levels of services to children and youth across the state. The partnerships that the MHSOAC discussed in the draft report inspired both CBHDA and the California Alliance of Child and Family Services to co-sponsor Assembly Bill (AB) 2668 (Quirk-Silva, Weber) - Integrated School-Based Behavioral Health Partnership Program. Although AB 2668 was unable to move forward this session, CBHDA and our members continue to believe that coordination across our respective systems and identification of vulnerable children and youth through school-based partnerships will enable the provision of necessary behavioral health services.

General Comments: Overall, we want to congratulate the authors and the OAC on this comprehensive description of the challenges, successes and recommendations for strengthened coordination in providing school-based mental health services. Although we will dedicate much of this communication to providing some limited constructive feedback, we want to begin by expressing our overall support for the goals and intent of this publication and our praise for the authors of this ambitious work product.

In general, although the report does an excellent job of highlighting the critical role that the Department of Education and other educational agencies have in strengthening school-based collaborations on mental health services, the report is relatively silent on how resources used to fund educationally-related mental health services (ERMHS) should be part of an integrated effort to strengthen partnerships and collaboration on school-based mental health services. Any attempt to expand and integrate existing efforts to develop Schools as Centers of Wellness must include, build upon, and integrate this critical responsibility of schools to ensure mental health needs do not intervene with student instruction. The report mentions this responsibility, discusses the state decision giving schools the sole responsibility to provide ERMHS as resulting in siloed services, but the report does not include calls to integrate or braid the funding used to provide ERMHS as part of the efforts to strengthen school-based mental health services. We believe this is a significant oversight.

Background on ERMHS – In 2011, the Legislature and the Administration clarified that all California school districts are solely responsible for ensuring that students with disabilities, as designated by their Individualized Educational Plan, receive the ERMHS necessary to benefit from a special education program. Funding for ERMHS is distributed from the California Department of Education directly to Special Education Local Plan Areas (SELPAs) based on the average daily attendance of all pupils in the SELPA. SELPAs then determine how to allocate dollars to the individual districts and schools for ERMHS and other special education services.

ERMHS are provided by school credentialed staff. These school employees are generally not able to provide Medi-Cal Specialty Mental Health Services (SMHS). However, counties have existing models to integrate/coordinate ERMHS and SMHS including schools contracting with county behavioral health agencies to provide ERMHS on school sites. In this model, county behavioral health agencies also provide SMHS for students both on school sites and when necessary, in the community. In another model, county behavioral health agencies contract with appropriately trained school-based ERMHS staff to provide limited SMHS appropriate for delivery on the school site. Finally, in many counties, school staff provide ERMHS and county behavioral health agencies operate on school sites and provide SMHS. School staff refer students receiving ERMHS as well as other students, such as those described on page 12 that are meeting academic standards and may not qualify for ERMHS, for onsite SMHS.

Any report that seeks to explore Schools as Centers of Wellness must discuss the role of school funded ERMHS services and must include these existing school funds and ERMHS as part of the model.

With this concern in mind, CBHDA has provided feedback related Recommendations #1 & #7.

The Commission's Recommendations (summarized by CBHDA for ease of reading):

- **Sustainability and Funding (Recommendations #1 & #7)** - The mental health needs of school children cannot effectively be met with time-limited grants. One-time funds can be used as start-up funds, to develop service systems, engineer ways to better tap into and align existing funds, including federal Medicaid funds, and develop proposals for ongoing funds. The state needs to spend funds to initiate this effort and develop sustainable funding. One - time funds will be needed to ramp up spending and then be reduced as ongoing funds are incorporated. Grant funds often run out when programs begin to show impact. Funding should align with capacity building. The state and K-12 system of support should work together to develop and test options for braiding existing funds, including MHSA, Medi-Cal, and First 5.

  CBHDA Comment – CBHDA agrees that sustainable funding must be identified to establish effective programs and partnerships; however, we believe it is important not only to identify federal Medicaid funding streams, but to also leverage state funds currently allocated to Local Educational Agencies (LEAs) to provide support to children and youth, including ERMHS. On page 11, the list of funding that need to be braided misses the critical funding sources currently used to provide ERMHS, AB 114 ERMHS funding. These services and the funding used to pay for these services should be integrated and braided in any effort to create Schools as Centers of Wellness.

  We also suggest the inclusion of leveraging funds for children and youth who are being served through school-based partnerships who are privately insured. Various school-based partnerships, such as programs within Monterey County braid federal Medicaid, county

funds and funding sources dedicated to LEAs to provide services to children/youth, which has proven to be an effective service delivery model. We suggest specifying all the various funding sources to effectively promote the leveraging of these funds across various systems to sustain valuable programs. This may include funds associated with Proposition 98, Local Control Funding Formula (LCFF), LEA Medi-Cal Billing Option Program (BOP), School Based Medi-Cal Administrative Activities (SMAA), and funding allocated by Special Education Local Plan Areas (SELPA) for Educationally Related Mental Health Services (EHRMS), etc. It's also important to note that many school-based programs provide services to all children and youth regardless of Medi-Cal eligibility and it's important to leverage private insurance, when applicable.

- **Data and Management (Recommendation #5) -** The K-12 system of support should facilitate the local capacity for data and cross system management with education and mental health systems and facilitate ongoing policy evaluation at the state level.

  CBHDA Comment – CBHDA agrees that the ability to share data across systems is important at the local level; however, we believe it is equally as important for data and management systems to be appropriately coordinated across state agencies, including the California Department of Health Care Services (DHCS) and the California Department of Education (CDE), to effectively support cross system management at the local level to improve coordination across county behavioral health and the education system.

- **Workforce (Recommendation #6) -** The Budget Act of 2019-20 allocated to the Office of Statewide Health Planning and Development (OSHPD) funding for the MHSA Workforce Education and Training (WET) Program. OSHPD should be directed to work with county behavioral health and the K-12 System of Support to identify specific school-based workforce needs and allocate funding to students and educational providers.

  CBHDA Comment – As the OAC is aware, MHSA funds programs for school-age youth as well as for adults, communities of color, the LGBTQ+ community, those that are justice involved, those experiencing homelessness and others. The current OSHPD WET Program supports the expansion of the public mental health delivery system, which does include but is not solely for the benefit of school-based programs. We would recommend revising this recommendation to address WET funding in future budget years. OSHPD has already issued grant guidelines and Regional Partnerships have already submitted applications to secure OSHPD WET FY 2019-20 funding.

Thank you for the opportunity to review and provide feedback regarding the Commission's Schools as of Wellness Draft Report. If you have any questions, please feel free to contact me at (916) 556-3477x1118, or at egallardo@cbhda.org.

Sincerely,

Elia V. Gallardo, Esq.
Director of Government Affairs

California Alliance
Empowering lives. Enriching futures.

August 27, 2020

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

Dear Director Ewing:

We are pleased to submit comments on the Mental Health Services Oversight and Accountability Commission's (MHSOAC) draft report, *Every Young Heart and Mind: Schools As Centers of Wellness*. We applaud the MHSOAC for its focus on school based mental health services. We believe that schools offer a critical opportunity for intervention that will impact the lives of students and their families far beyond their school years. The California Alliance and our member agencies are deeply committed to providing comprehensive behavioral health services that are accessible, school and community-based, and culturally responsive.

Increasingly, policy makers see the need to center behavioral health services for children and youth in schools where most young people spend a good part of their days during the academic year. This evolution of policy offers both promise and considerable need for thoughtfulness. The California Alliance developed a set of principles that guide our policy focus on school-based mental health that we believe also apply to the MHSOAC's recommendations:

Principles:

School-based behavioral health services should:

1. Increase the likelihood that children and youth will receive the behavioral health services they need in order to grow, develop and thrive.

2. Be trauma informed.

3. Include strong collaboration between school districts, campus leadership and community-based providers.

4. Address children and youth's varying levels of need through the provision of multiple levels of support.

5. Meet the needs of children and youth when and where services, support and treatment can be delivered most effectively: e.g., in the classroom, clinic, home, and community; during school hours on days school is in session, as well as outside school hours and on days when school is not in session.

6. Reflect the crucial understanding that children and youth are who they are in the context of their families, tribes and communities, who should be viewed as critical partners and resources in meeting the needs of children and youth.

7. Ensure that those providing treatment, services and support have the necessary and appropriate qualifications.

8. Be supported by integrating funding streams in ways that prohibit the supplantation of existing funding and retain their categorical integrity. There is an urgent need to integrate funding streams to dramatically expand access and services.

With this lens, we reviewed the draft report, *Schools as Centers of Wellness*. We are incredibly supportive of the focus on schools and commit to working with the MHSOAC to advance this important cause. We have also identified a number of ways in which this brief can be strengthened. We propose the following for consideration in the final draft:

- The purpose of the paper appears to be a "call to action" and therefore, we would recommend inclusion of a detailed roadmap to achieve the vision for what integrated school mental health looks like for each student. The document recognizes partnerships and collaboration as a key factor in the successful delivery of school mental health care, but it does not paint a comprehensive picture of how non-profit community-based organizations currently work alongside school districts and educators to improve student outcomes, and how efforts to strengthen these partnerships could be redoubled to support integrated school mental health frameworks. The report should explicitly state that community-based organizations are a valued and essential partner in the implementation of any integrated school mental health model. Beyond a brief list of models/initiatives, a comprehensive list of research supporting evidence-based practices/best practices in school mental health should be included in the Appendices. We offer examples of such research below.

- We recommend the inclusion of the needs of students in special education, foster youth and transition age youth who all have unique needs. We believe this is a critical omission in the report. The report largely describes the student population as an aggregate; yet it does not sufficiently detail the specialized needs of foster youth, those enrolled in special education, and transition age youth. Notable elements of the report are the overarching framework, broad principles, and broad recommendations; however, additional details are necessary for the report to advance meaningful changes.

- We would like to see further description of Tier 2 and 3 services when they are described on page 33. Prevention and Early Intervention are critical, but we would also like to see a comprehensive approach that includes a structure for meeting the needs of students with more intensive service needs. Examples can be taken from the Seneca model featured in the appendix and we can gather service descriptions from several Alliance member agencies delivering school based mental health services.

- We believe services need to reflect the developmental status of the children – models and strategies can and should be age and developmentally appropriate. Services will vary depending on the developmental age of students and more direction could be provided to schools looking to build a comprehensive mental health program. This could look like a new section of the appendix to outline effective programs for various developmental stages. Staff and members of the Alliance can help flush this out further by providing expert input by practitioners in the field.

- There also should be more emphasis on inclusion of the whole family when delivering comprehensive mental health services. As we know, children and youth's mental health is directly connected to their caregivers' mental health and overall stability. This is critical in addressing issues of equity as full family services may prevent additional trauma such as the child being placed in foster care. This can be inserted into Guiding Principle 5 located on page 59. The Alliance and our member agencies believe that intensive intervention should include work with the family structure through the use of collateral services or case management. An example of a family preventive best practice would be the use of Wraparound for high risk students and families.

- We urge the MHSOAC to articulate more specific recommendations, so that policymakers and stakeholders understand the total statewide costs and investment necessary to create a truly integrated student mental health system. Studies like the one by Whitaker and colleagues (2018) looked at how a specific intervention delivered by practitioners in two different school settings differed; preliminary findings indicate promise. Other national research including Guo and his colleagues (2008) showed how the school-based health center model led to greater proportion of students accessing mental health care. Furthermore, a substantial body of literature outlines how a fully-functional integrated school mental health plan, which involves community-based organizations as partners along with other stakeholders, fits within a multi-tiered system of support framework (e.g., Positive Behavioral Interventions and Supports) – this latter point must be emphasized more strongly within the report to underscore the need for an evidence-based foundation from which targeted school mental health programs can grow. Without a more comprehensive analysis of the existing national research on school mental health services, it is difficult to discern whether the models or partnerships included in the current draft are effective.

- Lastly, one technical edit is related to the inclusion of Seneca Family of Agencies. The report mentions a visit to services at Grant Elementary on page 65. Alameda County should be edited to Contra Costa County. As mentioned above, we would also like to see additional community-based models included in the Appendix of the report and are happy to provide these from our member organizations.

Thank you for the opportunity to collaborate on this critical project, and we would welcome the opportunity to meet with the MHSOAC staff about our comments to discuss these issues in greater detail.

In partnership,

Christine Stoner-Mertz
Chief Executive Officer
California Alliance of Child and Family Services

California Association of School Psychologists

August 6, 2020

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Re: Draft Report: *Every Young Heart and Mind: Schools as Centers of Wellness*

Dear Mr. Ewing and Commissioner Gordon;

On behalf of the 6,500+ credentialed and licensed school psychologists serving students throughout California, thank you for the opportunity to engage with the Commission and comment on the draft report *Every Young Heart and Mind: Schools as Centers of Wellness*. We appreciate the Commission's attention to mental health services in schools and the opportunity to build stronger partnerships for the betterment of all students' mental health.

Although it is often thought that school psychologists' primary functions are assessing students for disabilities and serving on IEP teams, we are also skilled mental health professionals who provide in-depth psychological services with the goal of helping students succeed academically, socially, behaviorally, and emotionally. A survey conducted by CASP in May indicated that 85% of nearly 700 responding school psychologists have continued to provide mental health services to their students despite schools being physically closed. The most frequently reported barriers to delivering support virtually were students not wanting to participate, lack of parent communication, scheduling conflicts, and no or limited access to the Internet. Despite these challenges, school personnel are often the most trusted individuals for families.

As mental health professionals, school psychologists have long recognized the need for increased mental health services in schools (which has now been exacerbated by the Covid-19 pandemic and protests for racial justice). We appreciate that the draft report highlights many of the challenges we help our students face every day. We agree that it is imperative to recognize the whole child and give each the tools needed to be successful, whatever their individual circumstances may be. It is only by acknowledging and addressing the unique needs of each child that we can truly work towards a more equitable and appropriate education for all.

While we agree that community partnerships can play a vital role in serving the whole child and promoting academic success, we would be remiss if we did not accentuate the vital role played by trusted school-based mental health professionals. Simply put, school psychologists are uniquely qualified to meet students' mental health needs. Credentialed school psychologists and licensed educational psychologists are highly educated and specifically trained to meet children's mental health needs in the school setting. Our education is focused on serving school-age children and working within the school system and regulations, such as the Family Educational Rights and Privacy Act (FERPA) and California Education Code.

As noted in the draft report, most students receiving mental health services do so in schools; and, unfortunately, our schools currently employ well below the recommended number of credentialed school-based mental health professionals. These two data points are tragically inconsistent and beg the question – when school has been proven to be the vehicle by which most students receive mental health services, why aren't we bolstering school-based mental health services? In order to provide a comprehensive range of mental health services and support to the whole child, efforts to improve school-based mental health provision must include investments in credentialed school-based mental health professionals.

We respectfully request that future versions of the report more thoroughly reflect the mental health services currently successfully provided by school psychologists and our Pupil Personnel Services credentialed colleagues, school counselors and school social workers. To that end, attached with this letter you will find the following:

1. The draft report, with our comments entered in notes. We have, in purple, either highlighted or circled the text to which each comment pertains for ease in reading.
2. For reference related to our comments in the draft report and additional consideration:
   a. A brief document detailing the services school psychologists provide, including mental health services;
   b. Additional information on the role of school psychologists as mental health providers under the Federal Every Student Succeeds Act (ESSA); and
   c. Additional information on successful mental health service models wherein all services are provided by Pupil Personnel Services credentialed professionals.

At the behest of State Superintendent Tony Thurmond, a team is in the process of crafting a guide to the mental health services provided by credentialed school psychologists, counselors, and social workers. The guide will provide a deeper explanation of the mental health services and supports provided in schools by credentialed mental health professionals. We will be happy to provide the guide to your team upon its completion, which is anticipated for the end of August.

Finally, in the spirit of collaboration to improve student mental health, and to ensure the voices of Pupil Personnel Services credentialed mental health providers, who are part of our education system, are considered, we propose establishment of an advisory committee of Pupil Personnel Services credentialed mental health providers to support and provide feedback to the Commission's efforts regarding schools as centers of wellness. We would be happy to take a lead role in organizing such a committee.

Current events have conspired to make a focus on equitable student mental health services more important than ever. Thank you again for the opportunity to share our comments. Please do not hesitate to contact us if you would like to discuss our comments.

Regards,

Dr. Jeannine Topalian
President

Melanee Cottrill
Executive Director
melaneec@casponline.org
(916)715-2124

Cc: Kai LeMasson, MHSOAC
Andrea Ball, Ball/Frost Group

AGENDA ITEM 3

Action

October 22, 2020 Commission Meeting

Election of the Chair and Vice-Chair for 2021

Summary: Elections for the Mental Health Services Oversight and Accountability Commission Chair and Vice-Chair for 2021 will be conducted at the October 22, 2020 Commission Meeting. The MHSOAC Rules of Procedure state that the Chair and the Vice-Chair shall be elected at a meeting held preferably in September but no later than during the last quarter of the calendar year by a majority of the voting members of the Commission. The term is for one year and starts January 2021.

This agenda item will be facilitated by Chief Counsel, Filomena Yeroshek.

Enclosures (1): Commissioner Biographies

Handout: None

Mental Health Services
Oversight & Accountability Commission

Commissioner Biographies
October 2020

Reneeta Anthony, Fresno
Joined the Commission: January 2016
Reneeta Anthony has been executive director at A3 Concepts LLC since 2013. She was principal staff analyst at the Fresno County Department of Social Services from 2005-2012, at the Fresno County Department of Behavioral Health from 2004-2005 and at the Fresno County Human Services System from 2001-2004. Anthony was principal staff analyst at the Fresno County Department of Children and Family Services from 2000-2001, where she was senior staff analyst from 1999-2000. Commissioner Anthony fills the seat of a family member of an adult child with a severe mental illness.

Mayra Alvarez, Los Angeles
Joined the Commission: December 2017
Mayra Alvarez is the President of the Children's Partnership, a nonprofit children's advocacy organization. She served in the U.S. Department of Health and Human Services (HHS), most recently as Director of the State Exchange Group for the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services. She also served as the Associate Director for the HHS Office of Minority Health and was Director of Public Health Policy in the Office of Health Reform at HHS. Alvarez received her graduate degree from the University of North Carolina at Chapel Hill and her undergraduate degree from University of California Berkeley. Commissioner Alvarez fills the seat of the Attorney General/designee.

Lynne Ashbeck, Clovis
Current MHSOAC Vice Chair
Joined the Commission: February 2016
Lynne Ayers Ashbeck is the senior vice president of community engagement and population wellness for Valley Children's Healthcare. She has also served as vice president at Community Medical Centers; regional vice president at the Hospital Council of Northern and Central California; director of Continuing and Global Education at California State University, Fresno; and director of education at Valley Children's Hospital. She is an elected Councilmember in the City of Clovis, first elected in 2001. She is also a member of the California Partnership for the San Joaquin Valley Board of Director and the Maddy Institute Board of Directors. She received her Master of Arts degree from Fresno Pacific University and a Master of Science degree from California State University, Fresno. Vice Chair Ashbeck fills the seat of a representative of a health care service plan or insurer.

Senator Jim Beall, San Jose
Joined the Commission: February 2015
Jim Beall was elected to the California State Senate in 2012 and represents the 15th Senate District. He was elected to the State Assembly in November 2006, representing District 24. He is the chairman of the Senate Transportation and Housing Committee, in addition to serving on several other committees. He has spent three decades in public service as a San Jose City Councilman, a Santa Clara County Supervisor and an Assembly member. On the Commission, Senator Beall represents the member of the Senate selected by the President pro Tempore of the Senate.

Ken Berrick, Oakland
Joined the Commission: December 2018
Ken Berrick has been chief executive officer at Seneca Family of Agencies since 1985 and a trustee for Area 3 of the Alameda County Office of Education since 2008. He is a fellow of the Pahara Institute and a member of the Alliance for Strong Families and Communities, California Child Welfare Council, Alameda County Mental Health Services Act Planning Commission, California Alliance of Child and Family Services and Support, Opportunities and Rapport for Youth. Commissioner Berrick fills the seat of a mental health professional.

John Boyd, Psy.D, Folsom
Joined the Commission: June 2013
John Boyd is Sutter Health's Chief Executive Officer of Mental Health Services. He has an extensive background in healthcare administration and mental health. Prior to joining Sutter in 2008, he served as Assistant Administrator for Kaiser Permanente Sacramento Medical Center and has worked as both an inpatient and outpatient therapist in several organizations. He is a Board Member of National Mental Health America; he has also served in other appointed capacities, including City of Sacramento Planning Commissioner. Boyd is a Fellow with the American College of Healthcare Executives. He earned his doctorate in psychology at California School of Professional Psychology and his MHA from USC. Commissioner Boyd represents an employer with more than 500 employees.

Bill Brown, Lompoc
Joined the Commission: December 2010
Bill Brown was first elected as sheriff and coroner for Santa Barbara County in 2006. He had previously served as chief of police for the city of Lompoc from 1995-2007, and chief of police for the city of Moscow, Idaho from 1992-1995. He was a police officer, supervisor and manager for the city of Inglewood Police Department from 1980-1992, and a police officer for the city of Pacifica from 1977-1980. Prior to his law enforcement career, Sheriff Brown served as a paramedic and emergency medical technician in the Los Angeles area from 1974-1977. Sheriff Brown holds a master's degree in public administration from the University of Southern California and is a graduate of the FBI National Academy and the Delinquency Control Institute. Commissioner Brown fills the seat of a county sheriff.

Keyondria Bunch, Ph.D., Los Angeles
Joined the Commission: August 2017
Keyondria Bunch, Ph.D., has been a Supervising Psychologist for the Emergency Outreach Bureau School Threat Assessment Response Team at the Los Angeles County Department of Mental Health since 2019, where she has served in several positions since 2008. These include clinical psychologist for the Emergency Outreach Bureau, clinical psychologist for the Specialized Foster Care Van Nuys Co-Located Program, clinical psychologist for juvenile justice mental health quality assurance and a clinical psychologist for Valley Coordinated Children's Services. She was also an adjunct lecturer at Antioch University in 2015. Commissioner Bunch fills the seat of a labor representative.

Assemblymember Wendy Carrillo, Los Angeles
Joined the Commission: February 2018
Wendy Carrillo was elected to represent California's 51st Assembly District in December 2017. Assemblymember Carrillo has advocated for educational opportunity, access to quality healthcare, living wage jobs, and social justice. She was host and executive producer of community-based radio program "Knowledge is Power" in Los Angeles. Her previous work with Service Employees International Union (SEIU) Local 2015 included better working conditions for caregivers. She arrived to the United States as an undocumented immigrant from El Salvador and became a U.S. citizen in her early 20s. Assemblymember Carrillo represents the member of the Assembly selected by the Speaker of the Assembly.

Itai Danovitch, M.D., Los Angeles
Joined the Commission: February 2016
Itai Danovitch has been chair of the Psychiatry Department at Cedars-Sinai Medical Center since 2012, where he has held several positions since 2008, including director of addiction psychiatry clinical services and associate director of the Addiction Psychiatry Fellowship. He is a member of the American Society of Addiction Medicine and the American Psychiatric Association and past president of the California Society of Addiction Medicine. Danovitch earned a Doctor of Medicine degree from the University of California, Los Angeles School of Medicine and a Master of Business Administration degree from the University of California, Los Angeles School of Management. Commissioner Danovitch fills the seat of a physician specializing in alcohol and drug treatment.

David Gordon, Sacramento
Joined the Commission: January 2013
David Gordon has been county superintendent at the Sacramento County Office of Education since 2004. He served at the Elk Grove Unified School District as superintendent from 1995-2004. He worked at the California Department of Education as deputy superintendent from 1985-1991. He earned a Master of Education degree from Harvard University. Commissioner Gordon fills the seat of a superintendent of a school district.

Mara Madrigal-Weiss, San Diego
Joined the Commission: September 2017
Mara Madrigal-Weiss is the Director of Student Wellness & Positive School Climate and Foster and Homeless Youth Education Programs with the San Diego County Office of Education. Her experience includes working with school communities as a Family Case Manager, Protective Services Worker and Family Resource Center Director. Mara received her M.A. in Human Behavior from National University; a M.Ed in School Counseling and a M.Ed in Educational Leadership from Point Loma Nazarene University. Mara has been dedicated to promoting student mental health and wellness for over 19 years. She is a past president of the International Bullying Prevention Association (IBPA) the only international association dedicated to eradicating bullying worldwide. Mara is a member of the California Department of Education's Student Mental Health Policy Workgroup. At present Mara serves as the designee of the State Superintendent of Public Instruction as a Commissioner on the Mental Health Services Oversight and Accountability Commission.

Gladys Mitchell, Sacramento
Joined the Commission: January 2016
Gladys Mitchell served as a staff services manager at the California Department of Health Care Services from 2013-2014 and at the California Department of Alcohol and Drug Programs from 2010-2013 and from 2007-2009. She was a health program specialist at California Correctional Health Care Services from 2009-2010 and a staff mental health specialist at the California Department of Mental Health from 2006-2007. She was interim executive officer at the California Board of Occupational Therapy in 2005 and an enforcement coordinator at the California Board of Registered Nursing from 1996-1998 and at the Board of Behavioral Science Examiners from 1989-1993. She is a member of the St. Hope Public School Board of Directors. Mitchell earned a Master of Social Work degree from California State University, Sacramento. Commissioner Mitchell fills the seat of a family member of a child who has or has had a severe mental illness.

Khatera Tamplen, Pleasant Hill
Current MHSOAC Chair
Joined the Commission: June 2013
Khatera Aslami Tamplen has been the consumer empowerment manager at Alameda County Behavioral Health Care Services since 2012. She was executive director at Peers Envisioning and Engaging in Recovery Services from 2007-2012 and served in multiple positions at the Telecare Corporation Villa Fairmont Mental Health Rehabilitation Center from 2002-2007, including director of rehabilitation. Tamplen is a member of the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services National Advisory Council and a founding member of the California Association of Mental Health Peer Run Organizations. Chair Tamplen represents clients and consumers.

Tina Wooton, Santa Barbara
Joined the Commission: December 2010
Tina Wooton has worked in the mental health system since 1996, advocating for the employment of consumers and family members at the local, state and federal levels. From 2009 to her retirement in 2020 she served as the Consumer Empowerment Manager for the Santa Barbara County Department of Alcohol, Drug, and Mental Health Services. From 2005 through 2009 she worked as the Consumer and Family member liaison for the California State Department of Mental Health and was staff to the state Mental Health Services Act Implementation Team. Between 1997 and 2005 she served as Consumer Liaison for the Mental Health Association / County Mental Health of Sacramento and as service coordinator for Human Resources Consultants from 1994 through 1997. Wooton is Vice President of AMP (Arts Mentorship Program) for Santa Barbara Dance Arts and a Santa Barbara Elks member. Commissioner Wooton represents clients and consumers.

AGENDA ITEM 4

Action

October 22, 2020 Commission Teleconference

Contract Authorization

Presenter:

Brian R. Sala, Deputy Director for Research and Chief Information Officer

Summary:

The Commission will consider authorizing the Executive Director to enter into one or more contracts not to exceed $125,000 to support the Commission in implementing best practices in Information Technology security policy, practices, and policies, including Federal Bureau of Investigation Criminal Justice Information Services (CJIS) security compliant practices.

Background:

The Commission is actively engaged in telling the story of mental health outcomes, including how and when mental health services improve key indicators at the community and individual levels. This effort includes obtaining access to key, statewide databases in order to link mental health consumers in the Department of Health Care Services' Client Services Information (CSI) database to records relating to criminal justice, employment, education, and other critical outcomes.

Agencies vary in their specific requirements for data sharing agreements. CJIS security compliant practices are among the highest standards for policies and practices. As the Commission expands its research into understanding the impacts of California's mental health services on the negative consequences of mental illness, fulling documenting and demonstrating adherence to security practices at this high standard will support the Commission's ability to acquire and manage highly sensitive data from many sources.

The Commission executed a data sharing agreement in 2017 with the California Department of Justice (DOJ) to obtain historical arrest records, which the Commission matched to mental health clients in the Client Services Information (CSI) system maintained by the Department of Health Care Services. The Commission contracts with a provider to store this data in a secure data center and provide secure access to Commission staff. Since execution of the original agreement, DOJ revised its security policies to specify that the Commission itself, and not just its contracted providers, must have documented policies, practices

and procedures in place to meet CJIS standards for Non-Criminal Justice Agencies.

Staff intend to contract with one of the recognized, experienced CJIS compliance consultant contractors to support us in reviewing, documenting, and where necessary revising the Commission's information technology security policies and procedures to CJIS-compliant standards. The outcome of this contract will be further maturation of the Commission's IT security capacity and practices, as well as the ability to demonstrate to other agencies our compliance with industry best practices in data security policies and practices.

Enclosures: None.

Handouts: None.

Proposed Motion:

The Executive Director is authorized to enter into one or more contracts, not to exceed $125,000, to support the Commission in implementing best practices in Information Technology security policy, practices, and policies, including Federal Bureau of Investigation Criminal Justice Information Services (CJIS) security compliant practices.

AGENDA ITEM 5

Action

October 22, 2020 Commission Meeting

Statewide Virtual and Digital Strategy for Mental Health

Summary: The Commission will consider strategies for exploring the merits of expanding California's support for virtual and digital strategies to meet behavioral health needs. A strategic digital and virtual behavioral health initiative that is well informed by community input and that leverages public and private funds could improve access to care, meet growing needs and address some disparities.

Background: To meet the challenges presented by the COVID-19 pandemic, the State is exploring ways to improve access to preventative behavioral health support and early intervention services so that behavioral health needs do not escalate and require hospital-based care. To start, the State has expanded access to mental health crisis hotlines, peer support lines and warmlines. Recent changes in state policy also have facilitated the use of telemedicine to reduce barriers to care during required isolation orders and to prevent the escalation of needs into calls for emergency or crisis services.

At the same time, demand for prevention and early intervention services has increased interest in application- and web-based mental health support strategies that reduce pressure on crisis-oriented care delivery systems. The State has supported the development of a web-based navigation tool to improve public access to online mental health and related information tools and is using its public outreach campaigns to direct the public to utilize these resources.

While the State of California has adopted emergency regulations to support phone-based and video-based care delivery, and has begun to direct attention to digital mental health strategies, the State has not put in place a strategic initiative to support digital and virtual mental health care that could extend the impact of California's existing care delivery system, reduce costs and expand coverage. Digital and virtual mental health care is increasingly available to Californians with the capacity to self-fund their mental health care, but is largely unavailable to Californians with limited resources and those who rely on publicly funded mental health care, particularly communities of color, non-English fluent communities, or those lacking easy access to the Internet.

A range of questions needs to be explored as part of this work, including:

- How effective are behavioral health services and supports when they are delivered through digital and virtual strategies, for whom and under what conditions?

- What strategies are available to the State to support the use of these tools if demonstrated to be effective?

- What are the roles of the counties and other partners, public and private, in supporting digital and virtual behavioral health strategies?

Presenter: Toby Ewing, Executive Director

Enclosure: None

Handout: None

Proposed Motion: Authorize the Executive Director to work with the Administration and Legislature and support community engagement to explore the potential for a virtual and digital behavioral health strategy to improve access to care, improve outcomes and address disparities.

AGENDA ITEM 6

Information

October 22, 2020 Commission Teleconference

Staff Report

Presenters:

Toby Ewing, Executive Director
Brian R. Sala, Deputy Director for Research and CIO

Summary:

The Commission will hear staff updates relating to three distinct, near-term strategic opportunities to operationalize the Commission's Strategic Plan and to drive transformational change: (1) Guiding the development of county innovation plans, (2) Helping counties adapt to COVID-19, and (3) Allocating the next round of Triage grants.

Background:

The Commission's Strategic Plan (link to PDF) calls for driving transformational change by aligning research and evaluation, policy development, capacity building, incentives and innovation.

The Commission has developed a portfolio of projects that deploy two or more of those elements to help counties address the seven negative outcomes of the Mental Health Services Act. Examples include the Early Psychosis Early Learning Network (link to PDF); the school mental health project (link to project materials) and the Mental Health Student Service Act; and, the Together We Can report (Link to PDF) and the Innovation Incubator projects to reduce criminal justice involvement among those with mental health needs.

Three emerging opportunities. With each of these projects, the Commission has developed its own capacity to align these levers of change and is now better positioned to derive more public benefit from the following activities:

1. **Innovation funding and plan approval.** On average, each year California's counties have $100 million to invest in innovation projects. The Commission's Innovation Incubator is intended to facilitate the development of innovation plans that improve priority outcomes. The long-term goal is to encourage counties to plan ahead, build the capacity to innovate, and work together to accelerate learning and scaling.

   > **Near term opportunity:** Commission staff estimates that more than $40 million in county innovation funding is subject to reversion if plans are not approved by the Commission by June 30, 2021. Staff next week will present to the Innovation Subcommittee a draft report detailing those

estimates and recommending methods for improving transparency about the flow of innovation funds. Additionally, Commission staff is working with counties holding those funds to determine their areas of focus and the timing of their presentations to the Commission.

Commission staff also is identifying candidates for new multi-county innovation collaboratives. For example, some 30 counties have expressed interest in Solano County's innovation project to assess racial, ethnic and other community disparities and engage specific communities to reduce stigma and improve services.

2. **Adapting to COVID-19-related conditions.** The staff is developing a framework that includes reconnaissance from partners and stakeholders on how service systems have adapted to the disruptions of 2020, and where capacity building would be helpful. That information will be aligned with the Commission's established and emerging priorities – especially opportunities to address racial, ethnic and cultural disparities. The framework also will include those requests that the Commission has received and identify potential projects consistent with the Commission's strategic plan.

   > **Near term opportunity.** The framework is intended for the Commission to make informed choices considering community needs, overarching priorities, and the potential for selected activities to have the greatest impact. Commission staff will work with one or more Committee chairs to present the draft COVID-19-related framework and budget proposal for discussion and guidance from the committee and stakeholders.

3. **Triage grants.** The Commission has allocated two rounds of SB 82 "Triage Grants" and will allocate a third round beginning next year. In the second round, the Commission prioritized children and school-based partnerships. Commission staff is assessing how much funding will be available for the third round of grants and opportunities to prioritize those funds within the constraints of the SB 82 Triage program.

   > **Near term opportunity.** The law requires that half of the SB 82 funds be directed to children and half to adults; focus on issues of related to mental health crises; and, support the capacity of counties to hire additional staff. Within that framework, the Commission has flexibility to design the grants to address priority issues. In the coming months Commission staff will work with the Commission Chair and Committee Chairs to assess opportunities to deploy SB 82/Triage funds in ways that address priorities and strengthen the Commission's efforts to support capacity building for mental health systems of care.

Enclosures (6): (1) Motions Summaries from the September 24, 2020 Meeting; (2) Evaluation Dashboard; (3) Innovation Dashboard; (4) Calendar of Tentative Agenda Items; (5) Department of Health Care Services Revenue and Expenditure Reports Status Update; (6) Legislative Report to the Commission.

Handouts: None

Mental Health Services
Oversight & Accountability Commission

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Motions Summary

Commission Meeting
September 24, 2020

Motion #: 1

Date: September 24, 2020

Time: 9:44AM

Motion:

The Commission approves the August 27, 2020 meeting minutes.

Commissioner making motion: Commissioner Boyd

Commissioner seconding motion: Commissioner Alvarez

Motion carried 9 yes, 0 no, and 2 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☒	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☐	☐	☒
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Mitchell	☐	☐	☒
12. Commissioner Tamplen	☒	☐	☐
13. Commissioner Wooton	☐	☐	☐
14. Vice Chair Madrigal-Weiss	☒	☐	☐
15. Chair Ashbeck	☒	☐	☐

Mental Health Services
Oversight & Accountability Commission

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Motions Summary

Commission Meeting
September 24, 2020

Motion #: 2

Date: September 24, 2020

Time: 11:20AM

Motion: The Commission approves San Mateo County's Innovation Plan, including supporting technical assistance to other counties and requiring the fellows to commit to serve in the public sector for one year after training, as follows

The Commission approves San Mateo County's Innovation plan, as follows:

- Name: Addiction Medicine Fellowship in a County/Community Setting
- Amount: Up to $ 663,125 in MHSA Innovation funds
- Project Length: Four (4) Years

Commissioner making motion:

Commissioner seconding motion:

Motion failed 3 yes, 7 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☐	☒	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☐	☒	☐
7. Commissioner Bunch	☒	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☐	☒	☐
10. Commissioner Gordon	☐	☒	☐
11. Commissioner Mitchell	☐	☒	☐
12. Commissioner Tamplen	☐	☐	☒
13. Commissioner Wooton	☐	☐	☐
14. Vice Chair Madrigal-Weiss	☐	☒	☐
15. Chair Ashbeck	☐	☒	☐

Motions Summary

Commission Meeting
September 24, 2020

Motion #: 3

Date: September 24, 2020

Time: 12:03PM

Proposed Motion:

Allocate funding and authorize the Executive Director to enter into contracts to support the five (5) initiatives with the key activities presented in aggregate not to exceed $2,000,000.

Commissioner making motion: Commissioner Anthony

Commissioner seconding motion: Commission Danovitch

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☒	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Mitchell	☒	☐	☐
12. Commissioner Tamplen	☒	☐	☐
13. Commissioner Wooton	☐	☐	☐
14. Vice Chair Madrigal-Weiss	☐	☐	☐
15. Chair Ashbeck	☒	☐	☐

Summary of Updates

Contracts

New Contract: None

Total Contracts: **5**

Funds Spent Since the September Commission Meeting

Contract Number	Amount
17MHSOAC073	$0
17MHSOAC074	$0
18MHSOAC020	$0
18MHSOAC040	$0
19MHSOAC022	$0
Total	**$**

Contracts with Deliverable Changes

18MHSOAC040

MHSOAC
Mental Health Services
Oversight & Accountability Commission

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: $3,528,911.50

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	Complete	1/24/20	No
Data Collection and Management Report	Complete	6/15/20	No
Final Summative Evaluation Plan	Complete	7/15/20	No

Deliverable	Status	Due Date	Change
Data Collection Implementation Progress Reports	Not Started	10/15/20	No
Formative/Progress Evaluation Plan Implantation Reports and Summative Evaluation Implantation Progress Reports	Not Started	1/15/23	No
Statewide Conferences	Not Started	4/15/22	No
Midpoint Progress Report	Not Started	10/15/21	No
Revised Final Summative Evaluation Plan	Not Started	4/15/21	No
Data Quality Report and Summative Evaluation Progress	Not Started	4/15/22	No
Draft Summative Evaluation Final Report	Not Started	1/15/23	No
Final Report and Recommendations	Not Started	4/15/23	No

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: $3,528,911.50

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	Complete	1/24/20	No
Data Collection and Management Report	Complete	6/15/20	No
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection Implementation Progress Reports	Not Started	10/15/20	No

Deliverable	Status	Due Date	Change
Formative/Progress Evaluation Plan Implantation Reports and Summative Evaluation Implantation Progress Reports	Not Started	1/15/23	No
Statewide Conferences	Not Started	4/15/22	No
Midpoint Progress Report	Not Started	10/15/21	No
Revised Final Summative Evaluation Plan	Not Started	4/15/21	No
Data Quality Report and Summative Evaluation Progress	Not Started	4/15/22	No
Draft Summative Evaluation Final Report	Not Started	1/15/23	No
Final Report and Recommendations	Not Started	4/15/23	No

The iFish Group: Hosting & Managed Services (18MHSOAC020)

MHSOAC Staff: Rachel Heffley

Active Dates: 01/01/19 - 12/31/20

Total Contract Amount: $400,143

Total Spent: $387,822

To provide hosting & managed services (HMS) such as Secure Data Management Platform (SDMP) & a Visualization Portal where software support will be provided for SAS Office Analytics, Microsoft SQL, Drupal CMS 7.0 Visualization Portal, & other software products. Support services & knowledge transfer will also be provided to assist MHSOAC staff in collection, exploration, & curation of data from external sources.

Deliverable	Status	Due Date	Change
Secure Data Management Platform	Complete	01/01/19	No
Data Management Support Services	In-Progress	12/31/20	No

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: $1,171,008

Total Spent: $445,378

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	Yes
Quarterly Progress Report	Not Started	12/31/2020	No
Quarterly Progress Report	Not Started	03/31/2021	No
Quarterly Progress Report	Not Started	06/30/2021	No

The iFish Group: Hosting & Managed Services (19MHSOAC022)

MHSOAC Staff: Rachel Heffley

Active Dates: 01/01/20 - 12/31/20

Total Contract Amount: $313,604

Total Spent: $298,604

To provide hosting & managed services (HMS) such as Secure Data Management Platform (SDMP) & a Visualization Portal where software support will be provided for SAS Office Analytics, Microsoft SQL, Drupal CMS 7.0 Visualization Portal, & other software products. Support services & knowledge transfer will also be provided to assist MHSOAC staff in collection, exploration, & curation of data from external sources.

Deliverable	Status	Due Date	Change
Secure Data Management Platform	Complete	01/01/20	No
Data Management Support Services	In-Progress	12/31/20	No

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD
OCTOBER 2020

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	3	10	**13**
Participating Counties (unduplicated)	2	5	**7**
Dollars Requested	$1,941,224	$7,477,647	**$9,418,871**

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	2	1	$2,625,000	1

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	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	Colusa	Social Determinants of Rural Mental Health Project	$495,568	3 Years	4/17/2020	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	MH Integration for Older Adults in Residential Facilities	$544,252.00	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	Sonoma	Using Cognitive Technologies to Create Client Care Plans	$992,428	2 Years	11/13/2019	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	Modoc	INN and Improvement through Data (IITD)-Extension	$91,224	1 Year	3/4/2020	3/4/2020
Under Final Review	San Mateo	Co-location of Prevention Early Intervention Services in Low Income Housing	$925,000	4 Years	9/30/3019	2/24/2020

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	San Mateo	PIONEERS (Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve)	$925,000	4 Years	10/2/2019	2/24/2020

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

Calendar of Tentative Commission Meeting Agenda Items

Proposed 10/14/2020

Agenda items and meeting locations are subject to change

November 19, 2020: Sacramento, CA (Teleconference)

EPI Plus Funds Allocation

The Commission will hear recommendations made by the EPI Plus Advisory Committee on the allocation of available funds and determine the best strategies to support early psychosis and mood disorder programs.

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.

Staff Report Out

Commission 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.

January 28, 2021 Sacramento, CA (Teleconference)

Strategic Plan for the Research & Evaluation Division

The Commission will hear about the Strategic Plan for the Research and Evaluation Division

Adoption of amendments to the Rules of Procedure

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

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.

Staff Report Out

Commission 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.

DHCS Status Chart of County RERs Received
October 22, 2020 Commission Meeting

Attached below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated August 28th, 2020. This Status Report covers the FY 2016-17 through FY 2018-19 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

DCHS MHSA Annual Revenue and Expenditure Report Status Update

FY 2005-06 through FY 2016-17, all Counties are current

County	FY 17-18 Electronic Copy Submission Date	FY 17-18 Return to County Date	FY 17-18 Final Review Completion Date	FY 18-19 Electronic Copy Submission Date	FY 18-19 Return to County Date	FY 18-19 Final Review Completion Date
Alameda	3/25/2019	3/26/2019	4/9/2019	12/31/2019	1/2/2020	1/6/2020
Alpine	5/10/2019	5/13/2019	5/15/2019	5/11/2020	5/12/2020	5/28/2020
Amador	12/19/2018	12/19/2018	12/21/2018	12/20/2019	12/24/2019	1/17/2020
Berkeley City	12/28/2018	1/2/2019	1/8/2019	2/11/2020	2/13/2020	2/19/2020
Butte	6/26/2019		6/26/2019	1/6/2020	1/7/2020	1/31/2020
Calaveras	1/10/2019		1/11/2019	12/30/2019	1/2/2020	1/2/2020
Colusa	3/28/2019	4/25/2019	4/30/2019	2/28/2020	3/2/2020	3/27/2020
Contra Costa	12/31/2018	1/7/2019	1/22/2019	1/6/2020	1/6/2020	1/10/2020
Del Norte	12/31/2018		1/2/2019	12/31/2019	1/2/2020	1/22/2020
El Dorado	12/28/2018	1/3/2019	1/25/2019	12/31/2019	1/2/2020	1/3/2020
Fresno	12/28/2018	1/2/2019	1/2/2019	12/30/2019	1/2/2020	1/21/2020
Glenn	12/31/2018	1/7/2019	2/11/2019	12/23/2019	n/a	12/26/2019
Humboldt	12/20/2018	12/21/2018	1/2/2019	1/6/2020	1/6/2020	1/29/2020
Imperial	12/26/2018		1/2/2019	12/9/2019	12/13/2019	12/18/2019
Inyo	3/19/2019	3/20/2019	3/22/2019	3/5/2020	3/5/2020	6/3/2020
Kern	1/4/2019		1/7/2019	12/19/2019	12/24/2019	1/22/2020
Kings	1/31/2019	2/4/2019	2/11/2019	1/6/2020	1/7/2020	1/17/2020
Lake	7/12/2019		7/16/2019	1/13/2020	1/14/2020	1/17/2020
Lassen	1/8/2019	1/14/2019	1/31/2019	12/30/2019	1/2/2020	1/14/2020
Los Angeles	12/31/2018	1/14/2019	1/29/2019	1/31/2020	2/3/2020	2/20/2020

Agenda Item 5: DHCS Status Chart of County RERs Received
October 22, 2020 Commission Meeting

County	FY 17-18 Electronic Copy Submission Date	FY 17-18 Return to County Date	FY 17-18 Final Review Completion Date	FY 18-19 Electronic Copy Submission Date	FY 18-19 Return to County Date	FY 18-19 Final Review Completion Date
Madera	12/31/2018	1/7/2019	2/4/2019	1/7/2020	1/7/2020	1/22/2020
Marin	12/21/2018	12/21/2018	12/21/2018	12/23/2019	12/24/2019	12/26/2019
Mariposa	12/20/2018	1/3/2019	1/31/2019	12/19/2019	12/23/2019	1/29/2020
Mendocino	12/31/2018		1/3/2019	12/30/2019	1/2/2020	1/9/2020
Merced	12/21/2018	12/21/2018	12/31/2018	12/17/2019	12/23/2019	12/26/2019
Modoc	1/16/2019	1/16/2019	1/24/2019	2/3/2020	2/3/2020	2/4/2020
Mono	12/28/2018	1/3/2019	1/17/2019	12/27/2019	12/31/2019	1/3/2020
Monterey	3/5/2019	3/6/2019	9/4/2019	12/23/2019	12/26/2019	1/8/2020
Napa	12/28/2018	1/2/2019	1/4/2019	12/20/2019	12/26/2019	1/2/2020
Nevada	12/21/2018		12/21/2018	12/31/2019	n/a	1/23/2020
Orange	12/28/2018	1/2/2019	1/31/2019	12/27/2019	12/31/2019	12/31/2019
Placer	1/18/2019		1/22/2019	1/15/2020	1/16/2020	1/28/2020
Plumas	9/16/2019	9/17/2019	10/4/2019	3/19/2020	3/19/2020	3/26/2020
Riverside	12/31/2018		1/29/2019	12/31/2019	1/3/2020	1/28/2020
Sacramento	12/31/2018	1/2/2019	1/2/2019	12/27/2019	12/30/2019	1/13/2020
San Benito	3/8/2019	3/8/2019	3/18/2019	5/13/2020	5/14/2020	5/14/2020
San Bernardino	12/31/2018		1/2/2019	12/30/2019	12/31/2019	1/16/2020
San Diego	12/26/2018		1/15/2019	12/31/2019	1/6/2020	1/24/2020
San Francisco	12/31/2018	1/3/2019	1/30/2019	12/31/2019	1/3/2020	1/7/2020
San Joaquin	12/31/2018		1/7/2019	1/7/2020	1/10/2020	1/16/2020
San Luis Obispo	12/14/2018	12/18/2018	12/28/2018	12/30/2019	12/31/2019	1/16/2020
San Mateo	12/31/2018		1/2/2019	12/24/2019	12/30/2019	1/23/2020
Santa Barbara	12/21/2018	1/3/2019	1/14/2019	12/20/2019	12/26/2019	1/31/2020

Agenda Item 5: DHCS Status Chart of County RERs Received
October 22, 2020 Commission Meeting

County	FY 17-18 Electronic Copy Submission Date	FY 17-18 Return to County Date	FY 17-18 Final Review Completion Date	FY 18-19 Electronic Copy Submission Date	FY 18-19 Return to County Date	FY 18-19 Final Review Completion Date
Santa Clara	12/27/2018		1/2/2019	12/13/2019	12/16/2019	12/31/2019
Santa Cruz	12/31/2018	1/3/2019	1/7/2019	1/2/2020	1/7/2020	1/29/2020
Shasta	12/13/2018	12/17/2018	1/2/2019	12/18/2019	12/23/2019	12/30/2019
Sierra	12/28/2018		1/2/2019	12/19/2019	12/26/2019	1/29/2020
Siskiyou	9/3/2019	9/3/2019	9/24/2019	4/6/2020	4/8/2020	4/23/2020
Solano	12/31/2018	1/3/2019	2/21/2019	12/30/2019	1/2/2020	1/27/2020
Sonoma	1/16/2019	1/29/2019	2/1/2019	12/18/2019	12/26/2019	1/23/2020
Stanislaus	12/26/2018		1/3/2019	12/31/2019	1/3/2020	1/3/2020
Sutter-Yuba	1/7/2019	1/28/2019	1/31/2019	1/2/2020	1/6/2020	1/15/2020
Tehama	6/20/2019		8/12/2019	8/6/2020	8/12/2020	8/26/2020
Tri-City	12/31/2018	1/3/2019	1/30/2019	12/30/2019	12/31/2019	1/14/2020
Trinity	1/30/2019		2/7/2019	2/10/2020	2/10/2020	2/14/2020
Tulare	12/19/2018	12/21/2018	12/26/2018	12/19/2019	12/23/2019	12/23/2019
Tuolumne	12/11/2018	12/12/2018	12/12/2018	10/21/2019	10/23/2019	10/25/2019
Ventura	12/20/2018		12/21/2018	1/13/2020	1/16/2020	1/31/2020
Yolo	1/30/2019	1/31/2019	1/31/2019	12/20/2019	12/24/2019	1/3/2020
Total	59	39	59	59	57	59

State of California
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700 • Sacramento, CA 95814 • 916.445.8696 • mhsoac.ca.gov

2020 Legislative Report to the Commission
As of October 15, 2020

SPONSORED LEGISLATION

Assembly Bill 2112 (Ramos)

Title: Suicide Prevention

Summary: Suicide claimed the lives of 4,323 Californians in 2017. Suicide rates in California are increasing, especially in our rural communities. Despite the increasing number of deaths, there is mounting evidence that lives can be saved from suicide. Assembly Bill 114 (Chapter 38, Statutes of 2017) directed the Commission to develop a new strategic plan for suicide prevention for the State of California. Over the course of two years the Commission developed this plan based on the latest in research on suicide and its prevention, and with the input and guidance of our communities. The state's plan outlines over five years strategic steps state and local partners can take to save lives. To accelerate these lifesaving steps, the plan recommends the State establish an Office of Suicide Prevention.

Commission's Position: Assemblymember Ramos's Staff and the Co-Sponsor of AB 2112, the California Alliance of Child and Family Services Staff presented AB 2112 to the Commission at the February 27, 2020 Commission Meeting. The Commission agreed to Sponsor the bill, if the bill was amended and consistent with the recommendations in the Commission's 2019 report "Striving for Zero".

Status/Location: Signed by the Governor on September 25, 2020 – Chapter 142, Statutes of 2020.

Governor's Message to the Assembly:

To the Members of the California State Assembly

I am signing Assembly Bill 2112 because I believe that the Department of Public Health, working with stakeholders, can help to advance our understanding of the cause of suicide in order to identify ways to prevent it, particularly among especially vulnerable populations. I believe it is vitally important that we reach out with sensitivity and understanding to help those most in need of assistance.

However, the bill fails to identify funding for this important work. I look forward to partnering with the Legislature to identify and secure funding so that this program can be successfully implemented.

SUPPORTED LEGISLATION

Senate Bill 803 (Beall)

Title: Mental health services: peer support specialist certification.

Summary: Peer support is an evidence-based practice for the treatment of those with unmet mental health needs. The use of peer support specialists can reduce rehospitalization rates and inpatient days, increase use of outpatient services, lower overall cost of services, and improve outcomes for people with mental health needs. Almost every other state in the nation has established programs to train and certify peer specialists. SB 803, would add California to that list by requiring the establishment of a certification program for peer providers and provides the structure needed to maximize federal match for peer services under Medi-Cal.

California is behind in embracing peer support as an evidence-based model and in establishing a certification program that standardizes best practices. SB 803 will result in a more comprehensive and effective approach to mental health care. This certification would standardize high-quality peer and family support services leading to increased family support, a fuller continuum of wraparound services, and an individualized focus on clients in order to promote recovery and self-sufficiency.

Commission's Position: Executive Director Toby Ewing presented SB 803 to the Commission in January 2020, the Commission took a support position on this bill, with direction to staff to update the Commission as this bill evolves.

Status/Location: Signed by the Governor on September 25, 2020 – Chapter 150, Statutes of 2020

Senate Bill 854 (Beall)

Title: Health care coverage: substance use disorders.

Summary: Prohibits a mental health plan or insurer from imposing any prior authorization requirements or any step therapy requirements before authorizing coverage for FDA-approved prescriptions. It will also place the FDA-approved medications for treatment of substance use disorders on the lowest cost-sharing tier.

Commission's Position:
Executive Director Toby Ewing presented SB 854 to the Commission in January 2020, the Commission took a support position on this bill, with direction to staff to update the Commission as this bill evolves.

Status/Location: Senate – Dead.

SUPPORTED LEGISLATION

Senate Bill 855 (Wiener)

Title: Health coverage: mental health or substance abuse disorders.

Summary: Mental health and addiction are serious crises facing California residents. Insurance companies, under the California Parity Act of 1999, are currently required to fund emergency mental health services; however, the California Parity Act does not apply to all medically necessary mental healthcare nor to substance use disorders. SB 855 (Wiener) requires insurance companies to fund medically necessary mental healthcare and substance use disorder treatment, whether treatments are defined as urgent or not. This will allow people to receive care before being forced into full mental health crisis. SB 855 (Wiener) will also require health plans to cover out-of-network services at in-network rates if required services are not available in-network. This will give people with mental illness and substance use disorder the ability to access treatment sooner and get back on their feet without going into debt.

Commission's Position: Executive Director Toby Ewing presented SB 855 to the Commission in January 2020, the Commission took a support position on this bill, with direction to staff to update the Commission as this bill evolves.

Status/Location: Signed by the Governor on September 25, 2020 – Chapter 151, Statutes of 2020.

OPPOSED LEGISLATION

Senate Bill 665 (Umberg)

Title: Mental Health Services Fund: county jails

Summary: SB 665 would allow counties to use their MHSA funds for projects, programs, and services inside a county jail. The spirit of the MHSA is to help individuals outside institutional systems. While the Commission agrees that metal health services in jails and reentry programs are important, the jails have received funding from Proposition 47, the Community Corrections Partnerships, and others. When Californians passed the MHSA through Proposition 63, they were voting to spend more money outside as opposed to inside the jail system.

The Commission opposes SB 665 but does support counties looking at how individuals being discharged from jails are supported to ensure they are integrated into the community with necessary support to meet their needs.

Commission's Position: The Executive Director and staff from Senator Umberg's Office presented SB 665 to the Commission in July 2019, the Commission took a position to oppose this bill.

Status/Location: Assembly – Dead.

TECHNICAL ASSISTANCE

Assembly Bill 3229 (Wicks)

Title: Maternal mental health

Summary: Would require each county to submit to the Mental Health Services Oversight and Accountability Commission by January 31 of each year a report describing how the county is using moneys allocated to the county from the Mental Health Services Fund to address maternal mental health issues. The bill would require the commission to post on its internet website the reports submitted by the counties. By imposing new duties on the counties, the bill would impose a state-mandated local program.

Commission's Position:
The Commission directed staff to gauge interest and start to develop a proposal for a maternal mental health pilot project and bring bill back for a future meeting.

Status/Location: Assembly – Dead.

***Bills that have no action since 2019 are no longer listed on this report. We will continue to monitor all legislation and add bills to the report if action is taken.**

Governor Newsom Signs Bills to Expand Access to Quality Behavioral Health Care for all Californians & Help Homeless Californians Suffering Extreme Mental Illness on Our Streets & Sidewalks

Published: Sep 25, 2020

In his 2020 State of the State address, Governor Newsom proposed reforms to our behavioral health care system – two of which he is signing into law today

AB 1976 reforms Laura's Law by increasing access to care for those needing outpatient behavioral health treatment

SB 855 requires health plans and insurers to cover medically necessary treatment for all mental health and substance use disorders

Governor signs other related bills to help close gaps in behavioral health care

Legislation builds on Newsom Administration efforts to prioritize behavioral health

SACRAMENTO – Governor Gavin Newsom today signed a package of bills that will improve access to quality mental health and substance use disorder services for all Californians, as well as measures that help homeless Californians suffering from behavioral health challenges access the help they need.

Governor Newsom devoted the entirety of his 2020 State of the State address to the interwoven challenges of homelessness, housing insecurity and behavioral health and proposed a number of specific reforms – some of which he is signing into law today.

"The bills I am signing today will help Californians access the behavioral health services they need to recover," said Governor Newsom. "Earlier this year, I pledged to put these critical services within reach of more Californians, through reforming our Mental Health Services Act and laws that allow loved ones and service providers to ask courts to compel those who need treatment into community-based outpatient care. Today, we do just that."

In his 2020 State of the State address, Governor Newsom directly called for reforms to behavioral health laws that were ahead of their time when originally implemented decades ago, but now require improvements. Specifically, the Governor stated his support for removing conditions imposed on counties trying to implement Laura's Law. AB 1976 by Assemblymember Susan Talamantes Eggman (D-Stockton), which Governor Newsom signed today, accomplishes this by expanding county use of court-ordered outpatient treatment.

"The Assisted Outpatient Treatment demonstration project started by Laura's Law has shown for many years that we have the tools to provide effective, community-based mental health treatment to those with the greatest need. As a social worker I've long fought for the extension of these critical services, and expanding this program and finally making it permanent will ensure greater care for the people of California," said Assemblymember Eggman.

In his State of the State address, the Governor said Mental Health Services Act (MHSA) funds should be used for substance abuse treatment and not just mental health care. The Governor today signed AB 2265 by Assemblymember Sharon Quirk-Silva (D-Fullerton), which clarifies that specified MHSA funds can be used for treatment of co-occurring mental health and substance use disorders. Counties will now be able to use MHSA

funds to assess and treat individuals with a co-occurring disorder, increasing access to substance use disorder treatment, improving care coordination and leading to a more integrated behavioral health care system.

"The effects and uncertainty of the COVID-19 pandemic, economic loss, and devastating wildfires, have brought upon a crisis of stress, depression, and anxiety to Californians. Today Governor Newsom took an important step forward by signing AB 2265, which will provide much needed clarity to existing statute in order for counties to treat those who are experiencing mental health issues in addition to substance use or alcohol disorders," said Assemblymember Quirk-Silva.

Bills in this package will also divert, when appropriate, individuals in crisis at emergency rooms to sobering centers and mental health facilities and encourage the creation of a state office to identify and address causes of suicide.

SB 803 by Senator Jim Beall (D-San Jose) supports statewide standards for behavioral health Peer Support Specialists and adds these services as an option in Medi-Cal. Peer Support Specialists are people with lived experience with mental health and/or substance use disorders and are in a unique position to earn trust and build bridges for people on the path to recovery. Statewide standards will ensure consistency and quality of service while offering a level of validity and respect to the position, while satisfying a federal requirement to allow Medi-Cal billing. A signing message for SB 803 can be found here

"Peer support services are evidence-based, and a cost-effective model of care proven to reduce cost and increase participation in treatment. Forty-eight other states have seen the benefit and value of peer support services; now it is time for California to catch up and establish a peer support specialist certification process," said Senator Beall.

In addition, the Governor signed SB 855 by Senator Scott Wiener (D-San Francisco), a long-sought reform that strengthens California's mental health parity statute by requiring commercial health plans and insurers to provide full coverage for the treatment of all mental health conditions and substance use disorders and establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines.

"Mental healthcare is essential to a person's overall health, and today, we reaffirmed that people must have access to care for mental health and addiction challenges. California's mental health parity law has huge loopholes — which the insurance industry has used to deny critically important care — and today that loophole was closed. SB 855 sends a powerful message to the nation that California prioritizes the mental health of its residents. I'm proud of my colleagues and the Governor for getting it and enacting this legislation into law," said Senator Wiener.

This legislation builds on Governor Newsom's efforts to improve the state's behavioral health delivery system and help better serve individuals experiencing mental illness. In January, the Governor formed a Behavioral Health Task Force to address the urgent mental health and substance use disorder needs across California. Additionally, the 2020-2021 state budget approved strategies to strengthen enforcement of behavioral health parity laws including focused investigations of commercial health plans regulated by the Department of Managed Health Care to further evaluate plan compliance with parity and assess whether enrollees have consistent access to medically necessary behavioral health care services. In his State of the State address earlier this year, Governor Newsom said Mental Health Services Act funds should be used for substance abuse treatment and not just mental health care.

Governor Newsom also signed the following bills:

- AB 465 Assemblymember Susan Talamantes Eggman (D-Stockton) – Mental health workers: supervision.
- AB 1544 by Assemblymember Mike Gipson (D-Carson) – Community Paramedicine or Triage to Alternate Destination Act. A signing message can be found here.
- AB 1766 by Assemblymember Richard Bloom (D-Santa Monica) – Licensed adult residential facilities and residential care facilities for the elderly: data collection: residents with a serious mental disorder.
- AB 1979 by Assemblymember Laura Friedman (D-Glendale) – Foster youth: housing.
- AB 2112 by Assemblymember James C. Ramos (D-Highland) – Suicide prevention. A signing message can be found here.
- AB 2174 by Assemblymember James Gallagher (R-Yuba City) – Homeless multidisciplinary personnel teams.
- AB 2275 by Assemblymember Adrin Nazarian (D-North Hollywood) – State armories: homeless shelters: security.
- AB 2377 by Assemblymember David Chiu (D-San Francisco) – Residential facilities.
- AB 2553 by Assemblymember Philip Ting (D-San Francisco) – Shelter crisis declarations.
- AB 2960 by Assemblymember Mike Gipson (D-Carson) – Shelter crises: fire and life safety standards.
- AB 3242 by Assemblymember Jacqui Irwin (D-Thousand Oaks) – Mental health: involuntary commitment.
- SB 1065 by Senator Robert Hertzberg (D-Van Nuys) – CalWORKs: homeless assistance.

The Newsom Administration has prioritized behavioral health over the last two years – expanding access and addressing the evolving needs of at-risk Californians.

- The Behavioral Health Task Force, established this year, while working to plan for and implement a behavioral health system that meets the diverse needs of all Californians, is also focusing on the specific needs of children, people at risk of or experiencing homelessness, and people with criminal justice system involvement. Additionally, as societal and economic circumstances have changed – with COVID-19, the resulting recession, and heightened attention to racial injustice – the Behavioral Health Task Force is, in turn, working to adjust its own mission and objectives to identify and address related needs.
- In September 2020, the Office of Statewide Health Planning and Development awarded $17.3 million in grants to seven programs to help further build the pipeline of public mental health professionals in California. Collectively, the grantees will add 36 Psychiatry Residency slots and fund 336 Psychiatric Mental Health Nurse Practitioner slots. The funding will also help launch a new Child and Adolescent Psychiatry Fellowship program.
- In response to the current public emergency, the Department of Health Care Services (DHCS) launched the CalHOPE Warm Line at 1-833-317-HOPE (4673) and website at www.calhope.dhcs.ca.gov. The State COVID-19 and CalHOPE websites have a new page, Together for Wellness, with additional resources for children and families.
- DHCS submitted an $82 million proposal to the Federal Emergency Management Agency (FEMA) to launch an expansive program of crisis counseling support for all California, with a special focus on communities hardest hit

by the pandemic and the experience of racism. The proposal also includes support for schools to reach children and youth suffering from the impact of the emergency, a robust media campaign and more website resources to help get people the support they need to manage the crisis. The state expects grant approval within the next month.

- DHCS has leveraged over $260 million in federal opioid funding to support the Medication Assisted Treatment (MAT) Expansion Project, allowing easy access to opioid addiction treatment in emergency departments and hospitals, primary care clinics, drug treatment programs, jails and prisons, and other health care settings. DHCS also supports a media campaign, Choose Change California, to lower stigma about using medications for opioid use disorder. To date, over 19,000+ overdose reversals have been reported, over 650 new MAT access points have been created, and 30,000 new patients have been served.
- To positively impact behavioral health care delivery, DHCS is using Proposition 56 funds to create the Value-Based Payment Behavioral Health Integration (BHI) Incentive Program. The program aims to improve physical and behavioral health outcomes, care delivery efficiency and the patient experience by establishing or expanding fully integrated care into provider networks. DHCS anticipates completing the award process and beginning program implementation in 2020.
- DHCS also used Proposition 56 funds to support behavioral health navigators in over 200 California hospitals, to allow addiction treatment to be provided immediately for patients arriving at an emergency department. This project is part of the California Bridge program, which integrates addiction treatment into care at hospitals and emergency departments.
- DHCS, CDPH and the Surgeon General of California sent a letter to guide suicide screening and prevention strategies to all health care providers in the state, providing simple instructions and resources about what to do if they identify someone who is at risk.
- California's behavioral health professional associations have collaborated to develop a web-based resource, Covid19CounselingCA.org, to provide free counseling to health care workers in need of emotional support.