WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Meeting
January 25, 2018

Sacramento County Office of Education
David P. Meaney Education Center, Board Room
10474 Mather Blvd., Mather, CA 95655

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

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

John Boyd, Psy.D.
Chair
Khatera Aslami-Tamplen
Vice Chair

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

January 25, 2018
9:00 AM – 3:15 PM

Sacramento County Office of Education
David P. Meaney Education Center, Board Room
10474 Mather Blvd., Mather, CA 95655

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

Public Notice

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

All meeting times are approximate and subject to change. Agenda items are subject to action by the MHSOAC and may be taken out of order to accommodate speakers and to maintain a quorum.

As a covered entity under Title II of the Americans with Disabilities Act, the Commission does not discriminate on the basis of disability and upon request will provide reasonable accommodation to ensure equal access to its meetings. Sign language interpreters, assisted listening devices, or other auxiliary aids and/or services may be provided upon request. To ensure availability of services, please make your request at least three business days (72 hours) prior to the meeting by contacting Lester Robancho at (916) 445-8774 or email at mhsoac@mhsoac.ca.gov.

Approximate Times

9:00 AM **Convene and Welcome**

Chair John Boyd, Psy.D., will convene the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Meeting. Roll call will be taken.

9:10 AM **Action**

1: Approve November 16, 2017 MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the November 16, 2017 meeting.

- Public Comment
- Vote

9:20 AM **Information**

2: Overview of Governor's Proposed Budget for 2018-19

Presenters: Kris Cook, Budget Analyst; Elena Humphreys, Budget Analyst, Department of Finance

The presenters will provide an overview of the Governor's proposed budget for fiscal year 2018-19 and its impact on the community mental health system.

- Public Comment

9:50 AM **Information**

3: Assembly Bill 114 Progress Report

Presenters: Karen Baylor, Ph.D, LMFT, Deputy Director; Brenda Grealish, Assistant Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services

The presenters will provide an overview and update of the Department of Health Care Services' implementation of the fiscal reversion provisions of AB 114 and related matters, including Mental Health Services Act regulations.

- Public Comment

10:20 AM **Action**

4: San Joaquin County Innovation Plans (2)

Presenters: Frances Hutchins, Assistant Behavioral Health Director; Kayce Rane, Behavioral Health Consultant, Rane Community Development; Ruth Shim, MD, Ph.D, Researcher, University of California, Davis Behavioral Health Center of Excellence; Christine Noguera, Chief Executive Officer, Community Medical Centers; John Foley, Chief Executive Officer, Stockton Self-Help Housing

The Commission will consider approval of two Innovation Projects for San Joaquin County.

- Public Comment
- Vote

11:20 AM **Information**

5: Implementation of Assembly Bill 1315

Presenters: Norma Pate, Deputy Director; Tom Orrock, Chief of Commission Operations and Grants

The presenters will provide the program overview and work plan to implement the AB 1315 Early Psychosis Intervention Plus (EPI Plus) Program.

- Public Comment

11:40 AM **Information**

6: Executive Director Report Out

Presenter: Toby Ewing, Ph.D., Executive Director

Executive Director Ewing will report out on projects underway and other matters relating to the ongoing work of the Commission.

Informational Documents Included:

Enclosed are: (1) The Motions Summary from the November 16, 2017 Commission Meeting; (2) Evaluation Dashboard; (3) Calendar of Commission activities; and (4) Innovation Review Outline.

12:00 PM **General Public Comment**

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

12:15 PM **Lunch Break**

1:20 PM **Resolutions for former Commissioners Larry Poaster, Ph.D., and Richard Van Horn**

1:30 PM **Action**

7: Adoption of Amendments to the Prevention and Early Intervention and Innovation Regulations

Presenter: Filomena Yeroshek, Chief Counsel

The Commission will consider adopting the amendments to the Prevention and Early Intervention and Innovation regulations.

- Public Comment
- Vote

1:45 PM **Action**

8: Authorization for the Triage Grant Program Evaluation Contracts

Presenters: Norma Pate, Deputy Director; Tom Orrock, Chief of Commission Operations and Grants

The Commission will consider authorizing the Executive Director to enter into one or more contracts to evaluate the outcomes of the second round of Triage grant programs.

- Public comment
- Vote

2:00 PM **Action**

9: Legislative Priorities

Presenters: Toby Ewing, Ph.D., Executive Director; Donna Hardaker, Manager of Workplace Mental Health and Peer Relations, Sutter Health

The Commission will consider legislative priorities for the current legislative session including establishing a framework and voluntary standards for mental health in the workplace. The Commission will also consider possible support of current bills.

- Public Comment
- Vote

2:40 PM **Information**

10: Statewide Suicide Prevention Strategic Plan

Presenter: Brian R. Sala, Ph.D., Deputy Director; Ashley Mills, Senior Researcher

The presenter will provide a work plan for the Statewide Suicide Prevention Project.

- Public Comment

3:00 PM **General Public Comment**

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

3:15 PM **Adjourn**

AGENDA ITEM 1

Action
January 25, 2018 Commission Meeting

Approve November 16, 2017 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will review the minutes from the November 16, 2017 meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the MHSOAC Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None.

Enclosures: November 16, 2017 Commission Meeting Minutes.

Handouts: None.

Recommended Action: Approve November 16, 2017 Meeting Minutes.

Proposed Motion: The Commission approves the November 16, 2017 Meeting Minutes.

Mental Health Services
Oversight and Accountability Commission

STATE OF CALIFORNIA
EDMUND G. BROWN
Governor

John Boyd, Psy.D.
Chair
Khatera Aslami-Tamplan
Vice Chair
Toby Ewing, Ph.D.
Executive Director

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
November 16, 2017

Monterey Peninsula Unified School District
District Services Center
540 Canyon Del Rey Blvd.
Del Rey Oaks, CA 93940

866-817-6550; Code 3190377

Members Participating:

Tina Wooton, Chair
John Boyd, Psy.D., Vice Chair
Reneeta Anthony
Lynne Ayers Ashbeck
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
David Gordon
Mara Madrigal-Weiss
Gladys Mitchell

Members Absent:

Khatera Aslami-Tamplen
Senator Jim Beall
Itai Danovitch, M.D.
Larry Poaster, Ph.D.
Assemblymember Sebastian Ridley-Thomas
Deanna Strachan-Wilson

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Technology
Tom Orrock, Chief, Operations and Grants
Sharmil Shah, Psy.D., Chief of Program Operations
Ashley Mills, Senior Researcher and Project Lead
Angela Brand, Stakeholder Project Lead

CONVENE

Chair Tina Wooton called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:31 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Announcements

Chair Wooton reviewed the meeting protocols. She stated the Commission conducted three site visits to the Los Angeles Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) Center, the LGBTQ Youth Center, and the New Genesis Apartments in Los Angeles following the October meeting.

Vice Chair Boyd mentioned that there is a need for Commissioners to chair the standing committees for 2018: Evaluation, Fiscal Oversight, CFLC, and CLCC. He asked Commissioners to let him know if they are interested.

Commissioner Ashbeck asked for more information on each Committee. Executive Director Ewing summarized Committee makeup, roles, and meeting schedules.

Commissioner Anthony said she was interested in the Fiscal Oversight Committee and Commissioner Bunch indicated her interest in the CLCC but not as chair.

Commissioner Brown stated the Words to Deeds Committee of the Forensic Mental Health Association gives out awards that emphasize the mission of Words to Deeds, which is to change the paradigm of how mental illness and criminal justice are dealt with. He announced that Chair Wooton received the 2017 Paradigm Award on November 8, 2017, during the annual Words to Deeds Conference. He re-presented the award to Chair Wooton on behalf of the Forensic Mental Health Association in front of the Commission since he was unable to be in attendance during the presentation ceremony.

ACTION

1: Approve October 26, 2017, MHSOAC Meeting Minutes

Commissioner Mitchell asked why the language was changed for the Los Angeles/ Kern County Innovation motion from “provides status updates to the Commission at three and six months” to “provides status updates to the Commission at specified intervals, such as three and six months.” Ms. Yeroshek stated it was changed to provide flexibility depending on where the counties are in the implementation process.

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

The Commission approves the October 26, 2017, Meeting Minutes.

Motion carried 6 yes, 0 no, and 3 abstain, per roll call vote as follows:

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

The following Commissioners abstained: Commissioners Anthony, Ashbeck, and Gordon.

ACTION

2: <u>Criminal Justice and Mental Health Report</u>

Presenter: Ashley Mills, Senior Researcher and Project Staff Lead

Commissioner Brown stated Commissioners' suggestions from the last Commission meeting have been incorporated into the Draft Criminal Justice and Mental Health Report. He discussed the purpose and target audience of the report and stated it is not meant to be a comprehensive history on mental illness in the correctional system but is meant to be read, used, and acted upon. Other communities nationwide were studied to learn their creative solutions to this ongoing problem.

Commissioner Brown stated the study revealed varied approaches to the problem, but had in common a collaborative spirit of goodwill and resolve to combine forces, to recognize that individually there is no chance to solve the problem but, collectively in a spirit of goodwill, by combining forces and sharing resources, there is an opportunity to solve many aspects of this problem. The report recognizes that counties will be unable to implement all suggestions, but focuses on three priorities: to collaborate and combine resources, to provide crises services and alternatives to custody for individuals with mental illness, and to provide proper treatment and services for mentally ill individuals while they are in custody. Commissioner Brown asked the Commission to approve the report so the Governor and Legislature can have it in January for the upcoming legislative session.

Ashley Mills, Senior Researcher and Project Staff Lead, provided an overview, accompanied by a slide presentation, of the background, goal, subcommittee and stakeholder process, and findings and recommendations of the Criminal Justice and Mental Health Project.

Commissioner Questions and Discussion

Chair Wooton thanked Commissioner Brown and staff for their dedication to this work and recognized former Commissioner Richard Van Horn for his contribution. She stated the need to think about the language used to reduce stigma for individuals with mental health challenges who are incarcerated.

Commissioner Ashbeck asked what Commissioners can do to effect change, who is accountable to implement the recommendations, and what the Commission can do to track that work. Commissioner Brown stated the next step is for wide distribution of the report. He stated the Commission's role is to identify the problem, provide tools to solve that problem, and distribute the tools to counties and state officials who are responsible for enacting them. He suggested that the Commission receive periodic updates on the work being done in counties in response to the report.

Executive Director Ewing added that per the Rules of Procedure, the Commission can sponsor legislation consistent with the report, provide training and technical assistance, and both initiate and join collaboratives and partnerships.

Commissioner Ashbeck suggested that Commissioners lead the discussion with the sheriff, behavioral health directors, and others in their local communities.

Public Comment

Poshi Walker, Co-Director, Out for Mental Health and Mental Health America of Northern California (NorCal MHA), stated it is an amazing and excellent report. The speaker stated the need for stronger recommendations and referred to Recommendation 4 on page 62 and stated the concern that the report calls for the expansion of the Council on Criminal Justice and Behavioral Health (COMIO), but there are no consumers on its board. The speaker suggested that Recommendation 4 include a mandate for consumer involvement and leadership as part of adopting the final version of the report.

Rory O'Brien stated implicit bias training is mentioned as a need in Finding 6 of the report but is not mentioned in the recommendation following Finding 6. The speaker asked that implicit bias training be included in Recommendation 6. The speaker stated page 31 of the report mentions co-responder approaches and how they have gained traction with wide-scale intervention and evaluation and asked that the recommendation include co-responder teams.

Robb Layne, Director of Communications and External Affairs, California Behavioral Health Directors Association (CBHDA), agreed with Commissioner Ashbeck about formally operationalizing the recommendations. The speaker asked to continue partnering with the MHSOAC and invited Commissioner Brown and Ms. Mills to attend the CBHDA Criminal Justice Committee to discuss implementation.

Jim Gilmer, on behalf of the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated REMHDCO sent a letter with their comments to staff. The speaker highlighted points from the letter and stated REMHDCO requests an addendum be attached to this report or an adjunct report that includes more testimony from stakeholders who were present at the numerous public hearings to increase cultural competency. The speaker asked that technical assistance in Recommendation 6 on page 9 of the report include increasing cultural competency.

Mel Mason, Co-Founder, Village Project, echoed the comments of the previous speakers and stated that even though the centrality of culturally-focused, community-based organizations in this work is implied throughout the report the report should explicitly and emphatically recommend these partnerships.

Chair Wooton suggested adding cultural competence to Recommendation 6, which would include the LGBTQ community recommendations. She asked staff to continue working on the implementation of the project with REMHDCO and the other organizations heard from throughout the report and this morning.

Commissioner Brown concurred with Chair Wooton's recommendations.

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

The MHSOAC adopts the Criminal Justice and Mental Health project report as revised to be consistent with the Commission's direction at the November 16, 2017 meeting, adding cultural competency including LGBTQ to recommendation number 6 and that staff continue working on the implementation of the report with REMHDCO and the other entities that have commented on the report.

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

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

ACTION

3: <u>Santa Clara County Innovation Plans</u>

Presenters: Toni Tullys, MPA, Director, Behavioral Health Services; Steve Adelsheim, MD, Director, Stanford Center for Youth Mental Health and Wellbeing; Jeanne Moral, Senior Health Care Program Manager, System Initiatives; Evelyn Tirumalai, MPH, Senior Mental Health Program Specialist, MHSA Coordinator; Lily Vu, MSW, Mental Health Program Specialist II, MHSA Innovations Coordinator

Toni Tullys, MPA, Director, Behavioral Health Services, provided an overview, accompanied by a slide presentation, of the demographics, current activities, and priorities of Santa Clara County, and the objectives, learning goals, and key components of the four proposed Innovation projects.

Steve Adelsheim, M.D., Director, Stanford Center for Youth Mental Health and Wellbeing, provided a brief overview of his background and additional information on the proposed Headspace Innovation project.

Commissioner Questions

Vice Chair Boyd stated the Headspace project will quickly become a best practice in the United States. He encouraged counties in California to participate in and learn from the Headspace project.

Commissioner Bunch stated sometimes the faith-based perspectives are counter to the clinician perspective. She asked how this is addressed in the Faith-Based Training and Supports project. Ms. Tullys stated there are progressive faith-based leaders in the county who have worked in mental health for a long time. The goal is to bring faith-based leaders to the table to help them better understand mental health needs.

Commissioner Bunch asked if there will be multicultural training around issues of race, gender, and LGBTQ issues. Ms. Tullys stated those issues will be incorporated into the cultural competency trainings.

Commissioner Madrigal-Weiss asked about the components that would be embedded into the behavioral health trainings for the Faith-Based Training and Supports project

and if they will include children's behavioral health issues. Ms. Tullys stated the intent is to create a training curriculum that would respect those needs.

Commissioner Madrigal-Weiss asked for greater detail on the transition age youth (TAY) sites. Ms. Tullys stated there are existing providers who are doing or are interested in doing employment in addition to offering direct services.

Commissioner Anthony asked about employment opportunities in the Psychiatric Emergency Response Team (PERT) project. Ms. Tullys stated PERT teams are crisis teams that connect individuals to community-based services. She stated there are currently no peers employed on the PERT teams.

Commissioner Mitchell referred to the Faith-Based Training and Supports project and the slide listing the County's faith communities and asked about Baptist participation in the project because it was Baptist was not listed on the slide. Ms. Tullys stated three of the county's faith-based centers are led by Baptist ministers. She stated the centers can serve increased numbers of individuals due to volunteers from the Baptist churches. She stated Baptist churches are not listed on the chart since the African American community is only three percent of the population. The chart came from an assessment of counties in terms of the populations and faith-based alignment.

Commissioner Gordon asked what the county anticipates for future augmentation of the Headspace project. Ms. Tullys stated the county has set aside up to $2 million for the project but that may be more than is needed.

Commissioner Ashbeck asked what is innovative about the PERT project. Ms. Tullys stated the team that follows behind the crisis response team is innovative in that it will connect individuals to a peer navigator who will connect them to services and supports.

Commissioner Ashbeck asked if adding a peer component to the existing mobile crisis response would be more cost-effective. Ms. Tullys stated a mobile crisis program will begin next month. She stated the community asked the county to add the PERT law-enforcement-connected project to high-suicide areas.

Chair Wooton stated the original PERT terms included clients and family members. She also asked about the two full time equivalent (FTE) Employment Specialists in the Client and Consumer Employment project. She stated the hope that one or two of those positions could be held by persons with lived experience. She encouraged incorporating peers into the Headspace staff.

Public Comment

Vicky Harrison, Manager, Standard Center for Youth Mental Health and Wellbeing, stated youth voice and involvement are key components of the Headspace project. The speaker read a letter of support for the project provided by a student.

Rochelle Ogendelli, Education Employment Specialist, read a letter of support for the Headspace project provided by a student.

Carol Chen, School In-services Coordinator, San Jose Unified School District, spoke in support of the Headspace project.

Wes Yukiyama, retired Clinical Social Worker, volunteer Chaplain for the main jail in San Jose, and a Disaster Mental Health Worker for the Red Cross, spoke in support of the Faith-Based Training and Supports project.

Stephen Hicken, Senior Division Director of Economic Development Services, Catholic Charities of Santa Clara County, spoke in support of the four proposed projects, particularly the Client and Consumer Employment project and the IPS model.

Beth Johns, Program Manager, Momentum Employment Services, spoke in support of the Client and Consumer Employment project and the IPS model.

Eila Latif, Director of Employment Programs, Catholic Charities of Santa Clara County, spoke in support of the Client and Consumer Employment project and the IPS model.

Sherri Sager, Chief Government and Community Relations Officer, Lucile Packard Children's Hospital Stanford, spoke in support of the Headspace project.

Poshi Walker stated concern that there is no mention of the stigma among faith-based leaders against individuals who identify as LGBTQ. The speaker suggested that the research of the Family Acceptance Project be included as part of the training within the Faith-Based Training and Supports project.

Robb Layne spoke in support of Santa Clara County's three-year plan update and the emphasis on data and consumer-based services. The speaker spoke in support of the Headspace project.

Commissioner Discussion

Commissioner Mitchell asked to incorporate Poshi's request into the Faith-Based Training and Supports project. Ms. Tullys stated the county would be happy to do that, along with incorporating the suggestions on culture into the Faith-Based Training and Supports project.

Commissioner Brown asked to vote collectively on the four proposed projects in the interest of time. He made a motion to approve the four innovation plans collectively with the addition of the LGBTQ and cultural competency training to be included in the Faith-Based Training and Supports project.

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

The MHSOAC approves Santa Clara County's four (4) Innovations Projects with the addition of the LGBTQ and cultural competency trainings to be included in the Faith-Based Training and Supports project.

1. Name: Client and Consumer Employment Project
   Amount: $2,525,148
   Project Length: Three (3) Years
2. Name: Faith-Based Training and Supports Project
   Amount: $608,964
3. Name: Headspace
   Amount: $572,273
   Project Length: Eight (8) Months (Ramp-up Period Only)
4. Name: Psychiatric Emergency Response Team (PERT)
   Amount: $3,688,511

Project Length: Two (2) Years Project Length: Two (2) Years

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

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

ACTION

4: <u>San Bernardino/Riverside County Innovation Plan</u>

Presenters: Dr. Teresa Frausto, Chief Psychiatric Officer; Michael Schertell, LCSW, Deputy Director; Dr. Georgina Yoshioka, Deputy Director; Michelle Dusick, Administrative Manager; Paul Gonzales, Administrative Services Manager; Angela Igrisan, Assistant Director, Programs; David Schoelen, Mental Health Services Administrator; Roderick Verbeck, Mental Health Services Administrator, Crisis; Suzanna Juarez-Williamson, Supervising Research Specialist, Evaluations

Angela Igrisan, Assistant Director, Programs, introduced Veronica Kelley, Director, San Bernardino County Department of Behavioral Health, and Stephen Steinberg, Director, Riverside County Department of Behavioral Health, who were in attendance.

Michael Schertell, LCSW, Deputy Director, Children, TAY, and Mental Health Services Act (MHSA), San Bernardino County Department of Behavioral Health, provided a brief overview of the innovative components and goals of the proposed project, and the collaboration between San Bernardino and Riverside Counties, the public and private sector hospitals, and the Hospital Association.

Michelle Dusick, Administrative Manager, shared her experience in navigating the system in her county for her child, who was experiencing mental health challenges. She stated the proposed project can improve that experience for thousands of individuals in the Inland Empire area.

Ms. Igrisan provided an overview, accompanied by a slide presentation, of the county context, demographics, project flow, and evaluation components.

David Schoelen, Mental Health Services Administrator, continued the slide presentation and discussed the main barriers to providing excellent care in community emergency rooms (ERs), and the goal, learning objective, and milestones of the proposed project.

Dr. Teresa Frausto, Chief Psychiatric Officer, continued the slide presentation and discussed current research findings.

Matthew Chang, M.D., Medical Director, Riverside County, continued the slide presentation and discussed the current psychiatrist shortage in the Inland Empire region and the Regional Emergency of Community Hospitals (REACH) team.

Paul Gonzales, Administrative Services Manager, continued the slide presentation and discussed the budget.

Commissioner Questions

Vice Chair Boyd noted that the telepsychiatry fee seems high. Ms. Dusick stated over 26,000 individuals will be served at approximately $1,700 per person. It is a bundled service that includes telepsychiatry. Mr. Schoelen stated it is approximately $325 per telehealth consultation.

Chair Wooton stated her concern that the large amount of funding will be put into ER response for clients. She asked if the county has community programs such as Crisis Stabilization Units (CSU), peer respite, and crisis residential programs. Mr. Schoelen stated Riverside County has been divided into three regions, each with a peer center, and a lived experience practitioner program integrated into the standard system of care.

Vice Chair Boyd asked about county mental health urgent care centers, the number of crisis stabilization unit beds per county, and whether they are walk-in or law enforcement drop-off centers. Roderick Verbeck, Psy.D., Mental Health Services Administrator, Crisis, Riverside County, stated the county has a large crisis system of care. The issue is that most of the individuals in the ER are placed on 5150 holds and are waiting to go to a psychiatric facility. Each of the three CSUs in Riverside County has twelve recliners. Dr. Georgina Yoshioka, Deputy Director, 24-hour and Emergency Services, San Bernardino County, stated the county has six CSU facilities with 16 beds each and three crisis walk-in centers.

Vice Chair Boyd asked why the proposed project is the best use of the Innovation dollars. Mr. Schoelen stated the data suggests that there are more individuals seeking psychiatric care in the ER than can be treated in alternative locations.

Commissioner Mitchell asked about the ethnic data makeup between the two counties and who has the ER data. Dr. Verbeck stated it is Caucasian, Hispanic, and African American. Ms. Dusick stated she did not know that information for San Bernardino County.

Commissioner Mitchell asked about diversity. Dr. Verbeck stated the members of the teams in Riverside County are diverse and speak a number of different languages. Ms. Dusick stated the employees represent the diversity in San Bernardino County; all services are offered in multiple languages.

Commissioner Bunch asked if the proposed project is used one time in the ER or if the consumers are followed through to other outpatient services. Mr. Schoelen stated outpatient services work is embedded in the mobile crisis teams for ongoing support for ninety days to ensure consumers are connected.

Commissioner Anthony asked about the implementation plan and ongoing review. Ms. Dusick stated implementation began with solidifying the Memorandum of Understanding (MOU) between the three large entities, establishing a set of regular meetings with primary stakeholders, and getting input from all entities. Mr. Schoelen stated positions have been added that are focused on implementing this plan and gathering good data.

Commissioner Ashbeck, mentioning she is a 10-year former employee of the Hospital Association and has worked in both Northern and Central California, asked about the value of the regional collaboration in terms of patients. Mr. Schoelen stated the census looks at the area as one metropolitan area, and, because of the large homeless rate, consumers can be transient. Establishing greater standards and access to care will increase accessibility and consistency of care.

Commissioner Ashbeck stated the learning questions are not innovative. She questioned whether the proposed project solves the underlying problem as described, which is that most of the individuals in the ER are placed on 5150 holds and are waiting to go to a psychiatric facility. Tele-psychiatry is not new and hospitals already do de-escalation training routinely so regional training would not have as much of an impact as implied in the plan. Commissioner Ashbeck stated she has seen behavioral health staff in the ED and referenced Fresno County who had behavioral health staff in the ED at one point and that program did not last long; the staff were not able to keep up in hospital processes. Mr. Schoelen stated the ERs want to actively partner with the county and see this project as a viable solution. He stated it is more than a 5150 issue—having knowledgeable staff who are trained in de-stigmatization, prevention, and who can connect patients to the proper services is just as important. Large numbers of individuals are not rising to the degree of intervention and are not receiving the services they need to stabilize themselves into recovery. This project fills that gap through educated, dedicated staff who are able to connect and engage people who would otherwise be missing from psychiatric services.

Commissioner Mitchell stated she is unsure that this project is the way to go at this time. She restated her concern about the lack of diversity in the project. She would like to hear more from Commissioners Ashbeck and Boyd.

Vice Chair Boyd agreed with Commissioner Ashbeck that many of the costs in the proposed project already exist. He stated the purpose of Innovation is not to cover existing costs, programs, or services.

Commissioner Madrigal-Weiss suggested investing resources into the community rather than ERs. Ms. Dusick agreed. She stated the county has invested resources in the community but this project is in response to stakeholder concern. She stated telepsychiatry is innovative because it will be with a contracted provider embedded in the emergency department who knows the community's resources and has access to medical records through a business agreement.

Commissioner Ashbeck asked if the ten hospitals proposed for telepsychiatry for $45 million will be linked. Ms. Dusick stated they do not have a shared database. Mr. Schoelen stated part of the innovation is determining how to connect the hospitals within the large geographical area. He noted that some areas do not have Internet capabilities.

Dr. Frausto stated there are not enough psychiatrists in Riverside and San Bernardino counties. She stated this project puts psychiatrists into the ERs where the patients are.

Vice Chair Boyd suggested that the counties look at the Emergency Department Information Exchange (EDIE) collective medical technologies. EDIE is a collective

medical technology that puts every ED at a county's finger tips. Many EDs use telehealth and telepsyciatric methods and remove silos of emergency room data and treatment. Emergency rooms are able to share data in real time amongst other emergency rooms through an automated process as opposed to manual processes. EDIE is currently being use in the Northwest and is expanding throughout the Bay Area.

Public Comment

Kevin Porter, Regional Vice President, Hospital Association of Southern California, spoke in support of the proposed project.

Poshi Walker recognized Commissioner Ashbeck's comments and stated mental health crisis is not the focus of ER staff training and is not in their skill set. The speaker spoke in support of the concept of providing support to ERs to improve services to persons experiencing a mental health crisis and suggested including peer support staff in this effort.

Veronica Kelley, Director, San Bernardino County Department of Behavioral Health, spoke in support of the proposed project.

Steve Steinberg, Behavioral Health Director, Riverside County Behavioral Health, spoke in support of the proposed project.

Andrea Crook, Director of Advocacy, Access California, spoke in opposition to the proposed project. The speaker stated she is alarmed that the project does not include peer positions and no peers in leadership positions were in attendance to discuss it. She asked for additional details on the stakeholder process.

John Aguirre, NorCal MHA, spoke in opposition to the proposed project. The speaker stated his concern for the lack of peer workers, transparency, and separate evaluation.

Commissioner Discussion

Commissioner Ashbeck made a motion to ask Riverside and San Bernardino Counties to come back with a reframed project that is possibly in phases and that looks at the protocol and pathways and moves into the staffing and telepsychology to make hospitals better at what they do, but mostly makes it better for the mental health consumer who goes to an ER.

Vice Chair Boyd stated the motion is not actionable enough to support. He suggested that the counties rethink what they want to do with innovation dollars and come back and present an actionable proposal.

Commissioner Ashbeck stated her intent is to have the county go back, rethink it, and possibly come back in phases with the same goal of better care in the ER and a better place for mental health consumers.

Commissioner Gordon stated he is not prepared to support a motion that gives such specific guidance to the counties.

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

The MHSOAC asks Riverside and San Bernardino Counties to return with a reframed Innovation plan that has the same end goal as the plan that was presented.

Motion carried 4 yes, 3 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Anthony, Ashbeck, Bunch, and Mitchell.

The following Commissioners voted "No": Vice Chair Boyd and Commissioners Gordon and Madrigal-Weiss.

The following Commissioners abstained: Chair Wooton.

GENERAL PUBLIC COMMENT

Poshi Walker stated concern that there is no consumer voice on the Council on Mentally Ill Offenders (COMIO) The speaker asked the Commission to support Stephanie Welch, the Executive Officer of the COMIO and help add a consumer to the Council.

Andrea Crook presented a supplement to the Innovation Review Outline and explained that ACCESS is charged with ensuring counties integrate MHSA statutory standards as well as implementation of MHSA funded services such as the Innovation plans. ACCESS has previously shared the supplement with the Client and Consumer Leadership Committee. The speaker requested time on the agenda for the February 2018 Commission Meeting for ACCESS ambassadors who are participating in their Ambassador Boot Camp program to introduce themselves to the Commission.

Regina Mason, President, Monterey County Branch, National Association for the Advancement of Colored People (NAACP), spoke about the Commission's role to advise the Governor and the Legislature on mental health policy. The speaker stated a concern that Prevention and Early Intervention (PEI) dollars issued by Monterey County Behavioral Health have never gone to an afterschool program serving African American children in a preventive way. The speaker asked for fair and equitable distribution of funding.

Rosaline Green Charles, representing parents of the Village Project, Inc., Mae C. Johnson Education and Cultural Enrichment Afterschool Academy, Monterey County, District 4, stated the Academy was promised $200,000 from Monterey County Behavioral Health that has never been received.

ACTION

5: <u>Award of Transition Age Youth (TAY) Stakeholder Contract</u>

Presenters: Tom Orrock, Chief of Commission Operations and Grants; Angela Brand, Stakeholder Lead

Tom Orrock, Chief of Commission Operations and Grants, provided an overview, accompanied by a slide presentation, of the background of the stakeholder contract process and Request for Proposals (RFP) development for an additional $170,000 per year for TAY advocacy support.

Angela Brand, Stakeholder Project Lead, continued the slide presentation and discussed the timeline and RFP process for evaluating the proposals. The proposal that received the highest points was submitted by Mental Health America of California and thus under the RFP should be awarded the TAY stakeholder contract.

Executive Director Ewing stated that the legislature had provided funds for stakeholder advocacy on behalf of TAY in the amount of $510,000 or $170,000 per year. The winning applicant, MHAC, only asked for a third of the dollars: a total of $170,000. After consulting with legal counsel and attorneys from Department of General Services, Executive Ewing recommended that the Commission pursue the original RFP to the conclusion and endorse the Notice of Intent to Award appeal process to completion. This option leaves $340,000 additional funds available for TAY.

Commissioner Questions

Commissioners asked clarifying questions about the winning applicant that proposed to do all the work for one-third the cost. Vice Chair Boyd asked if the additional funds will be subject to another competitive bidding process. Executive Director Ewing explained that in the initial round of stakeholder RFPs the MHSOAC released a second competitive process because price mattered and points were given for the proposed price. That is, the first TAY procurement cycle saw the price as a factor in the scoring. For this RFP, it was made explicit that the price was not a factor, so the Commission does not have to go out to another competitive bidding process.

Vice Chair Boyd asked if the Commissioners are required to approve what happens to the rest of the funding. Executive Director Ewing recommended that the Commission approve the original RFP and the question of the other dollars will come at a later date. He clarified that the Commission cannot offer more resources—make the leftover funding—available to the prevailing applicant for the same work it proposed because the applicant agreed to do the work outlined in the contract for $170,000.

Commissioner Gordon asked if there was any room for possible ambiguity in the RFP. Executive Director Ewing reiterated that the applicant's RFP included an itemized budget sheet that explicitly stated—in several places—that the agreed activities would amount to a budget of $170,000 for all three years.

Executive Director Ewing and Chief Counsel Yeroshek explained that after consulting with several attorneys, they recommend the proposed motion that is included in the meeting packet, and will work with and discuss options with the winning applicant.

Public Comment

Poshi Walker stated surprise that the applicant did not ask for the full funding and questioned how the proposal moved forward in the RFP process when the funding was for $510,000 and the applicant proposed and was awarded $170,000.

Commissioner Discussion

Commissioner Anthony asked if the balance of the unallocated funding could be rolled over into a future year instead of going out to another RFP. Executive Director Ewing stated this is a challenge because the Legislature expects the funds they allocated to be spent.

Commissioner Anthony stated the funding would not be allocated until the next fiscal year. Executive Director Ewing stated the structure of the RFP is that it would be $170,000 per year for three years. The applicants were asked to provide a budget that included annualized spending. In this case, the applicant provided a budget with total spending for the $170,000. He stated there are several options. He stated legal counsel suggested allowing the process to unfold today, working with the prevailing contractor, consulting with the Department of Finance, and bringing the TAY contract back to the Commission at a future date on the option taken for the balance of funding.

Commissioner Questions and Discussion

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

The MHSOAC approves the staff recommendation as follows:

- *Authorize the Executive Director to issue a "Notice of Intent to Award Contract" to the proposer receiving the highest overall score, Mental Health America of California.*
- *Establish November 27, 2017, as the deadline for unsuccessful bidders to file an "Intent to Protest" consistent with the five working day standard set forth in the Request for Proposal.*
- *Direct the Executive Director to notify the Commission Chair and Vice Chair of any protests within two working days of the filing and adjudicate protests consistent with the procedure provided in the Request for Proposal.*
- *Authorize the Executive Director to execute the contract upon expiration of the protest period or consideration of protests, whichever comes first.*

Motion carried 5 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Anthony, Gordon, and Madrigal-Weiss.

ACTION

6: <u>Schools and Mental Health Project Proposal</u>

Presenter: Toby Ewing, Ph.D., Executive Director

Commissioner Gordon thanked Commissioners for attending the site visit yesterday, the Monterey Park Elementary School for leading them on a tour, and Monterey County Behavioral Health, Monterey County Office of Education, and community partners for their presentations on the model school.

Commissioner Anthony stated she was impressed by the principal, staff, and children and that inclusiveness and student leadership were included in the activities.

Commissioner Madrigal-Weiss stated she appreciated that the school teaches students lessons that can be carried on for the rest of their lives: how to care about their own wellbeing, build skill sets to listen to their inner voices, and practice mindfulness techniques.

Executive Director Ewing stated the Commission previously directed staff to set aside a minimum of 50 percent of the Senate Bill (SB) 82 triage funds for children. He stated there is an opportunity to align those SB 82 dollars to incentivize more robust school/county/mental health partnerships and evaluate the impacts. He asked Commissioners to modify the previous direction to ensure that a portion of the SB 82 funds be dedicated to children to be made available to support strong county-school mental health partnerships consistent with the work the Commission saw yesterday. He asked the Commission to dedicate $30 million toward supporting strong county-school partnerships out of the minimum of 50 percent of the SB 82 funds. He stated the funds would be prioritized for counties that already have a strong relationship with the schools.

Executive Director Ewing suggested limiting the funds to three or four proposals to keep from spreading the funding too thin, which would allow counties to pursue projects for five years. He stated stakeholders have asked that counties be allowed to compete for funding for children separate from funding for adults.

Executive Director Ewing stated the proposal aligns the work of the Schools and Mental Health Project with the opportunity that triage dollars represents as incentive to the level of $30 million over three to five years. He stated Commissioner Senator Beall is in support of this proposal and plans to pursue legislation to reinforce the opportunity to ensure that children have access to these funds. Commissioner Senator Beall's letter is included in the meeting packet.

Public Comment

Kacey Rodenbush, Program Services Manager, Monterey County Behavioral Health, thanked the Commission for touring the facility and provided a brief overview of Monterey County's interconnected framework system of care.

Jim Gilmer spoke in support of the proposal.

Commissioner Questions and Discussion

Commissioner Anthony stated her hope that the programs are based upon proven practices and ensure fidelity throughout whatever educational approach they choose to use.

Executive Director Ewing asked about focusing on younger ages or all school-aged children and youth. Commissioner Gordon suggested latitude to focus across pre-K through 12th grade, but to ensure that in each of the projects there is some focus on pre-K through 3rd grade.

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

The MHSOAC authorizes staff consistent with this request to provide SB 82 funds in a competitive manner and that no less than $30 million of that amount be made available for county-school mental health partnerships that include a focus on ages pre-K through grade 3 but can be extended to include pre-K through grade 12. Counties are eligible to apply for children's dollars separate from adult dollars.

Motion carried 5 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Anthony, Gordon, and Madrigal-Weiss.

ACTION

7: Proposed Amendments to Prevention and Early Intervention (PEI) Regulations and Innovative Regulations: Commission Responses to Public Comments

Presenter: Filomena Yeroshek, Chief Counsel

Ms. Yeroshek provided an overview, accompanied by a slide presentation, of the four-step regulatory process, summary of public comments and staff's recommended responses, and next steps of the proposed amendments to the PEI and Innovation regulations.

Commissioner Questions and Discussion

Commissioner Anthony asked how the reporting of demographic information aligns with Substance Abuse and Mental Health Services Administration (SAMHSA) requirements for agencies to report on statics or other state requirements. Ms. Yeroshek stated the Commission is out front in terms of asking for information, especially sexual orientation and gender identity. She stated the Department of Health Care Services (DHCS) is required by law to begin asking for much of this information.

Public Comment

Poshi Walker spoke in support of the changes that were made to the recommendations on what to ask children under the age of 12. The speaker suggested that the Commission give direction for counties to allow and encourage parents to identify their children's gender because children may identify as a different gender than the one assigned at birth as early as they can speak. The speaker asked for support in the use of MHSA funds to help study the best ways to collect SOGI data among youth, especially those under the age of 12. The speaker noted that Assembly Bill (AB) 959, which requires four state agencies to collect SOGI data, does not have an age requirement.

Jim Gilmer spoke in support of the staff recommendations and, as an individual, agreed with Poshi Walker's suggestions.

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

The MHSOAC adopts staff's recommended responses to the public comments received during the 45-day public comment period, including the changes to sections 3560.010, 3726, and 3735 of the PEI regulations and section 3580.010 of the Innovative regulations.

Motion carried 5 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Anthony, Gordon, and Madrigal-Weiss.

INFORMATION

8: Innovation Sub-Committee Update

Presenter: Sharmil Shah, Psy.D., Chief of Program Operations

Sharmil Shah, Psy.D, Chief of Program Operations, stated the Commission directed staff to create an Innovation Toolkit to improve the innovation approval process. She presented several documents meant to streamline the process and make it easier for counties to submit their applications. She reviewed the Innovation Framework Decision Tree, the MHSOAC Innovation Review Process, the Innovative Project Recommended Template, and the Presentation Guidelines documents, which were included in the meeting packet.

Commissioner Questions

Commissioner Gordon stated the third box in the Innovation Framework Decision Tree is much of what was lacking in the proposal that was not approved. He stated this document should be helpful.

Commissioner Anthony stated her hope that counties will understand that the Commission will use this set of tools to follow their processes and understand the steps that they have taken and, when Commissioners ask questions, that counties will be prepared to fully answer those questions.

Public Comment

Andrea Crook shared Access California's Supplementary Guidelines for the Innovation Review Outline. The speaker stated that there was no consumer involvement in creating the tool, only county involvement and suggested incorporating the themes listed in Access California's Guideline document to ensure meaningful stakeholder participation and client-driven programs and services, recovery-oriented systems, services and practices, and outcomes, and that there is an expansion and strengthening of peer support services and increased stakeholder employment opportunities within the public mental health system.

Poshi Walker suggested including an opportunity to utilize the stakeholder contractors or subject matter experts for those marginalized voices that may not have risen up even during a community planning process. The speaker asked that part of the staff process for looking at these plans before they are presented to the Commission allow the stakeholder contractors to look at these plans and be given an opportunity to provide comments, so those comments can get back to the counties before they present their plans before the Commission. This would allow an opportunity for conversation and technical assistance, if needed, to make innovation plans more robust and more culturally sensitive to those marginalized voices.

Commissioner Discussion

Vice Chair Boyd agreed and encouraged continuing to advocate at the local level. He stated, if local engagement is working well and right and represented with all the intentions that are part of the MHSA, all that should be incorporated by the time the innovation plans are presented to the Commission.

ACTION

9: Contract Authorization

Presenter: Norma Pate, Deputy Director

Norma Pate, Deputy Director, stated two existing contracts that support the transparency data portal and evaluation activities will expire in December. She proposed to replace these with a single contract. She provided an overview, accompanied by a slide presentation, of the outline and cost benefit analysis of the single contract with enhanced support and storage.

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

The MHSOAC authorizes the Executive Director to enter into one or more contracts for an amount not to exceed $500,000 for ongoing maintenance and operations of the Transparency Data Portal environment, and ongoing maintenance and operations of the MHSOAC data warehouse and analytical environment.

Motion carried 5 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Anthony, Gordon, and Madrigal-Weiss.

INFORMATION

10: Executive Director Report

Presenter: Toby Ewing, Ph.D., Executive Director

Executive Director Ewing presented his report as follows:

Personnel

The number of applications for open positions at the MHSOAC have increased due to the work of the Commission.

Innovation

The focus has been on four key challenges: strategic impact, technical assistance, evaluation, and dissemination.

Legislation

AB 1134 established a fellowship program to provide a consumer perspective in the work of the Commission. The Legislature authorized the establishment of two policy fellowships - one for a consumer and one for a practitioner. The Commission will create an advisory committee to help frame that out. The goal is to provide a stipend of approximately $35,000 per year with health insurance.

AB 1315 established a special fund to receive private donations for purposes of putting funds into an early psychosis program. Staff is working with the Department of Finance to set that up. The Commission will create an advisory committee to help shape the investments that the Commission will make with those funds.

Project Updates

Criminal Justice and Mental Health

Staff has been receiving inquiries from legislative offices and talking with the Governor's office. Three to four pieces of legislation are anticipated to be drafted as a result of the work of this Committee, along with training and other partnership opportunities.

Fiscal Reporting Tool

The work of the Commission on Fiscal Reversion has led to legislation to direct Department of Health Care Services to identify funds that should have reverted as far back as 2005. The draft math on that funding is 274 million dollars sitting in county bank accounts for an extended period of time. Conversations have started to take place addressing funding sitting in county accounts and recently have been receiving some press coverage in San Diego, Sacramento, and other counties which was shared with Commissioners.

Fiscal Reversion

Several Sacramento County Board of Supervisors met with staff to discuss fiscal reversion and their more than two years of unspent MHSA funds – the county was not spending those dollars until the third year. Other counties may be in that same position. The Legislature and the auditor have asked the Commission to learn why these funds are not being spent as they come in, given the level of unmet need in the community. The January Commission meeting will include an update on the level of funds that have been made available to the counties, the expenditure rates, and how much is in the bank.

Schools and Mental Health

Commissioner Madrigal-Weiss has been appointed to the Schools and Mental Health Subcommittee. The Subcommittee will begin summarizing its activities and creating a report.

Research and Evaluation

The focus is in three areas: policy projects, individual project evaluations, and the data project.

Stakeholder Contracts

With the exception of $300,000, the balance of the $14 million has been allocated and organizations are beginning to work.

Commission Meeting Calendar

The next Commission meeting will be in Sacramento in January of 2018.

GENERAL PUBLIC COMMENT

Poshi Walker suggested that the Executive Director's report be moved up in future agendas. It is important for Commissioners to hear what the Executive Director has to say. The speaker suggested that the Commission have a conversation with the

Governor about appointing additional Commissioners to the Commission. Fifteen is not enough and the work is very important and vital. The speaker also suggested there be a policy on the length of time a county is given to present their innovation project and the number of county staff members who are allowed to make public comment in support of that project. The public comment period should be left for members of the public.

Rory O'Brien recognized the work of Executive Director Ewing in Sacramento in responding to the funds that were appropriated and not being used. The speaker echoed Regina Mason's earlier public comment about PEI dollars issued by Monterey County Behavioral Health that have never gone to an afterschool program serving African American children in a preventive way.

ADJOURN

There being no further business, the meeting was adjourned at 4:04 p.m.

AGENDA ITEM 2

Information

January 25, 2018 Commission Meeting

Overview of Governor's Proposed Budget for Fiscal Year 2018-19

Summary: The presentation will review the Governor's fiscal year (FY) 2018-19 proposed budget and discuss its impact on the Mental Health Services Act and the community mental health system.

Presenters: Kris Cook, Budget Analyst; Elena Humphreys, Budget Analyst, Department of Finance

Enclosure (1): MHSOAC Financial Oversight Report, January 2018

Handout: None

Recommended Action: Information Item Only

Motion: None

Mental Health Services
Oversight & Accountability Commission

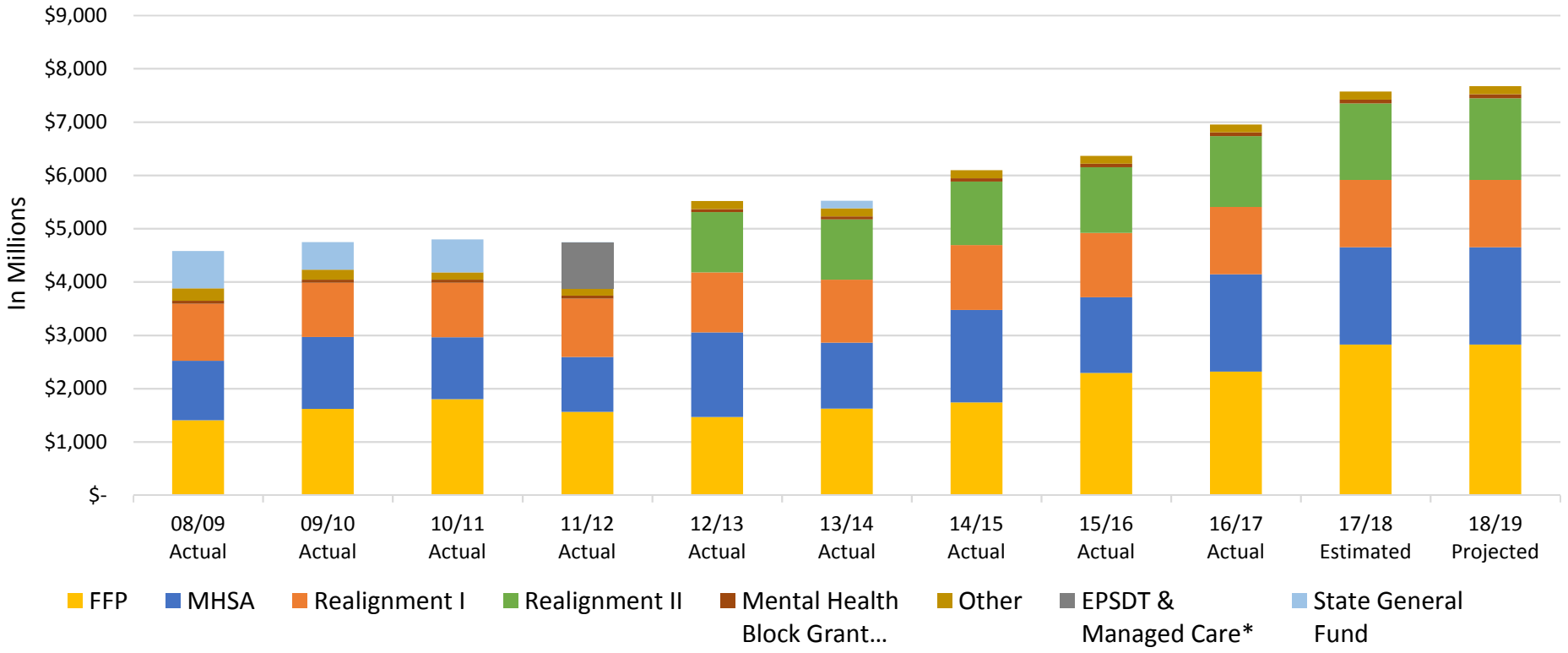
Financial Report

January 25, 2018

Mental Health Funding at the Local Level

FY 08/09 - 18/19

The graph below displays local mental health funding levels from FY 2008/09 to 2018/19 from different funding sources. Projected funding to the counties in FY 2018/19 is 67.3 percent higher than in FY 2008/09 and 10.3 percent higher than FY 2016/17.



MHSA funding for counties shown above is from the Governor's proposed budget. Actual amount distributed will be based on actual revenues deposited into the fund less the amount reserved and spent on administration.

Realignment I 1991: Transferred control of several health and mental health programs from the state to the counties, reduced State General Funds to the counties, and provided the counties with "new" tax revenues from increased sales tax and vehicle license fees dedicated to counties for their increased financial obligations for health and mental health programs.

Realignment II 2011: shifts "existing" state revenues from sales tax, vehicle license fee for various programs including EPSDT and mental health managed care. The total funds for the 2011 Realignment includes funds for Substance Use Disorders.

* One time redirected MHSA funding for EPSDT and Mental Health Managed Care. State General Fund amounts for Mental Health were replaced by Realignment I and Realignment II.

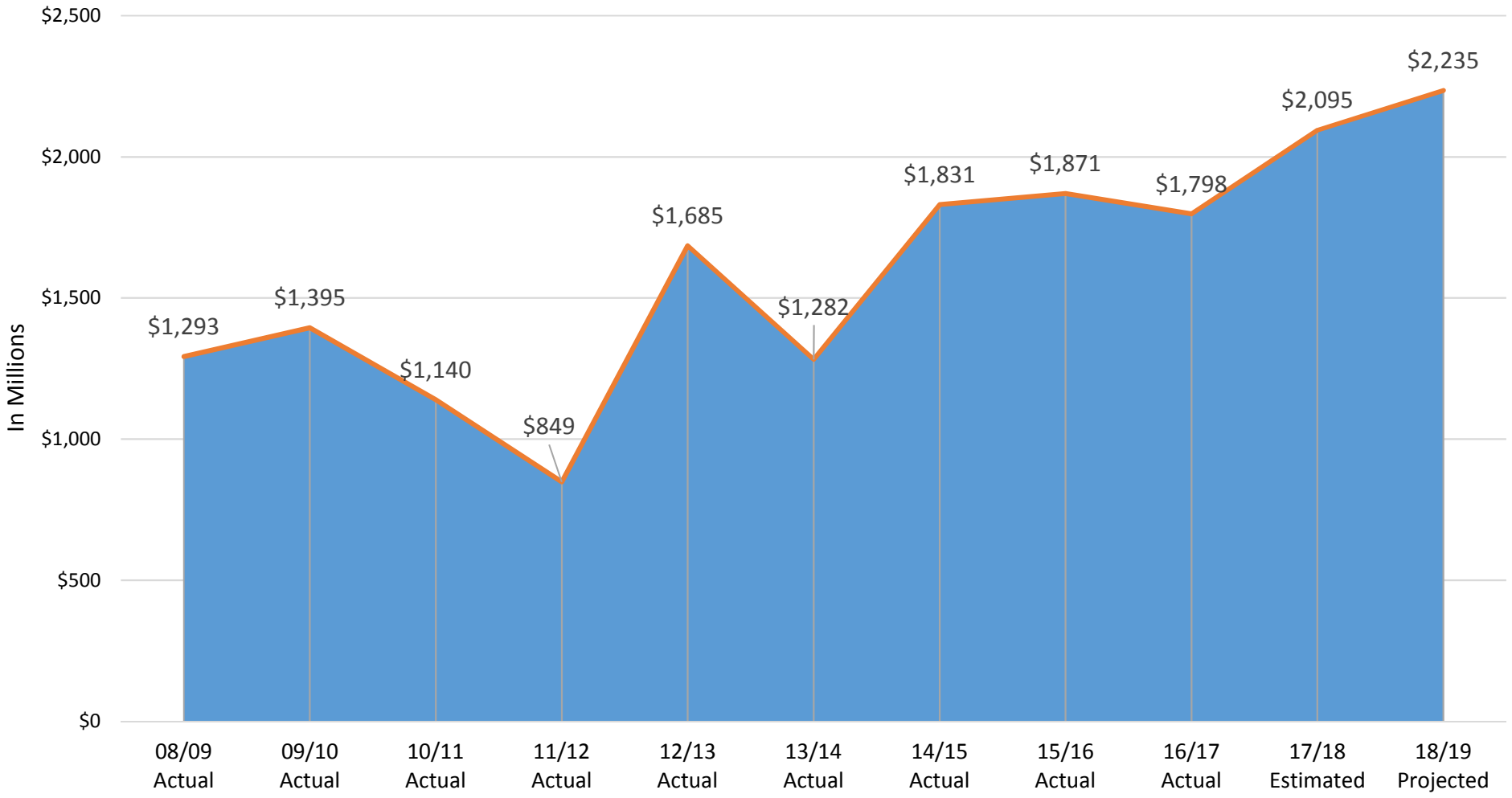
State General Fund in 2013/14 was for the California Health Facilities Financing Authority Senate Bill (SB) 82 Grants.

Source: Sources identified in Appendix 1
Jan 2018
Updated Semi-Annually

Total MHSA Revenue

FY 08/09 - 18/19

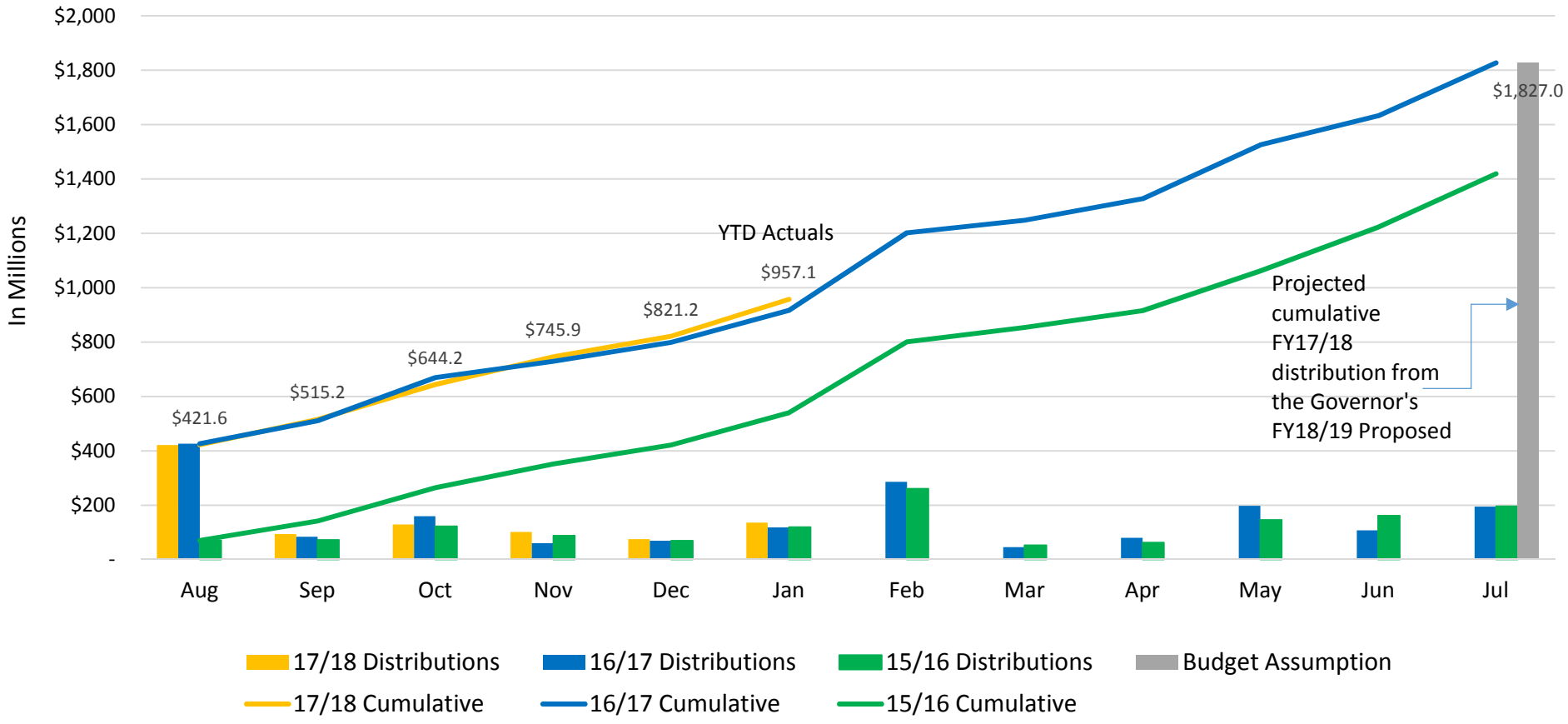
The graph below indicates the actual and estimated total MHSA Revenues deposited to the fund from FY 2008/09 to 2018/19. MHSA funding is susceptible to economic fluctuations as noted in the graph below. Each county is required to maintain a Prudent Reserve that is designed to preserve current levels of services in years with extreme decreases in revenue. Additionally, the State maintains a reserve for economic uncertainties in each special fund. The Governor's FY 2018/19 January Proposed Budget includes a projected reserve in the Mental Health Services Fund for FY 2018/19 of $1,165 million.



Source: Sources identified in Appendix 2
Jan 2018
Updated Semi-Annually

Mental Health Services Funds Distributed to Counties FY 2017/18

This chart reflects changes to distributions to the counties of MHSA Funds from August 2017 to January 2018. Funds are distributed to the counties in monthly lump sums and attributed in county accounts to Community Services and Supports, Prevention and Early Intervention, and Innovation. The distribution in FY 2017/2018 represents actual Mental Health Services funds distributed for the first 6 months of the fiscal year. Also shown are monthly and cumulative distributions for FY2015/16 and FY2016/17 and the projected cumulative distribution for FY17/18 included in the Governor's Proposed Budget for FY18/19.

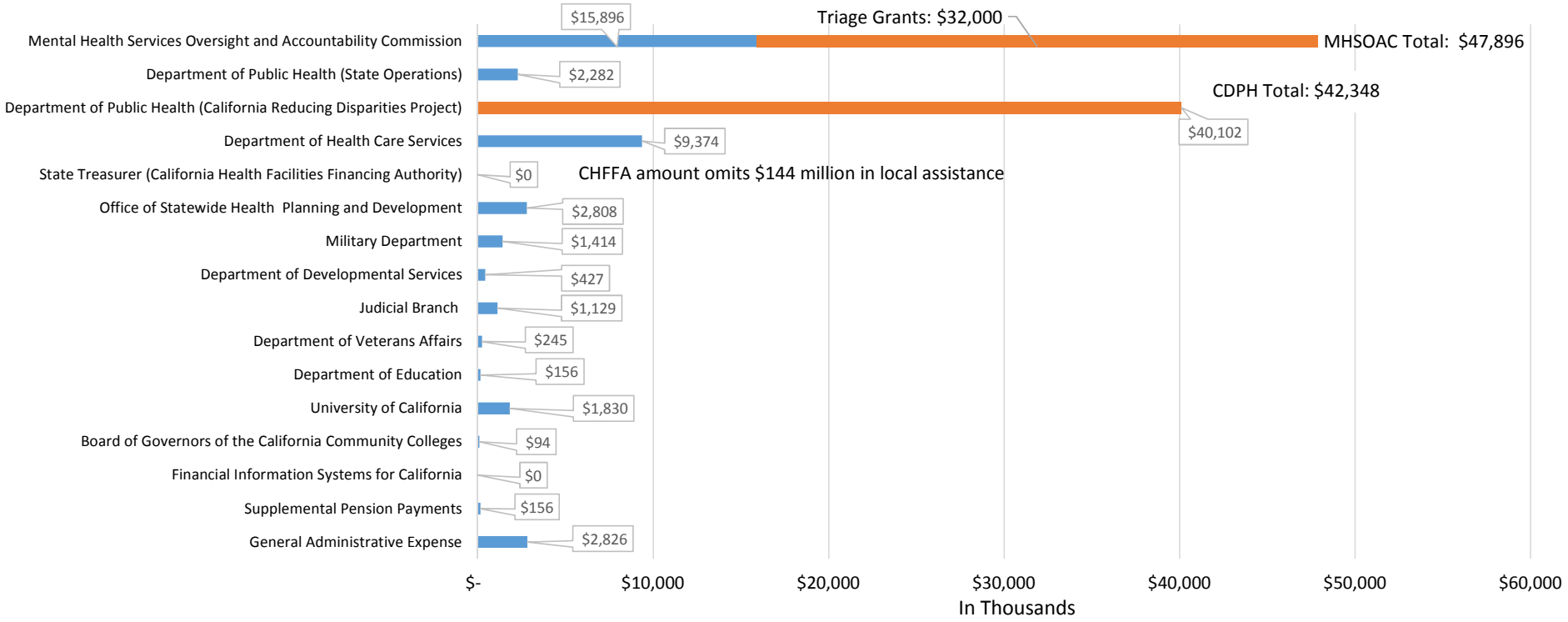


For a year to date, county by county summary of distributions, refer to the following link:
https://www.sco.ca.gov/Files-ARD-Payments/mentalhealthservices_ytd_1718.pdf

Sources: Governor's Proposed Budget, State Controller's Office and MHSOAC Staff Projections
Jan 2018
Updated Semi-Annually

MHSA Administration Funds by Department (In Thousands) FY 2018/19

This figure identifies the state entities that receive MHSA Administrative Funds. These funds are utilized for administration, services, research, etc. A portion of these funds were reappropriated from prior year administrative funds and are attributed to the 5% administrative cap for a different fiscal year than which they are expended. Zero amounts are shown for CHFFA ($265,000 in 2017/18) and FISCal ($135,000 in 2017/18). General Administrative Expense is now a general line item in the budget for each fund rather than line items in individual departmental budgets.



Amount Budgeted for Fiscal Year 2018/19 $ 110,739 Projected

Sources: Health and Human Services budget details, FY2018-19 and FY2017-18.
Jan 2018
Updated Semi-Annually

Appendix 1: Mental Health Funding Levels at the Local Level (In Millions) FY 08/09 - 18/19

	08/09 Actual	09/10 Actual	10/11 Actual	11/12 Actual	12/13 Actual	13/14 Actual	14/15 Actual	15/16 Actual	16/17 Actual	17/18 Estimated	18/19 Projected
State General Fund	$ 701.0	$ 518.0	$ 619.4	$ 0.1	$ -	$ 142.5	$ -	$ -	$ -	$ -	$ -
Realignment I	$ 1,072.4	$ 1,023.0	$ 1,023.0	$ 1,097.6	$ 1,124.0	$ 1,185.0	$ 1,216.7	$ 1,210.0	$ 1,259.3	$ 1,260.1	$ 1,259.7
Realignment II	$ -	$ -	$ -	$ -	$ 1,131.0	$ 1,129.0	$ 1,193.0	$ 1,230.3	$ 1,328.6	$ 1,432.9	$ 1,533.9
Mental Health Block Grant (SAMHSA)	$ 53.7	$ 54.0	$ 53.7	$ 53.1	$ 57.4	$ 57.4	$ 62.2	$ 63.1	$ 69.2	$ 74.2	$ 74.2
FFP	$ 1,404.6	$ 1,619.2	$ 1,799.9	$ 1,562.5	$ 1,465.0	$ 1,624.0	$ 1,743.0	$ 2,293.5	$ 2,319.6	$ 2,825.8	$ 2,825.8
MHSA	$ 1,117.0	$ 1,347.0	$ 1,165.1	$ 1,029.9	$ 1,589.0	$ 1,235.0	$ 1,730.1	$ 1,418.8	$ 1,827.0	$ 1,827.0	$ 1,827.0
EPSDT & Managed Care*	$ -	$ -	$ -	$ 861.2	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ 233.9	$ 187.6	$ 139.4	$ 139.4	$ 150.0	$ 150.0	$ 150.0	$ 150.0	$ 150.0	$ 150.0	$ 150.0
TOTAL	**$ 4,582.6**	**$ 4,748.8**	**$ 4,800.5**	**$ 4,743.8**	**$ 5,516.4**	**$ 5,522.9**	**$ 6,094.9**	**$ 6,365.7**	**$ 6,953.7**	**$ 7,570.1**	**$ 7,670.7**

State General Fund (SGF): Prior to the Governor's FY 2011/12 Budget Proposal, the primary obligations of the SGF provided counties with mental health dollars to fund specialty mental health benefits of entitlement programs including Medi-Cal Managed Care, Early and Periodic Screening Diagnosis Treatment (EPSDT) and Mental Health Services to Special Education Pupils (AB 3632). State General Fund for Mental Health was replaced by Realignment I and Realignment II. State General Fund in 2013/14 was for the California Health Facilities Financing Authority Senate Bill (SB) 82 Grants. These grants subsequently were funded from the MHSF.

Realignment I (1991): In the 1991/92 fiscal year, State-Local Program Realignment restructured the state-county partnership by giving counties increased responsibilities and funding for a number of health, mental health, and social services programs. This realignment provides counties with dedicated tax revenues from the state sales tax and vehicle license fee.

Realignment II (2011): Realignment is the shift of funding and responsibility from the State to the counties to provide mental health services, social services and public health. There are two sources of revenue that fund realignment: 1.0625 cents of State sales taxes and a portion of State vehicle license fees. The primary mental health obligation of realignment is to provide services to individuals who are a danger to self/others or unable to provide for immediate needs. It is also a primary funding source for community-based mental health services, substance abuse services, State hospital services for civil commitments and Institutions for Mental Disease (IMDs) which provide long-term care services. Realignment II is for behavioral health services more broadly. The numbers displayed exclude the fixed set-aside for Women and Children's Residential Treatment.

Mental Health Block Grant (SAMHSA): Mandated by Congress, SAMHSA's block grants are noncompetitive grants that provide funding for substance abuse and mental health services.

Federal Financial Participation (FFP): FFP is the federal reimbursement counties receive for providing specialty mental health treatment to Medi-Cal and Healthy Families Program beneficiaries. The amount of federal reimbursement received by counties is based on a percentage established for California and which is called the Federal Medical Assistance Percentage (FMAP) and gives counties the funding responsibility for EPSDT and Mental Health Managed Care. California's FMAP for 2017 is 50 percent.

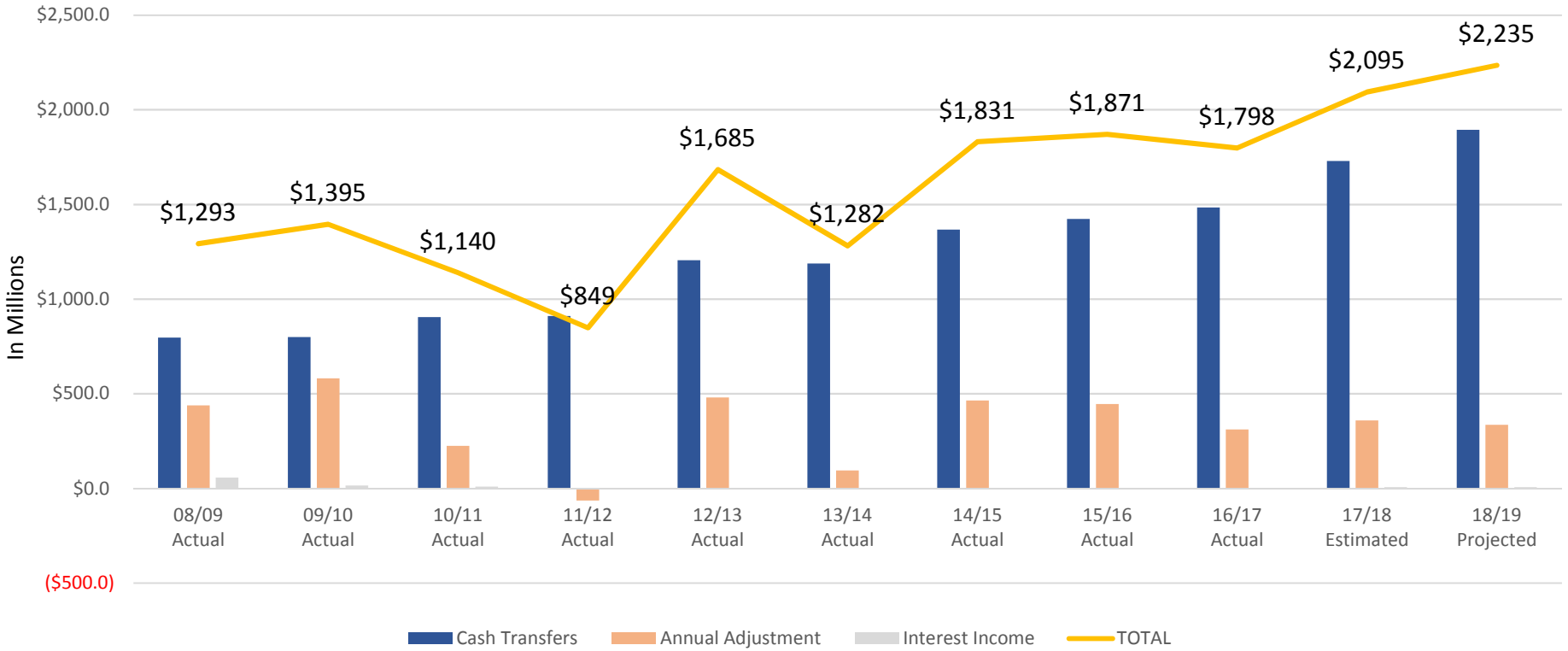
Proposition 63 Funds (MHSA): The MHSA is funded by a 1% tax on personal income in excess of $1 million. The primary obligations of the MHSA is for counties to expand recovery based mental health services, to provide prevention and early intervention services, innovative programs, to educate, train and retain mental health professionals, etc.

Other: Other revenue comes from a variety of sources--county funds are from local property taxes, patient fees and insurance, grants, etc. The primary obligation of the county funds is the maintenance of effort (the amount of services required to be provided by counties in order to receive Realignment funds). MHSOAC Fiscal Consultant Projections; these have not been updated since 2012/13.

Sources: FY 2018/19 Governor's Budget, and various.
Jan 2018
Updated Semi-Annually

Appendix 2: Total MHSA Revenue FY 08/09 - 18/19

This graph and chart displays in more detail the information found on the graph on page two, Total MHSA Revenue. The dollars identified below tie to Fund Condition Statement figures published by DOF.



	08/09 Actual	09/10 Actual	10/11 Actual	11/12 Actual	12/13 Actual	13/14 Actual	14/15 Actual	15/16 Actual	16/17 Actual	17/18 Estimated	18/19 Projected
Cash Transfers	$797.0	$799.0	$905.0	$910.0	$1,204.4	$1,187.4	$1,366.5	$1,423.5	$1,484.1	$1,729.7	$1,894.3
Annual Adjustment	$438.0	$581.0	$225.0	($64.0)	$479.8	$94.3	$464.1	$446.0	$311.7	$359.2	$335.1
Interest Income	$57.6	$14.9	$9.7	$2.7	$0.7	$0.5	$0.8	$1.2	$2.6	$5.9	$5.9
TOTAL	$1,292.6	$1,394.9	$1,139.7	$848.7	$1,684.9	$1,282.2	$1,831.5	$1,870.8	$1,798.3	$2,094.7	$2,235.3

Sources: Health and Human Services budget details, FY2018-19 and staff projections
Jan 2018
Updated Semi-Annually

AGENDA ITEM 3

Information

January 25, 2018 Commission Meeting

Assembly Bill 114 Progress Report

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will hear an overview and update on the implementation of the fiscal reversion provisions of Assembly Bill 114 (Chapter 38, Statutes of 2017) from Brenda Grealish, Acting Deputy Director, Department of Health Care Services (DHCS).

The Bill requires, in part,

- That the Department of Health Care Services determine the amount of unspent Mental Health Services Act funds held by the counties that were received during FY 2014-15 or earlier and due back to the State Mental Health Services Fund, as of July 1, 2017,
- That those unspent funds due back to the State are deemed reverted to the State Fund and returned to the counties from which they were reverted, in their original MHSA components (e.g., Community Services and Supports; Prevention and Early Intervention; or Innovation),
- That the counties are to expend the deemed reverted funds prior to July 1, 2020, according to expenditure plans that must be submitted no later than July 1, 2018.

Preliminary estimates suggest that more than $250 million dollars in unspent MHSA funds held by the counties would be deemed reverted.

The Commission may wish to consider the following questions:

- What is the Department's current estimate of unspent MHSA funds that will be deemed reverted under AB 114? How has that amount been determined and when will it be finalized?
- How many counties have not yet fully complied with Annual Revenue and Expenditure Report reporting requirements? What steps is the Department taking to obtain all required reports?
- What is the Department's timetable for issuing MHSA fiscal regulations, consistent with authority under AB 1467 (Chapter 23, Statutes of 2012) and any other relevant legal authority?
- How has the public been provided opportunities to participate in Departmental development of fiscal regulations, as well as letters or similar instructions to the counties regarding implementation of AB 114?
- What is the status of and timetable for Departmental review and auditing of counties' annual Cost Reports? How do these Cost Reports relate to MHSA Revenue and Expenditure Reports?

- How does the Department ensure county compliance with MHSA program and reporting requirements generally? What MHSA-related requirements are included in county mental health performance contracts, and how do those requirements related to MHSA program and reporting requirements? What is the status of and timetable for the Department's Triennial Oversight Reviews of county Mental Health Plans and how do those reviews relate to the Department's mental health compliance activities?

Presenter: Brenda Grealish, Acting Deputy Director, Mental Health and Substance Use Disorder Services, DHCS

Enclosures (5): (1) Brief Bio for Ms. Grealish; (2) Letter from MHSOAC inviting Dr. Karen Baylor (then-Deputy Director) to present; (3) Text of AB 114, (Chapter 38, Statutes of 2017), Sections 14-17; (4) Text of DHCS Information Notice 17-059; (5) DHCS Status Chart of County Revenue and Expenditure Reports Received.

Handouts: None.

Brenda Grealish

Acting Deputy Director, Department of Health Care Services

Brenda Grealish was appointed Acting Deputy Director for Mental Health and Substance Use Disorder Services in January 2018, and has served as Assistant Deputy Director for Mental Health and Substance Use Disorder Services within the California Department of Health Care Services (DHCS) since November 2014. As Assistant Deputy Director, Ms. Grealish is responsible for assisting the Deputy Director with the work under all of the mental health and substance use disorder divisions. Prior to her current position, Ms. Grealish served four years as a Deputy Director and as a Research Manager with the California Department of Corrections and Rehabilitation; and ten years in a variety of capacities with the California Department of Mental Health and DHCS, including as Chief of the Mental Health Services Division. Ms. Grealish holds Bachelor's and Master's Degrees in Psychology.

January 10, 2018

Karen Baylor, Ph.D., LMFT, Deputy Director
Mental Health and Substance Use
Disorder Services Division,
Department of Health Care Services
1501 Capitol Avenue, MS 4000
P. O. Box 997413
Sacramento, CA 95899-7413

Dear Deputy Director Baylor,

On behalf of the Commission, I am writing to thank you for agreeing to present at the January 25, 2018 Commission Meeting, to update and inform the Commission on DHCS progress towards implementation of the fiscal reversion aspects of Assembly Bill 114 (Chapter 38, Statutes of 2017) and related matters.

The Commission requests that you provide written testimony, if possible, to allow you to summarize your testimony and address questions Commissioners may have. Specifically, we ask you to discuss the following:

- **Amounts deemed reverted:** AB 114 adds Section 5892.1 to the Welfare and Institutions Code. This section includes a requirement for DHCS to provide to counties a determination of the Mental Health Services Act funding amounts subject to reversion and deemed reverted on or before July 1, 2017.

  On December 28, 2017, DHCS released Information Notice 17-059, informing the counties of the process the Department will use to determine amounts deemed reverted and the process and timetable for county appeals. That Information Notice reminded counties that the MHSA Annual Revenue and Expenditure Report (RER) for the Fiscal Year 2016-17 reporting period was due no later than December 31, 2018, and that any prior reports not yet submitted were expected to be submitted by that date as well.

  Please update the Commission regarding DHCS's determination of amounts "deemed reverted" pursuant to AB 114. Has the Department completed its determination of amounts subject to reversion, including

review of appeals from counties? If so, please provide the schedule of amounts subject to reversion, by County Mental Health Plan, MHSA Component, and Fiscal Year of allocation. If not, what is the timetable for completing this determination, and how will the Department make those determinations available to the public?

- **Submission and review of county RERs:** Please update the Commission regarding the status of DHCS receipt of RERs. How many counties have not yet submitted all required RERs, and what steps has DHCS taken to obtain missing reports?

  Has DHCS uncovered any data issues in its reviews of RERs, and what steps has DHCS taken in response to issues it has identified? What steps does DHCS undertake to review submitted RERs for accuracy and completeness?

- **Fiscal regulations timetable:** Under AB 1467 (Chapter 23, Statutes of 2012), DHCS was directed to develop and issue regulations implementing various aspects of the MHSA, including fiscal oversight. This Act directed DHCS to develop any such regulations "with the maximum feasible opportunity for public participation and comments." Please provide an update regarding the Department's development of regulations implementing fiscal responsibilities under the MHSA. What is the timetable for issuing draft regulations? How has DHCS involved or how will DHCS involve the public in developing these regulatory proposals?

- **Public participation:** AB 114 authorizes DHCS to enforce the fiscal reversion requirements of the MHSA via all-county letters or similar instructions, in lieu of adopted regulations, until such regulations are adopted or until July 1, 2019, provided that any such all-county letters or instructions are issued only after the Department has provided the opportunity for public participation and comments. Please provide an overview of Information Notice 17-059 and any other all-county letters or similar instructions the Department has prepared in order to implement, interpret or make specific Welfare and Institutions Code Sections 5892(h), 5892.1, and 5899.1. How has DHCS provided or how will DHCS provide opportunities for public participation and comment in those letters or instructions?

- **Cost Reports:** Pursuant to county contracts with DHCS, each county must submit accurate and complete cost reports for the previous fiscal year (FY) by December 31 following the end of the fiscal year. The Commission understands that counties may, in some cases, rely on completed cost reports in order to guide their completion of MHSA RERs.

  Please update the Commission regarding the status of county submissions of 2015-16 and 2016-17 cost reports and DHCS processing of cost reports for audit

purposes, as well as for summary reporting or republication.

- **Triennial Oversight Reviews:** DHCS conducts triennial oversight reviews of each county Mental Health Plan (MHP) to determine compliance with federal and state regulations as well as with the terms of the MHP contract. Please discuss the role of the triennial oversight reviews with respect to both MHSA and non-MHSA-related aspects of county performance contracts, and provide an update regarding county fulfillment of MHSA-specific performance requirement within the performance contracts.

Thank you again. We appreciate the continued collaboration between DHCS, the MHSOAC, and the public in promoting successful county implementation of the goals and values of the Mental Health Services Act.

Sincerely,

Brian R. Sala, Ph.D.
Deputy Director, Evaluation and Program Operations

Assembly Bill No. 114

CHAPTER 38

An act to amend Sections 1627, 1630, 102247, 103605, 103625, and 127662 of, to add Section 1629.5 to, and to repeal and add Section 127665 of, the Health and Safety Code, and to amend Sections 5892 and 5899 of, and to add Sections 5892.1 and 5899.1 to, the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor July 10, 2017. Filed with Secretary of State July 10, 2017.]

LEGISLATIVE COUNSEL'S DIGEST

AB 114, Committee on Budget. Public health.

Existing law requests the University of California to establish and administer the Umbilical Cord Blood Collection Program, until January 1, 2018, for the purpose of collecting units of umbilical cord blood for public use, as defined, in transplantation and providing nonclinical units for specified research.

This bill would extend the provisions of the program until January 1, 2023. The bill would also require the University of California, by January 1, 2022, if it elects to administer the program, to provide a report to the Assembly and Senate Committees on Health that addresses various topics relating to the program, including, among other things, the number of cord blood units collected and registered under the program, disaggregated by race and ethnicity.

Until January 1, 2018, existing law requires an applicant to pay an $18 fee for a certified copy of a birth certificate, except as specified. Existing law requires $2 of the $18 fee to be paid to the Umbilical Cord Blood Collection Program Fund. Moneys in the fund are available, upon appropriation by the Legislature, for purposes of the Umbilical Cord Blood Collection Program.

This bill would extend until January 1, 2023, the requirement that an applicant pay an $18 fee for a certified copy of a birth certificate and the requirement that $2 of that $18 fee be paid to the Umbilical Cord Blood Collection Program Fund. The bill would make conforming changes to related provisions.

Under existing law, the University of California has established the California Health Benefit Review Program pursuant to a request by the Legislature. Under existing law, specified members of the Legislature are authorized to request analysis by the university of legislation that proposes to mandate a health benefit or service or proposes to repeal a mandated health benefit or service, as defined. Under existing law, the university is

requested to provide the analysis to the appropriate policy and fiscal committees of the Legislature within 60 days after receiving a request for the analysis.

Existing law establishes the Health Care Benefits Fund to support the university in implementing the program. Existing law imposes an annual charge on health care service plans and health insurers, as specified, to be deposited into the fund. Existing law prohibits the total annual assessment pursuant to that provision from exceeding $2,000,000. Under existing law, the fund and the program become inoperative on July 1, 2017, and are repealed as of January 1, 2018.

This bill would extend the operation of the program and the fund for 3 years, and would authorize the continued assessment of the annual charge on health care service plans and health insurers for that purpose for 3 years.

This bill would make these provisions inoperative on July 1, 2020, and would repeal them as of January 1, 2021.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters by Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs by imposing a tax of 1% on annual incomes above $1,000,000. The MHSA establishes the Mental Health Services Oversight and Accountability Commission to oversee various parts of the act, as specified. Under the MHSA, funds are distributed to counties for local assistance, and must be spent for their authorized purpose within 3 years or revert to the state to be deposited into the fund and be available for other counties in future years. The MHSA permits amendment by the Legislature by a ⅔ vote of each house if the amendment is consistent with, and furthers the intent of, the MHSA.

This bill would amend the MHSA by instead requiring any funds subject to reversion as of July 1, 2017, to be reallocated to the county of origin for the purposes for which they were originally allocated. The bill would provide that as a county receives approval from the commission of a plan for innovative programs, the funds identified in the plan would not revert until 3 years after the date of the approval, but that funds allocated to a county with a population of less than 200,000 would not revert until 5 years, or 5 years after the date of the approval, as specified. The bill would also require funds subject to reversion on or after July 1, 2017, to be reallocated to other counties for the purposes for which the unspent funds were initially allocated to the original county. The bill would require the department, on or before July 1, 2018, to prepare a report to the Legislature identifying the funds subject to reversion prior to July 1, 2017, as specified. The bill would require counties with unspent funds subject to reversion that are deemed reverted and reallocated to prepare a plan to expend these funds on or before July 1, 2020. By imposing additional duties on counties, this bill would create a state-mandated local program. The bill would additionally require the department to annually publish a report on its Internet Web site relating to the funds subject to reversion, as specified. The bill would make legislative

findings and declarations stating that the provisions of this bill are consistent with, and further the intent of, the act.

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

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

This bill would appropriate $100,000 from the Mental Health Services Fund to the Mental Health Services Oversight and Accountability Commission to develop a statewide suicide prevention plan.

This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.

Appropriation: yes.

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

SECTION 1. Section 1627 of the Health and Safety Code is amended to read:

1627. (a) (1) On or before July 1, 2011, the University of California is requested to develop a plan to establish and administer the Umbilical Cord Blood Collection Program for the purpose of collecting units of umbilical cord blood for public use in transplantation and providing nonclinical units for research pertaining to biology and new clinical utilization of stem cells derived from the blood and tissue of the placenta and umbilical cord. The program shall conclude no later than January 1, 2023.

(2) For purposes of this article, "public use" means both of the following:

(A) The collection of umbilical cord blood units from genetically diverse donors that will be owned by the University of California. This inventory shall be accessible by the National Registry and by qualified California-based and other United States and international registries and transplant centers to increase the likelihood of providing suitably matched donor cord blood units to patients or research participants who are in need of a transplant.

(B) Cord blood units with a lower number of cells than deemed necessary for clinical transplantation and units that meet clinical requirements, but for other reasons are unsuitable, unlikely to be transplanted, or otherwise unnecessary for clinical use, may be made available for research.

(b) (1) In order to implement the collection goals of this program, the University of California may, commensurate with available funds appropriated to the University of California for this program, contract with one or more selected applicant entities that have demonstrated the competence to collect and ship cord blood units in compliance with federal guidelines and regulations.

Pages 4-15 Omitted

(2) Upon completion of the allocation in paragraph (1), the Controller shall distribute to counties ninety-eight million five hundred eighty-six thousand dollars ($98,586,000) from the Mental Health Services Fund for mental health services for special education pupils based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California.

(3) Upon completion of the allocation in paragraph (2), the Controller shall distribute to counties 50 percent of their 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, not to exceed four hundred eighty-eight million dollars ($488,000,000). This allocation shall commence beginning August 1, 2011.

(4) Upon completion of the allocation in paragraph (3), and as revenues are deposited into the Mental Health Services Fund, the Controller shall distribute five hundred seventy-nine million dollars ($579,000,000) from the Mental Health Services Fund to counties to meet the General Fund obligation for EPSDT for the 2011–12 fiscal year. These revenues shall be distributed to counties on a quarterly basis and based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California. These funds shall not be subject to reconciliation or cost settlement.

(5) The Controller shall distribute to counties the remaining 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, beginning no later than April 30, 2012. These remaining allocations shall be made on a monthly basis.

(6) The total one-time allocation from the Mental Health Services Fund for EPSDT, Medi-Cal Specialty Mental Health Managed Care, and mental health services provided to special education pupils as referenced shall not exceed eight hundred sixty-two million dollars ($862,000,000). Any revenues deposited in the Mental Health Services Fund in the 2011–12 fiscal year that exceed this obligation shall be distributed to counties for remaining fiscal year 2011–12 Mental Health Services Act component allocations, consistent with Sections 5847 and 5891.

(k) Subdivision (j) shall not be subject to repayment.

(*l*) Subdivision (j) shall become inoperative on July 1, 2012.

SEC. 14. Section 5892.1 is added to the Welfare and Institutions Code, to read:

5892.1. (a) All unspent funds subject to reversion pursuant to subdivision (h) of Section 5892 as of July 1, 2017, are deemed to have been reverted to the fund and reallocated to the county of origin for the purposes for which they were originally allocated.

(b) (1) The department shall, on or before July 1, 2018, in consultation with counties and other stakeholders, prepare a report to the Legislature identifying the amounts that were subject to reversion prior to July 1, 2017, including to which purposes the unspent funds were allocated pursuant to Section 5892.

(2) Prior to the preparation of the report referenced in paragraph (1), the department shall provide to counties the amounts it has determined are

subject to reversion, and provide a process for counties to appeal this determination.

(c) By July 1, 2018, each county with unspent funds subject to reversion that are deemed reverted and reallocated pursuant to subdivision (a) shall prepare a plan to expend these funds on or before July 1, 2020.

(d) (1) The requirement for submitting a report imposed under subdivision (b) is inoperative on July 1, 2022, pursuant to Section 10231.5 of the Government Code.

(2) A report to be submitted pursuant to subdivision (b) shall be submitted in compliance with Section 9795 of the Government Code.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this section, Section 5899.1, and subdivision (h) of Section 5892, by means of all-county letters or other similar instructions, until applicable regulations are adopted in accordance with Section 5898, or until July 1, 2019, whichever occurs first. The all-county letters or other similar instructions shall be issued only after the department provides the opportunity for public participation and comments.

SEC. 15. Section 5899 of the Welfare and Institutions Code is amended to read:

5899. (a) The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the County Behavioral Health Directors Association of California, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report. The instructions shall include a requirement that the county certify the accuracy of this report. This report shall be submitted electronically to the department and to the Mental Health Services Oversight and Accountability Commission. The department and the commission shall annually post each county's report on its website in a timely manner.

(b) The department, in consultation with the commission and the County Behavioral Health Directors Association of California, shall revise the instructions described in subdivision (a) by July 1, 2017, and as needed thereafter, to improve the timely and accurate submission of county revenue and expenditure data.

(c) The purpose of the Annual Mental Health Services Act Revenue and Expenditure Report is as follows:

(1) Identify the expenditures of Mental Health Services Act (MHSA) funds that were distributed to each county.

(2) Quantify the amount of additional funds generated for the mental health system as a result of the MHSA.

(3) Identify unexpended funds, and interest earned on MHSA funds.

(4) Determine reversion amounts, if applicable, from prior fiscal year distributions.

(d) This report is intended to provide information that allows for the evaluation of all of the following:

(1) Children's systems of care.
(2) Prevention and early intervention strategies.
(3) Innovative projects.
(4) Workforce education and training.
(5) Adults and older adults systems of care.
(6) Capital facilities and technology needs.

(e) If a county does not submit the annual revenue and expenditure report described in subdivision (a) by the required deadline, the department may withhold MHSA funds until the reports are submitted.

(f) By October 1, 2018, and by October 1 of each subsequent year, the department shall, in consultation with counties, publish on its Internet Web site a report detailing funds subject to reversion by county and by originally allocated purpose. The report also shall include the date on which the funds will revert to the Mental Health Services Fund.

SEC. 16. Section 5899.1 is added to the Welfare and Institutions Code, to read:

5899.1. (a) On or after July 1, 2017, funds subject to reversion pursuant to subdivision (h) of Section 5892 shall be reallocated to other counties for the purposes for which the unspent funds were initially allocated to the original county.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this section, Section 5892.1, and subdivision (h) of Section 5892, by means of all-county letters or other similar instructions, until applicable regulations are adopted in accordance with Section 5898, or until July 1, 2019, whichever occurs first. The all-county letters or other similar instructions shall be issued only after the department provides the opportunity for public participation and comments.

SEC. 17. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 18. The sum of one hundred thousand dollars ($100,000) is hereby appropriated from the Mental Health Services Fund to the Mental Health Services Oversight and Accountability Commission for the purpose of developing a strategic statewide suicide prevention plan. These funds shall be available for encumbrance or expenditure until June 30, 2018.

SEC. 19. The Legislature finds and declares that this act is consistent with, and furthers the intent of, the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.

SEC. 20. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 28, 2017

MHSUDS INFORMATION NOTICE NO.: 17-059

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES

SUBJECT: MENTAL HEALTH SERVICES ACT: IMPLEMENTATION OF WELFARE AND INSTITUTIONS CODE SECTION 5892.1.

The purpose of this Information Notice is to inform counties of the following:

- The process the Department of Health Care Services (DHCS) will use to determine the amount of unspent Mental Health Services Act (MHSA) funds subject to reversion as of July 1, 2017;
- The appeal process available to a county regarding that determination; and
- The requirement that by July 1, 2018, counties have a plan to expend the reverted funds by July 1, 2020.

Background

Assembly Bill (AB) 114 (Chapter 38, Statutes of 2017) became effective July 10, 2017. The bill amended certain Welfare and Institutions Code (WIC) Sections related to the reversion of MHSA funds.

AB 114 implemented provisions concerning funds subject to reversion as of July 1, 2017. Funds subject to reversion as of July 1, 2017, are deemed to have been reverted and reallocated to the county of origin for the purposes for which they were originally allocated (WIC Section 5892.1 (a)). Funds that could be subject to reversion as of July 1, 2017, were distributed to counties from Fiscal Year (FY) 2005-06 through FY 2014-15. By July 1, 2018, DHCS is required to prepare a report to the Legislature identifying the amounts of funds subject to reversion by county. Prior to releasing the report, DHCS is required to provide each county with the amount DHCS determined is

subject to reversion and a process for counties to appeal that determination (WIC Section 5892.1 (b)). Additionally, by July 1, 2018, counties are required to have a plan to spend those funds by July 1, 2020 (WIC Section 5892.1 (c)). Pursuant to WIC Section 5892.1, subdivision (e),[1] DHCS is providing counties with this Information Notice to implement these requirements.

Some of the changes in statute also pertain to funds subject to reversion after July 1, 2017. DHCS will issue a separate Information Notice regarding the requirements to implement those provisions.

This Information Notice supersedes all other reversion policies contained in Information Notices developed by the former Department of Mental Health and DHCS.

Process to determine the amount of funds subject to reversion as of July 1, 2017

Counties must spend funds allocated to Community Services and Supports (CSS), Prevention and Early Intervention (PEI) and Innovation (INN) components, including interest earned on the MHSA funds, within three fiscal years, including the FY when the funding was made available. For example, CSS funds made available in FY 2005-06 are available for expenditure in FY 2005-06, FY 2006-07, and FY 2007-08. Any funds distributed to a county for FYs 2005-06 through FY 2014-15 for CSS, PEI, and INN that were not spent within three years will be deemed to have been reverted and reallocated to the county of origin for the purpose it was originally allocated.

Counties must spend funds allocated to Capital Facilities and Technological Needs (CFTN) and Workforce Education and Training (WET) components, including interest earned, within ten fiscal years, including the fiscal year when the funding was made available. For example, WET funds made available in FY 2006-07 are available for expenditures in FY 2006-07, FY 2007-08, FY 2008-09, FY 2009-10, FY 2010-11, FY 2011-12, FY 2012-13, FY 2013-14, FY 2014-15, and FY 2015-16. Any funds distributed to the county for FYs 2006-07 through FY 2007-08 for CFTN or WET that were not spent within ten years will be deemed to have been reverted and reallocated to the county of origin for the purpose it was originally allocated.

[1] WIC 5892.1 (e) provides, "(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this section, Section 5899.1, and subdivision (h) of Section 5892, by means of all-county letters or other similar instructions, until applicable regulations are adopted in accordance with Section 5898, or until July 1, 2019, whichever occurs first. The all-county letters or other similar instructions shall be issued only after the department provides the opportunity for public participation and comments."

MHSA component revenue includes planning estimates or State Controller's Office (SCO) distributions for a fiscal year plus any interest earned by the Local Mental Health Services (MHS) Fund during that fiscal year.

A. Methodology

For each fiscal year from 2005-06 through 2014-15, DHCS will subtract component expenditures from component revenue, using the first-in-first-out method. The first-in-first-out method applies expenditures to the earliest fiscal year MHS fund distribution with a remaining balance. Once all revenue for a fiscal year has been spent or reverted, DHCS applies expenditures to the following year's revenue. For example, DHCS will apply FY 2012-13 component expenditures to funds received in FY 2012-13 until all FY 2012-13 funds have been spent or reverted before applying expenditures to FY 2013-14.

B. Sources of Data

DHCS will utilize the following sources of data in calculating reversion:

- Expenditures, as reported in the FY 2005-06 through FY 2016-17 MHSA Annual Revenue and Expenditure Reports (ARER). DHCS will use the sum of all expenditures funded with MHSA or interest, regardless of the fiscal year identified in the MHSA fund source;
- Planning Estimates and Component Allocations from FY 2005-06 through FY 2011-12 for CSS, PEI, INN, CFTN and WET components:
  - DMH Letter: 05-02
  - DMH Letter: 06-03, 06-09
  - DMH Letter: 07-06, 07-17, 07-19, 07-21,
  - DMH IN: 08-02, 08-09, 08-10, 08-13, 08-19, 08-20, 08-21, 08-25, 08-27, 08-36, 08-37
  - DMH IN: 09-03, 09-19, 09-20
  - DMH IN: 10-21, 10-27
  - DMH IN: 11-13
- Distributions made by the SCO beginning with FY 2012-13. DHCS will allocate total funding distributed each fiscal year as follows: 76% to the CSS component, 19% to the PEI component, and 5% to the INN component, which is consistent with Title 9, California Code of Regulations, Section 3930. Funds distributed by the SCO will include actual distributions to counties made from July through June of each FY. Distribution amounts are available in the Monthly Mental Health Service Fund reports on the SCO website; and

- Interest revenue, as reported in the FY 2005-06 through FY 2016-17 ARER.

Notice of Unspent Funds Subject to Reversion

DHCS will send each county mental health director, via certified mail, an official notice of unspent funds subject to reversion. The notice will include the amount of the county's unspent funds subject to reversion by FY and component, and a schedule with the revenue and expenditure data DHCS used to perform the calculation. The notice will also include instructions and forms for a county to appeal DHCS' determination.

Consequences for failure to timely submit ARERs

As noted above, to calculate the amount of a county's unspent funds subject to reversion as of July 1, 2017, DHCS needs all of that county's ARERs from FY 2005-06 through FY 2016-17. Counties are required to submit the FY 2016-17 ARER and any outstanding ARERs by December 31, 2017. If a County does not timely submit an ARER, the report DHCS submits to the Legislature, identifying the amount of funds subject to reversion as of July 1, 2017, will indicate where data for the applicable fiscal year is missing. In addition, counties' expenditure plans for unspent funds subject to reversion may only include funds from those fiscal years for which an ARER has been submitted to DHCS (see "Plan to Spend the Funds").

Process for Counties that Submit Late ARERs

Counties that fail to submit an ARER by the due date can subsequently submit it to DHCS, although the report DHCS submits to the Legislature will indicate the fiscal year for which data are missing. DHCS will provide the county with an updated official notice of unspent funds subject to reversion. A county may appeal the determination in the updated official notice of unspent funds subject to reversion (see "Appeal Process"). Once a final amount has been determined, the county must prepare an updated plan to spend its reallocated funds.

Appeal Process

Should a county disagree with the amount of unspent funds subject to reversion, as determined by DHCS and wish to appeal the revenue or expenditure amount used to make the determination, the county must submit an appeal to DHCS via email at MHSA@dhcs.ca.gov. Appeal forms and instructions will be included in the official notice of unspent funds subject to reversion. DHCS will immediately acknowledge receipt of the appeal. Appeals must be received within the timeframe specified below:

- FY 2005-06 – FY 2007-08: **no later than 30 calendar days** from the date the county received the official notice of unspent funds subject to reversion**;**
- FY 2008-09 – FY 2010-11: **no later than 45 calendar days** from the date the county received the official notice of unspent funds subject to reversion;
- FY 2011-12 – FY 2013-14: **no later than 60 calendar days** from the date the county received the official notice of unspent funds subject to reversion; and
- FY 2014-15: **no later than 30 calendar days** from the date the county received the official notice of unspent funds subject to reversion.

Due to the timeframes specified in statute pursuant to AB 114, DHCS will not consider late appeals.

DHCS will review the appeal and notify the county, via email, of its determination within 30 days of receipt of the county's appeal.

Plan to Spend the Funds

Every county must develop a plan to spend its reallocated funds and post it to the county's website. The county must submit a link to the plan to DHCS via email at MHSA@dhcs.ca.gov by July 1, 2018. Each county's Board of Supervisors (BOS) must adopt a final plan within 90 days of the county posting the plan to the county's website. Each county must submit its final plan to DHCS and the MHSOAC within 30 days of adoption by the county's BOS. A county may not spend funds that are deemed reverted and reallocated to the county until the county's BOS has adopted a plan to spend those funds.

In addition, each county must comply with the following:

- The expenditure plan must account for the total amount of reverted and reallocated funds for all impacted FYs, as indicated in the applicable notice of unspent funds subject to reversion or in the final determination on an appeal;
- The county must include the plan in the County's Three-Year Program and Expenditure Plan or Annual Update, or as a separate update to the County's Three-Year Program and Expenditure Plan, and comply with WIC Section 5847(a);
- Reallocated funds must be expended on the component for which they were originally allocated to the county;

- If reallocated funds were originally allocated to the INN component, the funds are subject to the requirements of California Code of Regulations, Article 9, Sections 3900-3935;
- The county must follow the stakeholder process identified in WIC Section 5848 when determining the use of reallocated funds; and
- The county must report expenditures of reallocated funds, by component, on its Annual MHSA Revenue and Expenditure Report.

A county may expend reallocated funds for an already approved program/project or use the reallocated funds to expand an already approved program/project provided the program/project is in the same component as the component for which the funds were originally allocated to the county, which must be in compliance with applicable MHSA statutes and regulations.

Failure to Prepare a Spending Plan for Reallocated Funds

If a county fails to prepare a plan and submit a link to the plan by the required deadlines, the county will be substantially out of compliance with the MHSA. Per WIC Section 5899(e), DHCS will work with the SCO to develop a process to withhold 25% of the county's monthly allocations from the MHS Fund until the county submits a link to the plan. DHCS will work with the SCO to develop a process for the SCO to release withheld funds when the county submits the plan.

Prior to withholding funds, DHCS will email the county a written notice of non-compliance. If a county wishes to appeal the withholding of funds:

- **Within 5 calendar days of receiving the notice of non-compliance,** the county must advise DHCS that it wishes to appeal and whether it requests a hearing to present evidence and argument. If the county requests a hearing DHCS will schedule the hearing, providing the county at least 20 calendar-days' notice. All hearings will be conducted by phone; and
- **Within 20 calendar days of receiving the notice of non-compliance,** the county must either submit a link to a plan to spend the reallocated funds or provide an explanation of the county's failure to timely prepare a plan. If a county submits a link to a plan, DHCS will not withhold funds.

DHCS will decide whether administrative sanctions are necessary within 5 working days of receiving county's explanation for its failure to comply or within 5 working days of a hearing and email county its decision. **All county communications to DHCS during**

the appeal process shall be via email at MHSA@dhcs.ca.gov, except for the hearing.

Any reallocated MHSA funds that are unexpended as of July 1, 2020, will be reverted to the State and reallocated to other counties.

If you have any questions, please contact Donna Ures at donna.ures@dhcs.ca.gov or (916) 324-0401.

Sincerely,

Original signed by

Karen Baylor, Ph.D., LMFT, Deputy Director
Mental Health & Substance Use Disorder Services

Attached below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated January 16, 2018.

This Status Report covers the FY 2012-13 through FY 2016-17 County RERs.

For each reporting period, the Status Report provides a date received by the Department of the County's RER and a date on which Department staff completed their "Final Review."

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. MHSOAC staff process data from County RERs for inclusion in the Fiscal Reporting Tool only after the Department determines that it has completed its Final Review.

The Department also publishes on its website a web page providing access to County RERs. This page includes links to individual County RERs for reporting years FY 2006-07 through FY 2015-16. This page can be accessed at http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx.

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 and a data reporting page at http://mhsoac.ca.gov/documents?field_county_value=All&date_filter%5Bvalue%5D%5Byear%5D=&field_component_tid=46.

Department of Health Care Services

Status of County MHSA RER Submission

County	FY 12-13		FY 13-14		FY 14-15		FY 15-16		FY 16-17		1/16/2017
	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Submitted to MHSOAC
Alameda	1/4/2015	1/6/2015	1/10/2017	1/5/2017	9/14/2017	9/29/2017	9/29/2017	1/3/2018	1/2/2018	1/3/2018	**1**
Alpine	9/12/2016	9/13/2016	9/12/2016	9/13/2016	6/26/2017	6/26/2017	11/22/2017	11/27/2017			
Amador	10/30/2015	9/9/2016	9/8/2016	3/27/2017	3/27/2017	3/27/2017	4/7/2017	4/10/2017			
Berkeley City	7/6/2015	7/17/2015	4/18/2016	5/2/2016	5/2/2016	7/26/2016	4/13/2017	4/13/2017			
Butte	4/10/2015	4/13/2015	3/7/2016	3/7/2016	4/4/2016	6/23/2016	4/17/2017	4/18/2017			
Calaveras	12/1/2015	12/1/2015	12/18/2015	1/19/2016	1/4/2016	1/13/2016	4/18/2017	4/19/2017			
Colusa	3/27/2015	8/4/2015	11/16/2015	11/16/2015	1/8/2016	2/10/2016	5/17/2017	5/17/2017			
Contra Costa	4/13/2015	4/14/2015	3/8/2016	3/14/2016	3/8/2016	3/14/2016	4/17/2017	4/18/2017	12/29/2017		
Del Norte	4/1/2015	4/15/2015	11/2/2015	1/4/2016	5/13/2016	5/16/2016	4/17/2017	5/19/2017			
El Dorado	4/1/2015	4/7/2015	12/15/2015	8/29/2016	2/9/2016	2/11/2016	4/17/2017	4/19/2017	12/29/2017		
Fresno	3/25/2015	4/21/2015	10/30/2015	11/12/2015	12/14/2015	12/18/2015	4/17/2017	4/18/2017	12/29/2017		
Glenn	4/30/2015	5/1/2015	10/30/2015	11/4/2015	3/17/2016	3/24/2016	7/20/2017	7/20/2017			
Humboldt	2/10/2015	4/8/2015	6/3/2016	6/6/2016	9/30/2016	10/3/2016	4/13/2017	4/18/2017	12/21/2017		
Imperial	4/1/2015	4/8/2015	10/28/2015	11/3/2015	12/31/2015	1/4/2016	4/27/2017	4/27/2017	12/28/2017	1/9/2018	
Inyo	5/29/2015	6/29/2015	11/19/2015	12/5/2015	2/24/2016	2/24/2016	5/9/2017	5/9/2017			
Kern	3/27/2015	4/2/2015	11/12/2015	11/12/2015	10/31/2016	10/31/2016	**5/30/2017**				
Kings	4/17/2015	6/5/2015	4/7/2016	7/26/2016	4/7/2016	5/2/2017	5/2/2017	5/24/2017			
Lake											
Lassen	3/30/2015	7/27/2015	11/1/2015	12/16/2015	9/21/2016	9/29/2016	5/18/2017	5/25/2017			
Los Angeles	5/6/2015	7/29/2015	10/17/2016	10/19/2016	4/20/2017	4/21/2017					
Madera	4/1/2015	11/8/2016	11/13/2016	12/7/2016	12/6/2016	12/7/2016	**5/12/2017**				
Marin	3/11/2015	3/12/2015	9/6/2016	9/6/2016	10/21/2016	10/21/2016	5/10/2017	5/11/2017			
Mariposa	6/26/2015	6/29/2015	9/23/2016	9/23/2016	9/23/2016	9/28/2016	5/18/2017	5/19/2017			
Mendocino	5/1/2015	5/1/2015	10/28/2015	10/28/2015	5/31/2017	5/31/2017	8/31/2017	8/31/2017			
Merced	5/9/2015	10/15/2015	10/20/2015	10/21/2015	3/28/2017	3/29/2017	7/21/2017	7/21/2017			
Modoc	3/11/2015	3/12/2015	10/27/2015	11/10/2015	3/24/2016	3/25/2016	4/17/2017	4/19/2017			
Mono	5/1/2015	6/2/2015	3/30/2016	4/4/2016	3/30/2016	4/6/2016	4/25/2017	6/20/2017			
Monterey	4/27/2015	5/6/2015	10/20/2017	10/23/2017							
Napa	6/17/2015	8/25/2017	8/18/2017	8/25/2017	8/18/2017	8/25/2017	11/9/2017	11/13/2017			
Nevada	4/1/2015	4/2/2015	11/3/2015	11/23/2015							
Orange	4/1/2015	4/7/2015	10/29/2015	10/5/2016	12/30/2015	12/30/2015	12/27/2016	4/13/2017	12/29/2017		
Placer	4/1/2015	12/16/2017	10/4/2016	10/5/2016	11/15/2016	11/17/2016	4/14/2017	4/18/2017	12/22/2017		
Plumas	11/3/2015	11/3/2015	4/10/2017	4/10/2017	6/8/2017	6/23/2017					
Riverside	4/1/2015	4/6/2015	10/30/2015	11/2/2015	5/12/2017	5/15/2017	6/9/2017	6/12/2017	12/29/2017		
Sacramento	12/11/2015	12/11/2015	9/21/2016	9/21/2016	5/8/2017	5/8/2017	6/19/2017	6/20/2017	12/29/2017		
San Benito	4/8/2015	4/14/2015	4/18/2016	4/19/2016	10/24/2016	3/8/2016	9/8/2017	9/12/2017			
San Bernardino	4/1/2015	4/14/2015	11/17/2015	11/17/2015	5/19/2016	5/19/2016	5/1/2017	5/1/2017			
San Diego	4/8/2015	4/8/2015	12/2/2015	9/28/2016	12/18/2015	5/26/2017	5/26/2017	5/26/2017			
San Francisco	4/17/2015	4/21/2014	10/30/2015	11/2/2015	3/4/2016	3/4/2016	7/5/2017	9/18/2017			
San Joaquin	4/2/2015	4/7/2015	11/10/2016	11/10/2016	6/8/2017	6/13/2017	10/3/2017	10/4/2017	12/29/2017		
San Luis Obispo	4/3/2015	4/6/2015	11/6/2015	9/29/2016	1/15/2016	1/15/2016	5/12/2017	5/16/2017			
San Mateo	3/15/2016	3/17/2016	9/28/2016	10/3/2016	5/9/2017	5/9/2017	10/10/2017	10/18/2017			
Santa Barbara	4/2/2015	5/8/2015	5/24/2017	5/24/2017	5/24/2017	6/20/2017	5/24/2017	6/20/2017	12/22/2017		
Santa Clara	4/18/2017	4/20/2017	4/18/2017	4/20/2017	5/5/2017	5/11/2017	12/18/2017	1/4/2018			
Santa Cruz	4/2/2015	4/17/2014	3/18/2016	3/23/2016							
Shasta	10/29/2015	11/2/2015	10/29/2015	9/30/2014	10/7/2016	10/7/2016	4/14/2017	4/17/2017			
Sierra	10/9/2015	11/2/2015	10/17/2016	10/18/2016	10/17/2016	10/17/2016	**8/16/2017**				
Siskiyou	10/30/2015	3/24/2017	6/30/2017	7/10/2017	6/30/2017	7/10/2017	6/30/2017	7/10/2017			
Solano	4/1/2015	4/6/2015	10/29/2015	11/3/2015	12/29/2015	12/30/2015	3/23/2017	4/4/2017	12/28/2017		
Sonoma	12/18/2015	11/20/2016	12/6/2016	12/6/2016	4/10/2017	4/10/2017	6/26/2017	6/27/2017			
Stanislaus	3/19/2015	4/3/2015	10/27/2015	10/28/2015	12/22/2015	12/22/2015	4/5/2017	4/5/2017			
Sutter-Yuba	11/19/2015	12/22/2015									
Tehama	5/29/2015	6/19/2015	3/31/2016	4/4/2016	4/29/2016	5/11/2017	5/8/2017	5/16/2017			
Tri-City	4/3/2015	4/16/2015	10/30/2015	2/3/2016	12/30/2015	2/3/2016	4/6/2017	4/6/2017	12/29/2017		
Trinity	10/9/2015	10/14/2015	3/23/2016	3/23/2016	9/19/2016	9/23/2016	7/14/2017	7/14/2017	1/4/2018		
Tulare	3/26/2015	6/9/2015	12/3/2015	12/3/2015	3/17/2016	3/22/2016	4/12/2017	4/12/2017	12/26/2017		
Tuolumne	4/1/2015	4/7/2015	10/26/2015	11/2/2015	12/23/2015	12/28/2015	4/10/2017	5/18/2017			
Ventura	6/19/2015	6/30/2015	10/29/2015	11/3/2015	12/31/2015	1/4/2016	4/14/2017	4/27/2017			
Yolo	4/2/2015	4/7/2015	6/16/2017	6/21/2017	6/21/2017	6/21/2017					
Total	**58**	**58**	**57**	**57**	**54**	**54**	**51**	**48**	**16**	**2**	

1 : New RER Submissions received this week 1/16/2018

AGENDA ITEM 4

Action

January 25, 2018 Commission Meeting

San Joaquin County Innovation Plans (2)

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will consider approval of San Joaquin County's request to fund the following two (2) new Innovative (INN) projects for a total amount of $17,678,205 (see below for project breakdown).

(A) **Assessment and Respite Center - $11,216,688**

(B) **Progressive Housing - $6,461,517**

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

- San Joaquin County is proposing to work with Community Medical Centers, a Federally Qualified Health Center (FQHC), to establish a stand-alone clinic location to screen, assess, and refer individuals for the purposes of providing respite and assessment to those who are unserved and underserved.
- San Joaquin County proposes to adapt the *Housing First* model for housing persons who are homeless and have serious mental illness and possibly co-occurring disorders. To accomplish this, the County proposes a system of housing that will reflect an individual's probable development through stages of recovery.

Presenter(s):

- Frances Hutchins, Assistant Behavioral Health Director; San Joaquin County Behavioral Health Services
- Kayce Rane, Behavioral Health Consultant, Rane Community Development
- Ruth Shim, MD, PhD., Researcher, University of California, Davis Behavioral Health Center of Excellence
- John Foley, Chief Executive Officer, Stockton Self-Help Housing
- Christine Noguera, Chief Executive Officer, Community Medical Centers

Enclosures (5): (1) Biographies for San Joaquin County Innovation Presenters; (2) Assessment and Respite Center Project Brief (3) Assessment and Respite Center Staff Analysis (4) Progressive Housing Project Brief (5) Progressive Housing Staff Analysis.

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

Additional Materials (1): Link to the County's complete Innovation Plans are available on the MHSOAC website at the following URL:

http://mhsoac.ca.gov/document/2018-01/san-joaquin-county-inn-plan-description-assessment-and-respite-center

Proposed Motion: The MHSOAC approves San Joaquin County's Innovation Projects, as follows:

Name: Assessment and Respite Center
Amount: $11,216,688
Project Length: Five (5) Years

Name: Progressive Housing
Amount: $6,461,517
Project Length: Five (5) Years

San Joaquin County MHSA Innovation Plan Presentations: Biography of Presenters

Tony Vartan, LCSW, is the Behavioral Health Director for San Joaquin County. Mr. Vartan has worked in public mental health services in San Joaquin and Stanislaus counties and was the Chief Executive Officer of a private behavioral health hospital for many years. Mr. Vartan has an extensive background in hospital administration, quality and performance improvement, risk management and financial operations.

Frances Hutchins, MPA, is the Assistant Behavioral Health Director for San Joaquin County. Ms. Hutchins has coordinated behavioral health administration and MHSA planning for San Joaquin County and also has an extensive background in substance use disorder prevention and treatment. Ms. Hutchins is a member of the County's Homelessness Task Force, Community Health Improvement Planning Committee, and its Opioid Abuse Prevention Coalition.

Kayce Garcia Rane, MCP, is a MHSA Strategic Planning contractor working with Behavioral Health Services. Ms. Rane has led MHSA community program planning processes for San Joaquin County since 2008 and has facilitated numerous cross-sector partnerships for San Joaquin County to improve linkages to mental health treatment services, transform juvenile probation services, and promote quality and access improvements for early care and education.

Ruth Shim, MD, MPH, is an Associate Professor of Department of Psychiatry and Behavioral Sciences at UC Davis and will lead the UC Davis Behavioral Health Center of Excellence's evaluation of San Joaquin County's proposed INN plans. Dr. Shim is also the Director of Cultural Psychiatry within the Department and has published on the *strategies for reducing disparities in mental health treatment* and the *social determinants of mental health*. She is a member of the American Association of Community Psychiatrists, American Psychiatric Association, American Public Health Association, and the Group for the Advancement of Psychiatry.

Christine Noguera, MS, is the Chief Executive Officer of Community Medical Centers. Ms. Noguera has over 35 years' experience in the operations and leadership of community health centers in California. She is bilingual in English and Spanish and her work has included an emphasis on the establishment of high quality, culturally and linguistically appropriate primary care services, utilizing an integrated team model approach to move health care outcomes forward.

John Foley, is the Executive Director of Sacramento Self-Help Housing. Mr. Foley and the team at SSHH have been providing housing support and assistance to homeless individuals in Sacramento County for over 25 years. Under Mr. Foley's leadership SSHH has expanded its tenant portfolio and added supportive services including homeless outreach, rental assistance and tenant coaching programs, and a serial inebriant program in partnership with local law enforcement and health care providers.

SAN JOAQUIN COUNTY
Greatness grows here.

Behavioral Health Services
A Division of Health Care Services Agency

Tony Vartan, MSW, LCSW, BHS Director

MHSA Innovation Project Synopsis: Assessment and Respite Center (ARC)

The Need: There are significant barriers to accessing mental health treatment services for vulnerable and underserved populations. BHS utilization data reveals significant disparities in accessing timely and appropriate mental health treatment services, including: low penetration rates amongst Latinos; over utilization of emergency and crisis services by African Americans; and low engagement of individuals that have had at least one episode of homelessness within the past year.

The Challenge: A range of systemic challenges, many associated with the initial assessment process, continues to impede access and linkages to services amongst unserved and underserved individuals.

(1) There exists a confusing system whereby some services are only available through the primary healthcare system and others through the separate public mental health system - depending on diagnosis and medical necessity. For most people, where to get help can be confusing;
(2) Some underserved and unserved populations are untrusting of County operated services and are reluctant to engage in public mental health services;
(3) Some individuals may not attend mental health services due to stigma; this bias usually does not apply to primary health care services;
(4) The assessment process is reported to be onerous, stigmatizing, and difficult to navigate – often requiring multiple appointments; and
(5) The clinical assessment process is less responsive to the presenting needs of individuals that are homeless and/or are under the influence than is recommended by consumers, case managers, and clinical staff.

The Solution: Community-based health centers are emerging as new partners in the provision of mild to moderate mental health treatment and substance use recovery services. Community clinics are less stigmatizing, and neighborhood based, making them easier to access for many individuals. Community health centers and mental health departments need to develop: (1) seamless protocols for joint screening and assessment – creating a no wrong door approach to services; and (2) a new approach to the assessment process that is responsive to the most pressing concerns expressed by individuals who are homeless, hungry, and/or under the influence – many of whom are unable or unwilling to complete the assessment process until their basic needs are met.

The Project: Integrate assessment and stabilization services within a community health clinic in order to provide timely, walk-in assessments, respite, brief interventions, medication assisted treatment services, mild-moderate mental health services, and other needed health care services. Re-design the assessment process so that is more flexible, culturally responsive, and appropriate for those with co-occurring disorders and/or basic needs that must be initially met. Offer direct linkages to a range of stabilization services including withdrawal management, housing, respite, and case management in order to stabilize high-risk individuals and successfully engage them into treatment services.

This project will operate within a continuum of services that includes:

(1) Whole Person Care Homeless Outreach Teams;
(2) Proposition 47 funded Withdrawal Management and Case Management Services; and
(3) Progressive Housing and other two other MHSA funded projects to increase the availability of housing for individuals with mental illnesses.

The project also aligns with the recommendations of the County's Homelessness Taskforce and the Stepping-Up Initiative Steering Committee.

The Partner: Community Medical Center is a federally qualified health center operating in San Joaquin County for over forty years. With over a dozen neighborhood clinics, they offer a range of linguistically and culturally competent primary health, behavioral health, and dental care services to over 80,000 low-income individuals annually. Over 80% of employees are racial and ethnic minorities.

The Goal: The Assessment and Respite Center (ARC) will begin operations at the CMC Waterloo Clinic. Within the first year it is anticipated that the ARC will serve 20 individuals a day. It is anticipated that demand will quickly exceed the facility capacity – a second program site will be created after the first year of operations. Simultaneously, CMC intends to adapt protocols for joint BHS-CMC screening and assessment processes throughout all of their CMC San Joaquin Clinics. This will allow CMC to offer coordinated mental health screening, assessment, and linkages to services amongst any of the existing 80,000 patients by the third year of the project.

The Learning Question: BHS seeks to understand whether the new assessment processes will result in more at-risk individuals completing assessments and successfully linking to services and supports. Additionally, the evaluation will determine if the new model of collaborative assessments within a primary care setting will result in greater utilization of mental health services by individuals from unserved/underserved communities. Program objectives are to:

(1) Increase access to services among underserved populations, as measured by:
- increase rate of completed assessments;
- increase successful linkages to services;
- increase in planned service utilization; and
- increase service retention for underserved populations.

(2) Reduce the negative consequences of untreated mental illness, as measured by:
- improve consumer well-being as measured by the *Adult Needs and Strengths Assessment;* and
- reduce the number and/or duration of hospitalizations, jail stays, or homelessness among participants of intensive stabilization services provided through the ARC.

Sustainability: CMC's financial projections anticipate that within five years, the increased number of patients brought into CMC services through the expansion of behavioral health services will create a self-sustaining program over time. However, this project is a test of a method for improving access and linkages to services. Should the model prove successful, BHS may consider ongoing funding to support improved access and linkage to services through other MHSA component funding.

Budget Summary

1. BHS Program Costs:

None Assigned

2. CMC Contracted Program Services:

A. CMC Personnel:

- Program Manager (1)
- PA/ NP (1)
- LCSW (2)
- Licensed Vocational Nurse (6)
- Medical Assistants (6)
- AOD Counselors (2)
- Peer Support Counselors (6)
- Patient Navigator (2)

B. CMC Operations:

- Rent (with improvements)
- Utilities
- Maintenance
- Non-recurring costs (start-up)
- Medical Supplies
- Medications / Pharmacy
- Client Food
- Office Supplies

C. CMC Operating Costs, Projected Revenue, and INN Funding:

	2017/18 (6 mo.)	2018/19	2019/20	2020/21	2021/22	2022/23 (6 mo.)	Total (60 mo.)
ARC Costs	$296,033	$2,234,455	$2,275,777	$2,317,925	$2,360,914	$1,236,584	$10,721,688
ARC Revenue			$187,500	$487,500	$1,132,500	$1,236,584	$3,044,084
ARC INN	$296,033	$2,234,455	$2,088,277	$1,830,425	$1,228,414	$0	$7,677,604

3. Total Project Budget

INN Use of Funds	2017/18 (6 mo.)	2018/19	2019/20	2020/21	2021/22	2022/23 (6 mo.)	Total (60 mo.)
Community Medical Centers to operate ARC Program	$296,033	$2,234,455	$2,088,277	$1,830,425	$1,228,414	$0	$7,677,604
UC Davis BHCE to evaluate ARC Program	$ 49,500	$ 99,000	$ 99,000	$ 99,000	$ 99,000	$ 49,500	$ 495,000
TOTAL PROJECT COSTS	$345,533	$2,333,455	$2,187,277	$1,929,425	$1,327,414	$49,500	$8,172,604

STAFF INNOVATION ANALYSIS— SAN JOAQUIN COUNTY

Name of Innovative (INN) Project: **Assessment and Respite Center**

Total INN Funding Requested for Project: **$11,216,688**

Duration of Innovative Project: **Five (5) Years**

Review History:

Approved by the County Board of Supervisors: November 7, 2017
County submitted Innovation (INN Project): October 23, 2017
MHSOAC consideration of INN Project: January 25, 2018

Project Introduction:

In order to address barriers in access to services and reverse utilization trends, San Joaquin County proposes to develop a Screening, Assessment and Referral Center to address barriers getting services to their target population of the unserved, underserved, and high-risk individuals. The County states that conducting on the ground outreach and providing new services is not sufficient to address the County's need. Subsequently, the County proposes it will pilot a new screening and assessment policy to create more consumer focused and culturally responsive services. The County will partner with Community Medical Centers, a Federally Qualified Health Center (FQHC), to create an environment that will comprise of the following:

1) Allow individuals who are referred, a period of respite/contemplation and engagement with a peer partner; and

2) Offer a physical examination and brief treatment prior to completing the assessment of mental health issues, treatment or recommended service; and

3) Provide stabilization services, including housing and/or withdrawal management (p. 14)

In the balance of this brief we address specific criteria that the MHSOAC looks for when evaluating Innovation Plans, including:

- What is the unmet need that the county is trying to address?
- Does the proposed project address the need?
- Are there clear learning objectives that link to the need?
- Will the proposed evaluation allow the county to make any conclusions regarding their learning objectives?

In addition, the MHSOAC checks to see that the Innovation meets regulatory requirements, that the proposed project aligns with the core MHSA principles, promotes learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four allowable primary purposes.

The Need

The County reports that several demographic groups are not receiving culturally responsive and appropriate mental health services.

Current data metrics indicate that there is an underutilization of mental health services by transitional aged youth, Latinos, African Americans, homeless persons, veterans, LGBTQ persons and recent immigrants, and that these individuals are not receiving sufficient or any services at all. High patterns of crisis or episodic utilization have also been observed.

The County's 2017 Point in Time (PIT) count identified over 1,500 homeless individuals, 20% of whom were chronically homeless, and 30% of whom reported as having a mental health concern. In addition, the County reports the second highest crime rate in the state, with 100 individuals booked into jail on a daily basis. Of those booked, the sheriff reports an estimated 40% have a mental health issue and due to staffing shortages, the majority of the persons booked and then released are not discharged with any sort of mental health assessment or treatment plan.

The County reports that "assessing mental health treatment services amongst low income residents of San Joaquin County who have Medi-Cal benefits is difficult due to California's bifurcated mental health system—with some mental health treatment services offered through primary care physicians and others offered through a public mental health system" (p. 5). Further compounding this, the County reports that "the complete screening and assessment process can require multiple appointments, often with different practitioners, and requires sharing sensitive information in order to demonstrate severity of need" (p. 6).

The Response

To address these issues, the County is proposing to work with Community Medical Centers, an FQHC, to establish a stand-alone clinic location for the purposes of providing respite and assessment to individuals who are unserved, underserved, and inappropriately served. The Assessment and Respite Center will also provide structured linkages to a range of stabilization services and support. The clients often times may not be able to commit due to distrust, intoxication, or a greater need to bypass their chronic health or behavioral health concerns and address other more immediate needs such as getting food or finding a safe place to live (p. 20). Therefore, structured linkages were to assist clients in following through with assessments and referrals to treatment services.

Instead of having to go back and forth between treatment facilities to either complete the assessment process or obtain services, the County proposes five tasks to complete with the development of this Center: 1) Outreach, screening and engagement; 2) Initial triage and evaluation; 3) Respite or Referral to Stabilization services; 4) Assessment of symptoms and needs; and 5) Case planning and linkage to treatment services.

The Respite or Referral to Stabilization task will allow participants at the Respite Center to stay until they are comfortable with completing the assessment processes. Through the assessment of their symptoms and needs, as well as case planning and linkage to treatment services, the Respite Center will provide non-therapeutic services to clients. These services will assist clients with completing a psychological assessment and facilitate successful engagement in an appropriate level of treatment, utilizing six (6) evidence based treatments. More services provided by the Respite Center, in parallel with the assessment/screening protocol, will include housing services, substance use disorder treatment, behavioral health services, primary health care services, case management services, and a peer partner to assist the client with system navigation. Other features pertaining to the center's services are outreach, screening and engagement and initial triage and evaluation.

Research conducted by the County and MHSOAC staff show that:

- No counties specifically contract with Federally Qualifying Health Centers (FQHC) to offer stand-alone centers for the purpose of assessment and guiding unserved individuals, particularly homeless and those at risk of incarceration, to appropriate levels of care
- No centers target transient, homeless and frequently incarcerated individuals who are medically and behaviorally under or unserved because of their psychiatric diagnoses
- There are no FQHC's that provide pre-treatment services, stabilization services, or conduct psycho-social assessments
- No centers offer medically monitored withdrawal management, rapid housing and primary care services in an accessible location

Other research indicates that trust and cultural awareness are critical to successful participation and completion of outcomes. Because of its voluntary and open door policy, the Center uses the unique position of peer advocate/navigators and centralization of services to address the County's learning goals as well as address the County's traditionally unserved and underserved populations.

The Community Planning Program (CPP) Process

Based on the recommendation of the San Joaquin County Planning Stakeholder Steering Committee, the Community Program Planning (CPP) Process continued in 2017 and the County focused on target populations of unserved and underserved adults. Clients with serious mental illness and their family members comprised 53% of the community meeting participants and 51% of the survey respondents. (p. 38). Clients with serious mental illness and their family members comprised 53% of the community meeting participants and 51% of the survey respondents (p. 38). The County conducted community meetings, focus group discussions, and surveys; all efforts indicated that the largest portion of feedback was received from Client/Stakeholder surveys. The County distributed 665 surveys and in return received 600.

Throughout the year, community meetings, focused group discussions, public hearings

and surveys were held which provided opportunities to solicit suggestions, review, and provide feedback on ideas, etc. Three (3) consumer service programs hosted client discussion groups and the behavioral health planning team met with additional stakeholders (i.e. law enforcement, primary health providers, housing providers, and substance use treatment providers). All groups collaborated to address the Board of Supervisors' directive to expand and enhance joint efforts across governmental and community based partners. No substantive public comments were made at the public hearing or during the review process; except to encourage the County to establish the program as quickly as possible.

This Innovation Project was shared with stakeholders beginning December 18, 2017. No letters of opposition or support were received in response.

Learning Objectives and Evaluation

San Joaquin County intends on piloting a collaborative approach to provide mental health assessments as well as linkages to behavioral health services. This approach will introduce a stand-alone clinic for assessment and respite services for unserved and underserved populations in the county. The County seeks to determine if the Assessment and Respite Center will increase access to mental health services as well as reduce symptoms of untreated mental and emotional illnesses.

The target population of the program will be homeless individuals; non-serious, non-violent offenders; and other unserved and underserved populations with behavioral concerns. **The County may wish to clarify what additional unserved and underserved populations they will serve, as well as the number of clients they intend on serving annually.** Consistent with MHSA Standards, the program will properly assess high-risk individuals in order to link them to appropriate services.

To evaluate the Assessment Respite Center program, San Joaquin County has identified both systematic and individual outcomes. Systematic outcomes will examine impacts the collaborative effort has on the mental health services delivery system, specifically: utilization of the assessment process, increases in mental health services, as well as whether or not there is an increase in mental health participation from the unserved/underserved communities. At the individual level, the County seeks to examine short term outcomes, such as increased psycho-social functioning, increased physical health, decreased substance use, and increased optimism for the future. Long term outcomes may include increased housing stability, and decreased incarceration and/or recidivism rates. Methods to collect data to measure these outcomes will come from a number of sources, including: pre and post psycho-social assessments, treatment utilization and cost data, program participation data, and client focus groups. An appropriate design to evaluate the Assessment and Respite Center program will be developed in collaboration with the UC Davis Behavioral Health Center.

The Budget

The proposed budget for this Innovation Project is $11,216,688 over five (5) years. The majority of the budget is going towards the costs of personnel which will be paid to the Contracted Service Provider and Community Medical Centers, who will be

responsible for the operations and management of the Assessment and Respite Center. Personnel costs total $8,433,388, or 75% of the total budget. Staff required for this project will include a Program Manager, Physician's Assistant or Nurse Practitioner, two (2) Licensed Clinical Social Workers, six (6) Licensed Vocational Nurses, six (6) Medical Assistants, two (2) AOD counselors, six (6) Peer Support Counselors and two (2) Patient Navigators. The County has supplied base salary information for all positions and the budget includes a 2% annual cost of living adjustment.

The County lists total direct costs as $1,023,291, 9% of the total budget, and indirect costs as $1,265,009, which is 11.3% of the total budget. The evaluation component will be contracted out to UC Davis Behavioral Health Center for Excellence and the County has allotted $495,000 (4.4%) of the total budget. Project deliverables and the scope of work will then be determined upon project approval.

The County indicates the Assessment and Respite Center (ARC) is anticipated to eventually generate revenue from patients who may be reimbursed for services received. Over the five (5) year duration of the project, the County estimates total operating cost of the ARC will be $10,721,688; however, a projected amount of $3,044,084 will be generated to offset that total amount for a net amount of $7,677,604 for operating costs to run the ARC.

The County may wish to identify a contingency plan for operating costs if the anticipated funding through reimbursements is not generated and if the proposed Center is going to be continued.

The County wishes to utilize primarily MHSA Innovation Funds and hopes to additionally offset the operating costs of the ARC by generated revenue.

Regarding sustainability, the County states a determination will be made with input from the community whether and how this project will continue, subject to approval from the Board of Supervisors. Continuation of this project will be based on success rates and program participants having increased access and usage of available mental health services. If the program is unable to be continued in its entirety, some of the program costs may possibly be absorbed by Prevention & Early Intervention funding.

Additional Regulatory Requirements

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

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http://www.peerrespite.net/california/

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Tony Vartan, MSW, LCSW, BHS Director

MHSA Innovation Project Synopsis: Progressive Housing

The Need: Individuals with a serious mental illness require a safe and stable place to live in order to engage in treatment services and meet recovery goals. However affordable housing options are scarce, putting many individuals with mental illnesses at risk of homelessness, jeopardizing recovery goals.

The Challenge: Housing rents have skyrocketed in San Joaquin County, (by 92% over the last five years), squeezing many individuals into an increasingly competitive rental market. Further, 257 beds in fifteen board and care homes have been lost due to facility closure over the past two years – nearly a quarter of the previously available housing opportunities. The challenge of finding solutions for homeless individuals with mental illnesses is also growing in San Joaquin County. The 2017 Point-in-Time Homelessness Count found over 1,550 homeless individuals, with 31% reporting a mental health concern.

For low-income individuals with co-occurring mental illnesses and substance use disorders, and with recent experiences of homelessness, finding a safe, affordable and stable place to live can be next to impossible. Many of these individuals end up homeless, living in motels, or living in substandard housing. This challenge is faced by counties throughout the State who struggle to secure housing for their mental health consumers.

The Solution: Develop a model of cost-effective recovery-oriented housing that moves individuals out of homelessness while simultaneously addressing substance use recovery, mental health treatment needs, and preparing individuals to live more independently.

The Project: Progressive Housing is a modified approach to *Housing First*, a promising practice of placing mentally ill consumers in housing as a precursor to treatment services. The *Housing First* model shows mixed results with reductions in arrests and emergency hospitalizations but no significant changes in recovery outcomes.

Progressive Housing places individuals in shared housing, with each home representing a different stage on the recovery continuum, including contemplation; active treatment; and sober living houses. This will help create a no fail approach by which individuals can move up and down the housing continuum based on their current stage within the recovery process. The shared housing approach also reduces per-person housing costs, reduces isolation, and introduces a peer support component.

Shared recovery oriented housing will further promote wellness, by reducing isolation and creating a supportive environment. Consumer choice programming will fund group recreation, learning, and wellbeing activities for residents to improve socialization and behavioral skills. Case management and treatment services will be leveraged through other MHSA component funding.

Progressive Housing will leverage additional program services in order to create a comprehensive program. Mental health services will be provided for all consumers with serious mental illnesses through existing programs. Individuals identified with mild/moderate mental health concerns may be treated through a partnership with Community Medical Centers. Primary health care services, case management, and other wraparound services will also be leveraged through existing programs.

Clients will be asked to contribute a nominal portion of their personal income from Social Security or General Assistance to their own cost of living for food and sundries; this helps build personal responsibility and prepare consumers for more independent living arrangements. All houses will keep basic pantry supplies and necessities stocked to assure no one is hungry. Contributions to the general food budget will vary based on the recovery stage of the clients in the house.

The Partner: Sacramento Self Help Housing has over 30 years-experience in creating housing opportunities for homeless individuals.

The Goal: Progressive Housing hopes to open six houses annually for the first three years, serving approximately 90 enrolled clients by project termination. Program goals include increased access to and participation in treatment services, increased housing stability, and decreased the negative consequences of untreated mental illnesses.

The Learning Question: BHS will test whether this adaptation results in increased retention in services, improves client recovery outcomes; is more cost effective than other models of developing new affordable housing (such as purchase, lease or construction); and whether the model can be replicated and rapidly deployed such that it can be expanded to other jurisdictions depending on need and market conditions. Program objectives include:

(1) Increase access to services among homeless individuals with serious mental illnesses, as measured by:
    - Increase retention into mental health treatment services
    - Increase utilization of planned services
(2) Improve recovery outcomes for program participants as measured by:
    - Increase matriculation to permanent housing
    - Decrease substance use
    - Increase community integration (participation in socialization and wellness activities)

Sustainability: Over the long term BHS seeks to determine if the Progressive Housing model will result in improved outcomes for consumers, including better engagement with treatment services, for a target population of consumers with co-occurring disorders, homelessness or prior incarcerations which limit access to other affordable housing solutions.

The evaluation will seek to determine which components of the adapted program model are most linked to the outcomes realized. For example, will the emphasis on peer partners, consumer choice programming, or other program modifications result in better outcomes than *Housing First* as usual. Based on evaluation findings, BHS will determine which program components need to be sustained over the long term. Primary project components (e.g. rent for housing and mental health treatment services) will continue for all individuals that remain engaged in the program.

Budget Summary

1. BHS Program Costs:

A. Personnel

- Project Director (.15 FTE)
- Housing Liaison (.25 FTE)
- Peer Partners (2 PT @ 1.5 FTE)

B. BHS Operating Costs

- Motor Pool (2 cars @ $10,700 per car per year)
- Participation Incentives $50 per house per month
- Activity Supplies & Equipment $2,000 annual
- Clothing, linen, personal items $1,800 per house
- Staff Training & Education $1,000 a year
- Client Trainings $500 per house per year

2. SSHH Contracted Program Services:

A. SSHH Personnel:

- Project Manager
- House Case Plan Manager
- Housing Locator Specialist (.5 FTE)
- Resident House Managers
- Housing Operations
- Property Management

B. SSHH Operations:

- Rent
- Security deposits
- Utilities
- Client Food
- Household maintenance supplies
- Telephone
- Staff mileage
- Client Transportation
- Maintenance Costs
- Furnishings

3. Total Project Budget

	2017/18 (6 mo.)	2018/19	2019/20	2020/21	2021/22	Total (60 mo.)
BHS	$85,602	$183,795	$192,692	$193,944	$188,521	$844,554
SSHH	$226,853	$732,553	1,193,000	$1,548,711	$1,470,346	$5,171,463
Evaluation	$49,500	$99,000	$ 99,000	$ 99,000	$ 99,000	$445,500
Total	$361,955	$1,015,348	$1,484,692	$1,841,655	$1,757,867	$6,461,517

STAFF INNOVATION SUMMARY - SAN JOAQUIN COUNTY

Name of Innovative (INN) Project:	**Progressive Housing**
Total INN Funding Requested for Project:	**$6,461,517**
Duration of Innovative Project:	**Five (5) Years**

Review History:

Approved by the County Board of Supervisors:	November 7, 2017
County Submitted Innovation (INN) Project:	October 23, 2017
MHSOAC Consideration of INN Project:	January 25, 2018

Project Introduction:

The County proposes to adapt the *Housing First* model for individuals who are homeless and have serious mental illness and possibly co-occurring disorders. To accomplish this, the County proposes a system of housing that will reflect an individual's probable development through stages of recovery. The County will provide four (4) distinct levels of services at each of the houses; including pre/post assessment, engagement and linkage to routine mental health services, stabilization and recovery support, and finally, independent permanent housing. These services are in sync with recovery from the start of pre-contemplation to the end of "graduation." The County proposes to partner with Stockton Self Help Housing, an affiliate of Sacramento Self Help Housing, to provide them with a record of successful housing programs.

In the balance of this brief we address specific criteria that the MHSOAC looks for when evaluating Innovation Plans, including:

- What is the unmet need that the county is trying to address?
- Does the proposed project address the need?
- Are there clear learning objectives that link to the need?
- Will the proposed evaluation allow the county to make any conclusions regarding their learning objectives?

In addition, the MHSOAC checks to see that the Innovation meets regulatory requirements, that the proposed project aligns with the core MHSA principles, promotes learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one (1) of the four (4) allowable primary purposes.

The Need

The County states that there is a severe housing shortage due in part to rental market rate increases (50% since 2007), board and care facilities closing (16 have closed since 2015), a catastrophic fire destroying 47 resident houses located in the largest supportive housing facility for individuals with serious mental illness, and increased opposition against the development of affordable housing units for mentally ill persons. As a result of this housing shortage, there have been extended stays in hospitals, emergence of residential treatment programs, and creation of acute facilities. The county reports that in 2017, there were about 1500 homeless persons and approximately 30% (450) of them reported having some kind of mental health issue/concern. Further, during the County's community program planning process, they reported that a number of the participants had a "fear and frustration with finding a safe and affordable place to live because of rental conditions."

In addition to all of the above, the San Joaquin County Homeless Taskforce created recommendations which were adopted by the County Board of Supervisors, which include:

- The creation of uniform discharge policies to prevent individuals being discharged into homelessness;
- Adoption of a *Housing First* strategy to reduce upfront barriers to housing; and
- Fostering new collaborative strategies to prevent homelessness before it occurs. (page 9)

The Response

In their research, the County learned about the success of the *Housing First* model as well as two additional models (Linear and Supportive Housing); however, they note that none are able to resolve the homeless problem. In fact, some researchers in the larger communities confirm this and have written that there are "limited kinds of homeless people who are best served by the *Housing First* model." The criticism doesn't dismiss that *Housing First* works; however, it reveals that *Housing First* doesn't work in all cases, and must be adapted to local conditions, and must be inclusive of education, employment, and human services to the re-housed homeless. What the County proposes and what the research supports is a continuum of housing--a modification to the original *Housing First* model.

The County proposes a project that will provide four (4) different levels of supportive housing and mental health services that align with the recovery phases. Level 1 housing will be a pre-post assessment and contemplative process. The participant, designated as a guest, will decide if they are ready to participate in treatment interventions. Then at Level 2, participants will be in a shared housing environment, staffed by a house manager and will engage in, and be provided with, linkages to routine mental health services such as withdrawal management, substance use disorder recovery services, and primary care. Next at Level 3, participants are deemed to have "stabilized" and are successfully

participating in treatment and services. The participant will be in a shared housing environment and participate with a portion of their income contributing to monthly expenses for the household. At this level, participants can also start developing a plan to obtain permanent housing. Finally, Level 4 is available for participants who are stable, in routine treatment, are ready to obtain independent housing, pay rent from SSI or other income, and may maintain this residence for a year or more. The County believes that a better demonstration of the recovery process occurs when participants move between various housing levels versus having them forcefully leave a housing program and re-apply to a different program if they cannot meet a particular housing criterion. With relatively low barriers, a participant may move from Level/house to Level/house to accommodate where they are within their recovery process.

To accomplish this continuum of housing, the County indicates they are partnering with and obtaining master leases through Stockton Self Help Housing and several other service, referral, and collaborative partners.

The county may wish to address/clarify how it, or its housing partner, will address the potential impact of NIMBYism and how they will take advantage of protections provided by Senate Bill 167, enrolled September 2017, as it may relate to preventing discrimination for housing developments.

https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB167

The Community Program Planning (CPP) Process

Based on the recommendation of the San Joaquin County Planning Stakeholder Steering Committee, the Community Program Planning (CPP) Process continued in 2017 and the County focused on target populations of unserved and underserved adults. Clients with serious mental illness and their family members comprised 53% of the community meeting participants and 51% of the survey respondents (p. 38). The County conducted community meetings, focus group discussions, and surveys; all efforts indicated that the largest portion of feedback was received from Client/Stakeholder surveys. The County distributed 665 surveys and received 600 in response. Additionally, in January 2017, housing experts convened meetings and key stakeholders contacted homeless service providers to assess housing needs and vetted out the proposed service provider partnership.

Based on the survey responses, other outreach efforts, and the decision made by the Board of Supervisors to have the county work on resolving the homeless problem in San Joaquin, the County as a result spent considerable time collecting data and doing research regarding homelessness. Finally, because the Steering Committee had established that the target population of any Innovative project should be un- and underserved populations this housing plan was developed and submitted for 30 day review. (Documents related to the CPP process are included as part of the Innovation proposal. These items include the survey, letters from respondents, and PowerPoint presentations from meetings).

The substantive comments from the review period/process highlighted that the project lacked an explanation of where the houses will be located (Stockton or Sacramento) as well as a number of how many persons will inhabit every house.

This Innovation Project was shared with stakeholders beginning December 18, 2017. No letters of opposition or support were received in response.

Learning Objectives and Evaluation

San Joaquin County intends on adapting the *Housing First* model for consumers with co-occurring mental health disorders. The County will build on practices from Linear Residential Treatment models that will allow for more consumer choice in treatment. The County seeks to determine if the adaptation of the *Housing First* Program model increases access to mental health services as well as improve recovery outcomes for consumers compared to the current program model. The *Housing First Model* modifies other models by adapting a treatment first approach to housing as well as incorporating lessons learned from a prior innovation project relative to consumer driven services. **The County may wish to identify lessons learned from the prior innovation project identified and how it has informed the current project.**

The target population of the program will be homeless individuals or those at-risk of homelessness that have co-occurring serious mental illness and substance use disorders. The County estimates that 30 individuals will be enrolled on an annual basis for a total target population of 90 enrolled clients by the time the project ends (6 houses x 5 clients/house= 30 total clients for **each** of the first three years of the project for a total of approximately 90 clients served). Consistent with MHSA Standards, the program will create housing for clients to stabilize their living situation while also providing supportive services on-site.

To evaluate the Progressive Housing project, San Joaquin County has identified three (3) major outcomes: better treatment outcome gains in comparison to prior studies on *Housing First*; cost effectiveness of the *Housing First* model in comparison to other approaches; and timeliness to implement the Housing First model compared to other approaches. **The County may wish to identify how their primary purpose—increase in access to mental health services—will be measured.** Methods to collect data to measure these outcomes will come from a number of sources, including: pre and post psycho-social assessments, treatment utilization and cost data, program participation data, client focus groups, among others. An appropriate design to evaluate the Progressive Housing project will be developed in collaboration with the UC Davis Behavioral Health Center.

The Budget

The proposed budget for this Innovation Project is $6,461,517 over five (5) years. A total of $470,086 (7.3%) of the budget is allocated for personnel expenses to hire a Project Director, Housing Liaison, and two (2) peer partners. The County lists total operating costs at $374,468 (5.8%) of the total budget which is comprised of direct

costs in the amount of $206,200 (3.2%) and indirect costs in the amount of $168,268 (2.6%). The evaluation component will be contracted out to UC Davis Behavioral Health Center for Excellence and the County has allotted $445,500 (6.9%) of the total budget. Project deliverables and the scope of work will then be determined.

A significant portion of the budget is going towards the cost of personnel and direct/indirect costs which will be paid to the Contracted Service Provider, Stockton Self Help Housing, who will be responsible for the operations and management of the housing component of the project. Personnel costs, including salary and benefits, are $1,891,261, or 29% of the total budget. Staff that will be hired will include a Project Manager, House Case Plan Managers (1 FTE per 9 houses), Housing Locator Specialist, Resident House Managers (1 per house), House Operations Specialist as well as a Property Manager. The County estimates it will cost approximately $3,565 per month to operate one household which is comprised of the following: rent, utilities, client food, household supplies, telephone, staff mileage, client transportation, and maintenance costs.

The County wishes to utilize MHSA Innovation Funds and will not seek to use any other type of funding, although participants residing in houses may eventually leverage rental fees with their income.

Regarding sustainability, the County states that if the program cannot be continued, the core services providing housing and treatment will be continued at some level, while other parts of this project will have to be suspended. Continuation of this project will be based on success rates and program participants having increased access and usage of available mental health services. If the program in its entirety is unable to be continued, some of the program costs can be funded through existing Community Service & Supports funding as well as working with the Housing Authority of San Joaquin County to provide housing vouchers to discharged participants, who may be given priority status.

The County may wish to discuss how the decision to suspend certain services will affect the residents and what safeguards are in place to ensure continuity of the suspended services. Further, the county may wish to discuss what parts of the housing project will be suspended.

The County may wish to discuss the proposed monthly cost for client's food which is listed at $350 for the entire household, or $70 per person/month (5 people per household) and whether there are some additional funds being utilized to supplement this budget item.

Additional Regulatory Requirements

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

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AGENDA ITEM 5

Information

January 25, 2018 Commission Meeting

Implementation of Assembly Bill 1315

Summary: The Commission will be provided with an overview of the Early Psychosis Intervention Plus (EPI-Plus) Program that was created by Assembly Bill 1315 (Mullin), Chapter 414, Statutes of 2017. This law provides an opportunity for public/private collaboration to support early psychosis intervention programs. The Commission is required to create an advisory committee for the EPI-Plus Program and the Chair of the Commission or a designee will serve as the Chair for the committee. The Commission will create a nomination and application process and the Chair of the Commission will appoint members to the committee.

Background: AB 1315 established the EPI- Plus Program, which provides opportunities for the Commission to receive public/private donations and creates an EPI-Plus Fund within the State Treasury to allow the Commission to deposit donations into an account so that the available funding can be disbursed to counties through a competitive grant process. AB 1315 also requires counties that are interested in applying for the grants to contribute funding for their program through other county funding sources. The Commission is authorized to implement the EPI-Plus Program without taking regulatory action until January 1, 2019, at which time the Commission must adopted regulations.

Advisory Committee: The advisory committee will provide advice and guidance to the Commission on:

- Evidence based approaches for the detection and intervention of early psychosis and mood disorders,
- Clinical research studies,
- The creation of a competitive selection process to provide grants to county and city behavioral health departments, and
- Make recommendations to the Commission regarding the program regulations and standardized outcome measures to be collected.

Members of the advisory committee are appointed by the Commission Chair based on a nomination and application process. Members of the advisory committee include:

- The Chair of the Commission, or his or her designee, shall serve as the chair of the committee.
- The president of the County Behavioral Health Directors Association of California, or his or her designee.

- The director of a county behavioral health department that administers an early psychosis and mood disorder detection and intervention-type program in his or her county.
- A representative from a nonprofit community mental health organization that focuses on service delivery to transition-aged youth and young adults.
- A psychiatrist or psychologist.
- A representative from the Behavioral Health Center of Excellence at the University of California, Davis, or a representative from a similar entity with expertise from within the University of California system.
- A representative from a health plan participating in the Medi-Cal managed care program and the employer-based health care market.
- A representative from the medical technologies industry who is knowledgeable in advances in technology related to the use of innovative social media and mental health information feedback access.
- A representative knowledgeable in evidence-based practices as they pertain to the operations of an early psychosis and mood disorder detection and intervention-type program, including knowledge of other states' experiences.
- A representative who is a parent or guardian caring for a young child with a mental illness.
- An at-large representative identified by the Chair.
- A representative who is a person with lived experience of a mental illness.
- A primary care provider from a licensed primary care clinic that provides integrated primary and behavioral health care.

Presenters: Norma Pate, Deputy Director; Tom Orrock, Chief of Program Operations and Grants

Enclosure: (1) Assembly Bill 1315 (Mullin), Chapter 414, Statutes of 2017

Handouts: A PowerPoint will be provided at the meeting

Assembly Bill No. 1315

CHAPTER 414

An act to add Part 3.4 (commencing with Section 5835) to Division 5 of the Welfare and Institutions Code, relating to mental health.

[Approved by Governor October 2, 2017. Filed with Secretary of State October 2, 2017.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1315, Mullin. Mental health: early psychosis and mood disorder detection and intervention.

Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Oversight and Accountability Commission to oversee various mental health programs funded by the act. Proposition 63 requires the State Department of Health Care Services, in coordination with counties, to establish a program designed to prevent mental illnesses from becoming severe and disabling.

This bill would establish an advisory committee to the commission for purposes of creating an early psychosis and mood disorder detection and intervention competitive selection process to, among other things, expand the provision of high-quality, evidence-based early psychosis and mood disorder detection and intervention services in this state by providing funding to the counties for this purpose. The bill would require a county that receives an award of funds to contribute local funds, as specified.

This bill would prescribe the membership of the advisory committee, including the chair of the commission, or his or her designee. The committee would, among other duties, provide advice and guidance on approaches to early psychosis and mood disorder detection and intervention programs.

This bill also would establish the Early Psychosis and Mood Disorder Detection and Intervention Fund within the State Treasury and would provide that moneys in the fund shall be available, upon appropriation by the Legislature, to the commission for the purposes of the bill. The fund would consist of private donations and federal, state, and private grants. The bill would authorize the commission to elect not to make awards if available funds are insufficient for that purpose. The bill would authorize the advisory committee to coordinate and recommend an allocation of funding to the commission for clinical research studies, as specified. The bill would require the results of those studies to be made available annually to the public. The bill would also state that funds shall not be appropriated from the General Fund for the purposes of the bill and that implementation of the grant program shall be contingent upon the deposit into the fund of at least

$500,000 in nonstate funds for the purpose of funding grants and administrative costs for the commission.

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

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

(a) Fifty percent of all mental illness begins by the age of 14 and 75 percent by the age of 24, yet young people are often afraid to reach out for help.

(b) Psychotic symptoms, such as hallucinations, delusions, unusual or disorganized behaviors or speech, and negative actions, such as social withdrawal, usually emerge during late adolescence or early adulthood and derail important developmental milestones, such as developing relationships, completing school, or entering the workforce.

(c) Approximately 100,000 adolescents and young adults in the United States experience first episode psychosis each year.

(d) Untreated psychosis increases a person's risk for suicide, involuntary emergency care, and poor clinical outcomes, and may initiate a trajectory of accumulating disability into later adulthood.

(e) The average delay in receiving appropriate diagnosis and treatment for psychotic disorders is 18.5 months following the onset of psychotic symptoms.

(f) In the United States, people diagnosed with psychotic and mood disorders, such as bipolar disorder, major depression, and schizophrenia, die an average of 11 years earlier than the general population.

(g) Changing the paradigm from reactive to proactive early detection and treatment has demonstrated efficacy and cost benefit as recognized by the National Institute of Mental Health, the federal Centers for Medicare and Medicaid Services, and the federal Substance Abuse and Mental Health Services Administration, along with documented outcomes from other states, such as New York.

(h) According to numerous documented reports, including analyses and research conducted by the federal Substance Abuse and Mental Health Services Administration, and the National Institute of Mental Health, evidence-based strategies have emerged to identify, diagnose, and treat the needs of individuals with early serious mental illness, including psychotic symptoms and disorders.

(i) Clinical research conducted worldwide, and within California and the United States, supports a variety of evidence-based interventions for ameliorating psychotic symptoms and promoting functional recovery-oriented treatment, including cognitive and behavioral psychotherapy, low doses of atypical antipsychotic medications, family education and support, educational and vocational rehabilitation, and coordinated care approaches to case management.

(j) Empowering patients and families with innovative social media and mental health information feedback access that harnesses advances in

technology can provide a valued and unique opportunity to assist individuals with mental health needs and to optimize care.

(k) Early psychosis detection and intervention happens within the community and at schools, primary care providers, churches, and other social institutions that have established relationships with adolescents and young adults.

(*l*) When it comes to mental health care, California must move from stage four crisis care to stage one early detection, intervention, and prevention, just as we approach treatment for other serious illnesses.

(m) Creating public/private partnerships dedicated to expansion of evidence-based prevention and early intervention services would generate additional revenue that would enhance the ability for counties throughout California to create and fund those programs.

SEC. 2. Part 3.4 (commencing with Section 5835) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 3.4. EARLY PSYCHOSIS INTERVENTION PLUS (EPI PLUS) PROGRAM

5835. (a) This part shall be known, and may be cited, as the Early Psychosis Intervention Plus (EPI Plus) Program to encompass early psychosis and mood disorder detection and intervention.

(b) As used in this part, the following definitions shall apply:

(1) "Commission" means the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845.

(2) "Early psychosis and mood disorder detection and intervention" refers to a program that utilizes evidence-based approaches and services to identify and support clinical and functional recovery of individuals by reducing the severity of first, or early, episode psychotic symptoms, other early markers of serious mental illness, such as mood disorders, keeping individuals in school or at work, and putting them on a path to better health and wellness. This may include, but is not limited to, all of the following:

(A) Focused outreach to at-risk and in-need populations as applicable.

(B) Recovery-oriented psychotherapy, including cognitive behavioral therapy focusing on cooccurring disorders.

(C) Family psychoeducation and support.

(D) Supported education and employment.

(E) Pharmacotherapy and primary care coordination.

(F) Use of innovative technology for mental health information feedback access that can provide a valued and unique opportunity to assist individuals with mental health needs and to optimize care.

(G) Case management.

(3) "County" includes a city receiving funds pursuant to Section 5701.5.

5835.1. (a) The Early Psychosis and Mood Disorder Detection and Intervention Fund is hereby created within the State Treasury. The moneys in the fund shall be available, upon appropriation by the Legislature, to the

commission for the purposes of this part. The commission may use no more than five hundred thousand dollars ($500,000) of the amount deposited annually into the fund for administrative expenses in implementing this part, including providing technical assistance.

(b) There may be paid into the fund all of the following:

(1) Any private donation or grant.

(2) Any other federal or state grant.

(3) Any interest that accrues on amounts in the fund and any moneys previously allocated from the fund that are subsequently returned to the fund.

(c) Moneys shall be allocated from the fund by the commission for the purposes of this part.

(d) Distributions from the fund shall be supplemental to any other amounts otherwise provided to county behavioral health departments for any purpose and shall only be used to fund early psychosis and mood disorder detection and intervention programs.

(e) The commission may elect not to make awards if available funds are insufficient.

(f) Funds shall not be appropriated from the General Fund for the purposes of this part.

5835.2. (a) There is hereby established an advisory committee to the commission. The Mental Health Services Oversight and Accountability Commission shall accept nominations and applications to the committee, and the chair of the Mental Health Services Oversight and Accountability Commission shall appoint members to the committee, unless otherwise specified. Membership on the committee shall be as follows:

(1) The chair of the Mental Health Services Oversight and Accountability Commission, or his or her designee, who shall serve as the chair of the committee.

(2) The president of the County Behavioral Health Directors Association of California, or his or her designee.

(3) The director of a county behavioral health department that administers an early psychosis and mood disorder detection and intervention-type program in his or her county.

(4) A representative from a nonprofit community mental health organization that focuses on service delivery to transition-aged youth and young adults.

(5) A psychiatrist or psychologist.

(6) A representative from the Behavioral Health Center of Excellence at the University of California, Davis, or a representative from a similar entity with expertise from within the University of California system.

(7) A representative from a health plan participating in the Medi-Cal managed care program and the employer-based health care market.

(8) A representative from the medical technologies industry who is knowledgeable in advances in technology related to the use of innovative social media and mental health information feedback access.

(9) A representative knowledgeable in evidence-based practices as they pertain to the operations of an early psychosis and mood disorder detection and intervention-type program, including knowledge of other states' experiences.

(10) A representative who is a parent or guardian caring for a young child with a mental illness.

(11) An at-large representative identified by the chair.

(12) A representative who is a person with lived experience of a mental illness.

(13) A primary care provider from a licensed primary care clinic that provides integrated primary and behavioral health care.

(b) The advisory committee shall be convened by the chair and shall, at a minimum, do all of the following:

(1) Provide advice and guidance broadly on approaches to early psychosis and mood disorder detection and intervention programs from an evidence-based perspective.

(2) Review and make recommendations on the commission's guidelines or any regulations in the development, design, selection of awards pursuant to this part, and the implementation or oversight of the early psychosis and mood disorder detection and intervention competitive selection process established pursuant to this part.

(3) Assist and advise the commission in the overall evaluation of the early psychosis and mood disorder detection and intervention competitive selection process.

(4) Provide advice and guidance as requested and directed by the chair.

(5) Recommend a core set of standardized clinical and outcome measures that the funded programs would be required to collect, subject to future revision. A free data sharing portal shall be available to all participating programs.

(6) Inform the funded programs about the potential to participate in clinical research studies.

5835.3. (a) It is the intent of the Legislature to authorize the commission to administer a competitive selection process as provided in this part to create new, and to expand and improve the fidelity of existing, service capacity for early psychosis and mood disorder detection and intervention services in California.

(b) The core objectives of this competitive selection process include, but are not limited to, all of the following:

(1) Expanding the provision of high-quality, evidence-based early psychosis and mood disorder detection and intervention services within California.

(2) Improving access to effective services for transition-aged youth and young adults at high risk for, or experiencing, psychotic symptoms, including the prodromal phase, or psychotic disorders.

(3) More comprehensively and effectively measuring programmatic effectiveness and enrolled client outcomes of programs receiving awards in the competitive selection process.

(4) Improving the client experience in accessing services and in working toward recovery and wellness.

(5) Increasing participation in school attendance, social interactions, physical health, personal bonding relationships, and active rehabilitation, including employment and daily living function development for clients.

(6) Reducing unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services and improving access to timely assistance to early psychosis and mood disorder detection and intervention services.

(7) Expanding the use of innovative technologies for mental health information feedback access that can provide a valued and unique opportunity to optimize care for the target population. This may include technologies for treatment and symptom monitoring.

(8) Providing local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for the target population, including transition-aged youth and young adults.

(9) Improving whole-person care by increasing access to, and coordination of, mental health and medical care services.

(c) Funds allocated by the commission shall be made available to selected counties, or counties acting jointly, through a competitive selection process, or to other entities for research, evaluation, technical assistance, and other related purposes.

(d) (1) Notwithstanding any other law, a county, or counties acting jointly, that receive an award of funds shall be required to provide a contribution of local funds.

(2) Upon approval of the commission, after consultation with the Department of Finance and the State Department of Health Care Services, other locally acquired funding, such as federal grants or allocations, or other special funds, may also be recognized for the purpose of contributing toward any contribution requirements.

(e) Awards made by the commission shall be used to create, or expand existing capacity for, early psychosis and mood disorder detection and intervention services and supports. The commission shall ensure that awards result in cost-effective and evidence-based services that comprehensively address identified needs of the target population, including transition-aged youth and young adults, in counties and regions selected for funding. The commission shall also take into account at least the following criteria and factors when selecting recipients of awards and determining the amount of awards:

(1) A description of need, including, at a minimum, a comprehensive description of the early psychosis and mood disorder detection and intervention services and supports to be established or expanded, community need, target population to be served, linkage with other public systems of health and mental health care, linkage with schools and community social services, and related assistance as applicable, and a description of the request for funding.

(2) A description of all programmatic components, including outreach and clinical aspects, of the local early psychosis and mood disorder detection and intervention services and supports.

(3) A description of any contractual relationships with contracting providers as applicable, including any memorandum of understanding between project partners.

(4) A description of local funds, including the total amounts, that would be contributed toward the services and supports as required by the commission through the competitive selection process, implementing guidelines, and regulations.

(5) The project timeline.

(6) The ability of the awardee to effectively and efficiently implement or expand an evidence-based program as referenced in this part.

(7) A description of core data collection and the framework for evaluating outcomes, including improved access to services and supports and a cost-benefit analysis of the project.

(8) A description of the sustainability of program services and supports in future years.

(f) The commission shall determine any minimum or maximum awards, and shall take into consideration the level of need, the population to be served, and related criteria as described in subdivision (e) and in any guidance or regulations, and shall reflect the reasonable costs of providing the services and supports.

(g) Funds awarded by the commission may be used to supplement, but not supplant, existing financial and resource commitments of the county or counties acting jointly, that receive the award.

(h) The commission may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, initiate an interagency agreement with another public entity, including the University of California system, or contract for necessary technical assistance to implement this part.

(i) The advisory committee may coordinate and recommend an allocation of funding to the commission for clinical research studies. The committee may recommend an amount not to exceed 10 percent of the total amount deposited in the Early Psychosis and Mood Disorder Detection and Intervention Fund for clinical research studies. The advisory committee may recommend, in conjunction with the principal investigators, the data elements to be included in clinical research studies funded pursuant to this subdivision. The results of the clinical research studies shall be made available annually to the members of the public, including stakeholders and Members of the Legislature. The results of clinical research studies shall be deidentified in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104-191), including Section 164.514 of Title 45 of the Code of Federal Regulations, and shall not contain any personally identifiable information according to the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code).

(j) The county and all award recipients shall comply with all applicable state and federal privacy laws that govern medical information, including, but not limited to, HIPAA and its implementing regulations, the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code), the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code), and Section 10850.

5835.4. Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the commission may implement this part without taking regulatory action until regulations are adopted. The commission shall adopt regulations implementing this part on or before January 1, 2019.

5835.5. Implementation of the grant program established pursuant to Section 5835.3 and the adoption of regulations pursuant to Section 5835.4 shall be contingent upon the deposit into the fund established pursuant to Section 5835.1 of at least five hundred thousand dollars ($500,000) in nonstate funds for the purpose of funding grants and administrative costs for the commission pursuant to this part.

O

AGENDA ITEM 6

Information

January 25, 2018 Commission Meeting

Executive Director Report

Summary: Executive Director Toby Ewing will report on projects underway, the Mental Health Services Oversight and Accountability Commission (Commission) calendar, and other matters relating to the ongoing work of the Commission.

Presenter: Toby Ewing, Executive Director

Enclosures: (1) Motions summary from the November 16, 2017 Commission Meeting; (2) Evaluation Dashboard Summary; (3) Evaluation Dashboard; and (4) Innovation Review Outline.

Handout: None

Recommended Action: Information item only

Mental Health Services
Oversight & Accountability Commission

Motions Summary

Commission Meeting
November 16, 2017

Motion #: 1
Date: November 16, 2017
Time: 9:50 AM

Text of Motion:

The Commission approves the October 26, 2017 Meeting Minutes.

Commissioner making motion: Commissioner Brown
Commissioner seconding motion: Commissioner Mitchell

Motion carried 6 yes, 0 no, and 3 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Wooton	☒	☐	☐
2. Vice-Chair Boyd	☒	☐	☐
3. Commissioner Anthony	☐	☐	☒
4. Commissioner Ashbeck	☐	☐	☒
5. Commissioner Aslami-Tamplen	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☒	☐	☐
8. Commissioner Bunch	☒	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☐	☐	☒
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Lynch	☐	☐	☐
13. Commissioner Mitchell	☒	☐	☐
14. Commissioner Poaster	☐	☐	☐
15. Commissioner Ridley-Thomas	☐	☐	☐
16. Commissioner Strachan-Wilson	☐	☐	☐

Motion #: 2
Date: November 16, 2017
Time: 10:32 AM

Text of Motion:

The MHSOAC adopts the Criminal Justice and Mental Health project report as revised to be consistent with the Commission's direction at the November 16, 2017 meeting, adding cultural competency including LGBTQ to recommendation number 6 and that staff continue working on the implementation of the report with REMHDCO and the other entities that have commented on the report.

Commissioner making motion: Commissioner Ashbeck
Commissioner seconding motion: Commissioner Mitchell

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

Name	Yes	No	Abstain
1. Chair Wooton	☒	☐	☐
2. Vice-Chair Boyd	☒	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Ashbeck	☒	☐	☐
5. Commissioner Aslami-Tamplen	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☒	☐	☐
8. Commissioner Bunch	☒	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Lynch	☐	☐	☐
13. Commissioner Mitchell	☒	☐	☐
14. Commissioner Poaster	☐	☐	☐
15. Commissioner Ridley-Thomas	☐	☐	☐
16. Commissioner Strachan-Wilson	☐	☐	☐

Motion #: 3
Date: November 16, 2017
Time: 11:59 AM

Text of Motion:

The MHSOAC approves Santa Clara County's four (4) Innovations Projects with the addition of the LGBTQ and cultural competency trainings to be included in the Faith-Based Training and Supports project.

1. Name: Client and Consumer Employment Project
   Amount: $2,525,148
   Project Length: Three (3) Years
2. Name: Faith-Based Training and Supports Project
   Amount: $608,964
   Project Length: Two (2) Years
3. Name: Headspace
   Amount: $572,273
   Ramp up Phase: Eight (8) Months (Ramp-up Period Only)
4. Name: Psychiatric Emergency Response Team (PERT)
   Amount: $3,688,511
   Project Length: Two (2) Years

Commissioner making motion: Commissioner Brown
Commissioner seconding motion: Vice Chair Boyd

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

Name	Yes	No	Abstain
1. Chair Wooton	☒	☐	☐
2. Vice-Chair Boyd	☒	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Ashbeck	☒	☐	☐
5. Commissioner Aslami-Tamplen	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☒	☐	☐
8. Commissioner Bunch	☒	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Lynch	☐	☐	☐
13. Commissioner Mitchell	☒	☐	☐
14. Commissioner Poaster	☐	☐	☐
15. Commissioner Ridley-Thomas	☐	☐	☐
16. Commissioner Strachan-Wilson	☐	☐	☐

Motion #: 4
Date: November 16, 2017
Time: 1:40 PM

Text of Motion:

The MHSOAC asks Riverside and San Bernardino Counties to return with a reframed Innovation plan that has the same end goal as the plan that was presented.

Commissioner making motion: Commissioner Ashbeck
Commissioner seconding motion: Commissioner Mitchell

Motion carried 4 yes, 3 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Wooton	☐	☐	☒
2. Vice-Chair Boyd	☐	☒	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Ashbeck	☒	☐	☐
5. Commissioner Aslami-Tamplen	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☐	☐	☐
8. Commissioner Bunch	☒	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☐	☒	☐
11. Commissioner Madrigal-Weiss	☐	☒	☐
12. Commissioner Lynch	☐	☐	☐
13. Commissioner Mitchell	☒	☐	☐
14. Commissioner Poaster	☐	☐	☐
15. Commissioner Ridley-Thomas	☐	☐	☐
16. Commissioner Strachan-Wilson	☐	☐	☐

Motion #: 5
Date: November 16, 2017
Time: 2:35 PM

Recommended Action

- Authorize the Executive Director to issue a "Notice of Intent to Award Contract" to the proposer receiving the highest overall score.
- Establish November 27, 2017 as the deadline for unsuccessful bidders to file an "Intent to Protest" consistent with the five working day standard set forth in the Request for Proposal.
- Direct the Executive Director to notify the Commission Chair and Vice Chair of any protests within two working days of the filing and adjudicate protests consistent with the procedure provided in the Request for Proposal.
- Authorize the Executive Director to execute the contract upon expiration of the protest period or consideration of protests, whichever comes first.

Commissioner making motion: Commissioner Anthony
Commissioner seconding motion: Vice Chair Boyd

Motion carried 5 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Wooton	☒	☐	☐
2. Vice-Chair Boyd	☒	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☐	☐	☐
8. Commissioner Bunch	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Lynch	☐	☐	☐
13. Commissioner Mitchell	☐	☐	☐
14. Commissioner Poaster	☐	☐	☐
15. Commissioner Ridley-Thomas	☐	☐	☐
16. Commissioner Strachan-Wilson	☐	☐	☐

Motion #: 6
Date: November 16, 2017
Time: 3:05 PM

Recommended Action:

The MHSOAC authorizes staff consistent with this request to provide SB 82 funds in a competitive manner and that no less than $30 million of that amount be made available for county-school mental health partnerships that include a focus on ages pre-K through grade 3 but can be extended to include pre-K through grade 12. Counties are eligible to apply for children's dollars separate from adult dollars.

Commissioner making motion: Commissioner Gordon
Commissioner seconding motion: Chair Tina Wooton

Motion carried 5 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Wooton	☒	☐	☐
2. Vice-Chair Boyd	☒	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☐	☐	☐
8. Commissioner Bunch	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Lynch	☐	☐	☐
13. Commissioner Mitchell	☐	☐	☐
14. Commissioner Poaster	☐	☐	☐
15. Commissioner Ridley-Thomas	☐	☐	☐
16. Commissioner Strachan-Wilson	☐	☐	☐

Motion #: 7
Date: November 16, 2017
Time: 3:20 PM

Text of Motion:

The Commission adopts staff's recommended responses to the public comments received during the 45-day public comment period, including the changes to sections 3560.010, 3726, and 3735 of the PEI regulations and section 3580.010 of the Innovative regulations.

Commissioner making motion: Vice Chair Boyd
Commissioner seconding motion: Commissioner Anthony

Motion carried 5 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Wooton	☒	☐	☐
2. Vice-Chair Boyd	☒	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☐	☐	☐
8. Commissioner Bunch	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Lynch	☐	☐	☐
13. Commissioner Mitchell	☐	☐	☐
14. Commissioner Poaster	☐	☐	☐
15. Commissioner Ridley-Thomas	☐	☐	☐
16. Commissioner Strachan-Wilson	☐	☐	☐

Motion #: 8
Date: November 16, 2017
Time: 3:34 PM

Text of Motion:

The MHSOAC authorizes the Executive Director to enter into one or more contracts for an amount not to exceed $500,000 for ongoing maintenance and operations of the Transparency Data Portal environment, and ongoing maintenance and operations of the MHSOAC data warehouse and analytical environment.

Commissioner making motion: Vice Chair Boyd
Commissioner seconding motion: Commissioner Gordon

Motion carried 5 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Wooton	☒	☐	☐
2. Vice-Chair Boyd	☒	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☐	☐	☐
8. Commissioner Bunch	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Lynch	☐	☐	☐
13. Commissioner Mitchell	☐	☐	☐
14. Commissioner Poaster	☐	☐	☐
15. Commissioner Ridley-Thomas	☐	☐	☐
16. Commissioner Strachan-Wilson	☐	☐	☐

MHSOAC Evaluation Dashboard

The Mental Health Services Oversight and Accountability Commission (Commission) Evaluation Dashboard assists in monitoring the major evaluation efforts currently underway. The Evaluation Dashboard provides information, objectives, and the status of all current deliverables for internal and external evaluation contracts and projects. Below is a list of all changes/updates to all evaluation projects, which are highlighted in red within the Dashboard.

Changes/Updates:

External Evaluation Contracts

- **Cloud Platform for SAS and Performance Monitoring** *The iFish Group*
  Update: Contract no longer exists.

- **Visualization Confirguration & Publication Support Services** *The iFish Group*
  Update: Contract Manager has changed. Contract end date changed.

- **Web Based Tools and Advice** *The iFish Group*
  Update: Contract (17MHSOAC022) title changed. Contract Manager changed. Contract active dates have changed. Total contract amount increased. Total spent is zero (0).

MHSOAC Evaluation Dashboard January 2018

(updated 1//17/18)

Current MHSOAC Evaluation Contracts & Deliverables

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, University of California, Los Angeles

Assessment of System of Care for Older Adults (14MHSOAC016)

MHSOAC Staff: Brian Sala

Active Dates: 06/01/15 – 06/30/18

Total Budget: $469,000

Total Billed To Date: $368,292

Objective: Assess progress made in implementing an effective system care for older adults with serious mental illness & identify methods to further statewide progress. This assessment shall involve gauging the extent to which counties have developed & implemented services tailored to meet the older adult population's needs, including un/underserved diverse older individuals, recognizing the unique challenges & needs faced. In order to bolster the State's ability to promote improvements in the quality of services for older adults, a series of indicators shall be developed specifically on mental health issues for older adults; these indicators shall be developed with the intention of incorporating them into future data strengthening & performance monitoring efforts. The Contractor shall also document the challenges & barriers to meeting the unique needs of this population, & strategies to overcome these challenges. Lessons learned, resultant policy & practice recommendations for improving & support older adult mental health programs at the State & local levels shall be developed & presented to the Commission.

Deliverables & Due Dates

Contract Duration		September 2015 – June 2018					
1	Proposed Research Methods	09/07/15					
2	Data Elements, Indicators, Policy Recommendations		06/30/16				
3	Summary/Analysis of Secondary/Key Informant Interview Data			02/28/17			
4	Focus Group Data Summary & Policy Recommendations including identification of findings specific to Spanish-language focus groups and English/Spanish comparisons				12/30/17		
5.1	Policy Brief & Fact Sheet(s)					12/30/17	

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

*Material highlighted in red indicates updates to the information * Indicates that a deliverable has undergone a status change

5.2	**Policy Brief #2 and Fact Sheets #2 (English) and #3 (Spanish)**						**12/30/17**

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

*Material highlighted in red indicates updates to the information * Indicates that a deliverable has undergone a status change

MHSOAC Evaluation Dashboard January 2018

(updated 1//17/18)

Mental Health Data Alliance

Enhanced Partner-Level Data (ELPD) Templates (16MHSOAC018)

MHSOAC Staff: Pu Peng

Active Dates: 09/01/16 - 06/30/17

Total Contract Amount: $58,000

Total Spent: $58,000

Objective: Provide individual counties with the ability to import, link, view, and generate reports for Full-Service Partnership Data Collection and Reporting System data. The EPLD template, originally designed with MS Access, had data limitations of 2GB, which made processing of statewide FSP DCR data challenging and inefficient. MHSOAC seeks to have the existing EPLD template data migrated from MS Access to MS implementation of Structural Query Language server. This would allow for automation of the data reporting processes such that statewide and county-level reports could be created by the MHSOAC.

Deliverables & Due Dates

Contract Duration		December 2016 – May 2017		
1	**Migration of EPLD data from MS Access to MS SQL**	**12/30/16**		
2	**Migration of EPLD Queries, Scripts & Reports from MS Access to MS SQL**		**05/26/17**	
3	**Automating reports to produce Statewide reports for ten (10) selected, existing EPLD reports- EPLD Report Automation**			**05/26/17**

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

*Material highlighted in red indicates updates to the information * Indicates that a deliverable has undergone a status change

MHSOAC Evaluation Dashboard January 2018

(updated 1//17/18)

Mental Health Services
Oversight & Accountability Commission

Mental Health Data Alliance

DOJ Criminal Data Linkage & Analysis (16MHSOAC027)

MHSOAC Staff: Pu Peng & Ashley Mills

Active Dates: 01/01/17 - 12/31/17

Total Contract Amount: $98,450

Total Spent: $0

Objective: The purpose of the project is to (1) identify the level of criminal justice involvement among those served in public mental health programs; (2) evaluate the quality of self-report of arrests for individuals who participate in the Full Service Partnership programs; and (3) evaluate longitudinal changes in criminal justice involvement for populations served by public mental health programs.

Deliverables & Due Dates

Contracts		October 2017 – March 2018				
1	Statewide Criminal Justice Data Linkage Report	11/14/17				
2.1	County Participation Confirmation Report		11/30/17			
2.2	Select County-Specific Criminal Justice Data Linkage Report			03/01/18		
3.1	Quarterly Progress Report 1Q2017				01/15/18	
3.1	Quarterly Progress Report 2Q2017					03/15/18

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

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MHSOAC Evaluation Dashboard January 2018

(updated 1//17/18)

Mental Health Data Alliance

CSI & DCR Data Analysis & Standardize Reporting (16MHSOAC036)

MHSOAC Staff: Pu Peng

Active Dates: 02/15/17 - 02/14/18

Total Contract Amount: $149,980

Total Spent: $123,156

Objective: The purpose of this project is to (1) develop an SQL server database backup and recovery strategy for Full Service Partnership (FSP) data collection and reporting and Client and Service Information (CSI) data and (2) provide training and guidance to support MHSOAC staff in analyzing FSP and CSI data for standardized reporting and evaluation.

Deliverables & Due Dates							
Contracts		March 2017 – February 2018					
1.1	SQL Server Environment Specification Report	03/31/17					
1.2	SQL Server Environment Specification Recovery Model Implementation Report		02/14/18				
1.3	Training and Documentation			02/14/18			
2.1	Initial, Updated, & Final Knowledge Transfer Report				04/07/17		
2.2-2.10	9 monthly updates to the Initial Knowledge Transfer Report (4) Complete					01/15/18	
2.11	Final Knowledge Transfer Report						02/14/18

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

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MHSOAC Evaluation Dashboard January 2018

(updated 1//17/18)

Mental Health Services
Oversight & Accountability Commission

The iFish Group

Visualization Configuration & Publication Support Services (16MHSOAC021)

MHSOAC Staff: Brandon McMillen

Active Dates: 10/31/16 – 7/28/18

Total Contract Amount: $1,000,000

Total Spent: $250,000

Objective: To make data from reports on programs funded under the Mental Health Services Act, available to the public via a Visualization Portal. The portal will provide transparency through the publication of information and statistics to various stakeholders. Resources will be provided to allow MHSOAC staff to evaluate, merge, clean, and link all relevant datasets; develop processes and standards for data management; identify and configure analytics and visualizations for publication on the MHSOAC public website; and manage the publication of data to the open data platform.

Deliverables & Due Dates

Contracts		October 2016 – July 2018			
1	**Fiscal Transparency Tool 1.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)**	**10/31/16**			
2	**Full Service Partnerships Tool 1.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)**		**1/27/18**		
3	**Providers, Programs, and Services Tool 1.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)**			**04/28/18**	
4	**Fiscal Transparency Tool 2.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)**				**07/28/18**

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

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MHSOAC Evaluation Dashboard January 2018

(updated 1//17/18)

Mental Health Services
Oversight & Accountability Commission

The iFish Group

Hosting and Managed Services (16MHSOAC022)

MHSOAC Staff: Brandon McMillen

Active Dates: 12/28/17 - 12/31/18

Total Contract Amount: $423,923

Total Spent: $0

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

Deliverables & Due Dates		
Contracts		**December 2017**
1	**Secure Data Management Platform**	**12/28/17**
2	**Visualization Portal**	**12/28/17**
3	**Data Management Support Services**	**12/31/18**

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

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Mental Health Services
Oversight & Accountability Commission

Innovation Review Outline

Regulatory Criteria

- **Funds exploration of new and/or locally adapted mental health approach/practices**
  - Adaptation of an existing mental health program
  - Promising approach from another system adapted to mental health
- **One of four allowable primary purposes:**
  - Increase access to services to underserved groups
  - Increase the quality of services, including measurable outcomes
  - Promote interagency and community collaboration
  - Increase access to services, including permanent supportive housing.
- **Addresses a barrier other than not enough money**
- **Cannot merely replicate programs in other similar jurisdictions**
- **Must align with core MHSA principles (e.g. client-driven, culturally competent, recovery-oriented)**
- **Promotes *learning***
  - Learning ≠ program success
  - Emphasis on extracting information that can contribute to systems change

Staff Summary Analysis Includes:

- **Specific requirements regarding:**
  - Community planning process
  - Stakeholder involvement
  - Clear connection to mental health system or mental illness
  - Learning goals and evaluation plan
- **What is the unmet need the county is trying to address?**
  - Cannot be purely lack of funding!
- **Does the proposed project address the need(s)?**
- **Clear learning objectives that link to the need(s)?**
- **Evaluation plan that allows the county to meet its learning objective(s)?**
  - May include process as well as outcomes components

AGENDA ITEM 7

Action

January 25, 2018 Commission Meeting

Adoption of Amendments to the Prevention and Early Intervention and Innovative Regulations

Summary: The Commission will consider adopting the final version of the amendments to the Prevention and Early Intervention (PEI) and Innovative Projects (INN) regulations. This final version consists of the proposed amendments the Commission adopted in July 2017 with the modifications adopted in November 2017. A copy of the final version of the PEI and INN regulations as amended is included in the meeting packet.

Background: The PEI and INN regulations were adopted by the Commission and took effect in October 2015. In response to several concerns raised by representatives of California's county behavioral health agencies about their ability to comply with the new regulations, the Commission formed a Subcommittee to work with the County Behavioral Health Directors, counties, consumers, family members, community mental health providers, and other stakeholders to address the concerns. Following a robust public input process, the Commission, at its July 2017 meeting, adopted the recommended proposed amendments to the PEI and INN regulations.

The July 2017 proposed amendments underwent a 45-day public comment period that ended on September 28, 2017. Staff received written comments from twelve different individuals/organizations suggesting changes to the proposed amendments. At the November 16, 2017 meeting, in response to some of the public comments, the Commission modified the July 2017 proposed amendments. The modifications underwent a 15-day public comment period that ended on December 22, 2017. Staff received only one written comment and that comment agreed with the modifications and proposed no further changes. A copy of the written comment is included in the meeting packet.

Next Steps

Upon Commission adoption of the amendments to the PEI and INN regulations, the rulemaking record will be closed and submitted to the Office of Administrative Law (OAL), the state entity that reviews and approves regulations.

The OAL reviews the rulemaking file to determine compliance with the following Administrative Procedure Act requirements:

- Authority: Whether the MHSOAC has the authority to issue the amendments;
- Reference: Whether the amendments correctly reference the specific statute they implement, interpret or make specific;
- Consistency: Whether the amendments are consistent with the law;
- Clarity: Whether the text of the amendments clear;
- Non-duplication: Whether the amendments are duplicative of the statute they implement, interpret or make specific;
- Necessity: Whether the amendments are necessary; and
- Procedural requirements: Whether the MHSOAC followed the procedural requirements.

Presenter: Filomena Yeroshek, Chief Counsel

Enclosures: (1) Final version of proposed amendments to the PEI regulations; (2) Final version of proposed amendments to the INN regulations; (3) Copy of the written public comment received during the 15-day comment period.

Handouts: PowerPoint presentation will be available at the meeting.

Proposed Motion

The Commission adopts the amendments to sections 3560, 3560.010, 3560.020, 3705, 3726, 3735, 3750, and 3755 of the PEI regulations and sections 3580 and 3580.010 of the INN regulations and authorizes the Executive Director to submit the rulemaking file to the Office of Administrative Law.

ENCLOSURE 1

Article 5. Reporting Requirements

Amend Section 3560 as follows:

Section 3560. Prevention and Early Intervention ~~Reports~~ Reporting Requirements.

(a) The County shall submit to the Mental Health Services Oversight and Accountability Commission the following ~~Prevention and Early Intervention reports~~:
  (1) The Annual Prevention and Early Intervention ~~Program and Evaluation~~ report as specified in Section 3560.010.
  (2) The Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report as specified in Section 3560.020.

Amend Section 3560.010 as follows:

Section 3560.010. Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report.

(a) The requirements set forth in this section shall apply to the Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report.
  (1) The first Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report is due to the Mental Health Services Oversight and Accountability Commission on or before December 30, 2017 as part of ~~the~~ an Annual Update or Three-Year Program and Expenditure Plan ~~and no later than December 30th every year thereafter except for years in which the Three-Year Program and Evaluation Report is due~~. Each Annual Prevention and Early Intervention Report thereafter is due as part of an Annual Update or Three-Year Program and Expenditure Plan within 30 calendar days of Board of Supervisors approval but no later than June 30 of the same fiscal year whichever occurs first. The Annual Prevention and Early Intervention Report is not due in years in which a Three-Year Prevention and Early Intervention Evaluation Report is due.
  (2) The Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report shall report on the required data for the fiscal year prior to the due date. For example, the Report that is due no later than June 30, 2020 is to report the required data from fiscal year 2018-19 (i.e. July 1, 2018 through June 30, 2019).
  (3) The County shall exclude from the Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing privacy and security regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.
    (A) When the County has excluded information pursuant subdivision (3) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:

1. A supplemental Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report that contains all of the information including the information that was excluded pursuant to subdivision (3). This supplemental report shall be marked "confidential."
2. A supplement to the Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report that contains the information that was excluded pursuant to subdivision (3). This supplement to the report shall be marked "confidential."

(b) The County shall report the following information annually as part of the Annual Update or Three-Year Program and Expenditure Plan. The report shall include the following information for the reporting period:

(1) For each Prevention Program and each Early Intervention Program list:
  (A) The Program name.
  (B) Unduplicated numbers of individuals served in the preceding fiscal year
    1. If a Program served both individuals at risk of a mental illness (Prevention) and individuals with early onset of a mental illness (Early Intervention), the County shall report numbers served separately for each category.
    2. If a Program served families the County shall report the number of individual family members served.

(2) For each Outreach for Increasing Recognition of Early Signs of Mental Illness Program or Strategy within a Program, the County shall report:
  (A) The Program name
  (B) The number of potential responders
  (C) The setting(s) in which the potential responders were engaged
    1. Settings providing opportunities to identify early signs of mental illness include, but are not limited to, family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.
  (D) The type(s) of potential responders engaged in each setting (e.g. nurses, ~~principles~~ principals, parents)

(3) For each Access and Linkage to Treatment Strategy or Program the County shall report:
  (A) The Program name
  (B) Number of individuals with serious mental illness referred to
    1. T~~t~~reatment that is provided, funded administered, or overseen by county mental health programs, and the kind of treatment to which the individual was referred.
    2. Treatment that is not provided, funded, administered, or overseen by county mental health, and the kind of treatment to which the individual was referred.
  (C) For referrals to treatment that are provided, funded, administered, or overseen by county mental health, the n~~N~~umber of individuals who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the Program to which they were referred.

(D) For referrals to treatment that are provided, funded, administered, or overseen by county mental health, the a~~A~~verage duration of untreated mental illness as defined in Section 3750, subdivision (f)(3)(A) and standard deviation.

(E) For referrals to treatment that are provide, funded, administered, or overseen by county mental health, the a~~A~~verage interval between the referral and participation in treatment, defined as participating at least once in the treatment to which referred, and standard deviation.

(F) "Referral" as used in this subdivision means the process by which an individual is given a recommendation in writing to one or more specific service providers for a higher level of care and treatment. Distributing a list of community resources to an individual does not constitute a referral under this subdivision.

(4) For each Improve Timely Access to Services for Underserved Populations Strategy or Program the County shall report:

(A) The program name

(B) Identify the specific underserved populations for whom the County intended to increase timely access to services.

(C) Number of referrals of members of underserved populations to a Prevention Program, an Early Intervention Program and/or to treatment beyond early onset.

(D) Number of individuals who followed through on the referral, defined as the number of individuals who participated at least once in the Program to which they were referred.

(E) Average interval between referral and participation in services to which referred, defined as participating at least once in the service to which referred, and standard deviation.

(F) Description of ways the County encouraged access to services and follow-through on referrals.

(G) "Referral" as used in this subdivision means the process by which a member of an underserved population is given a recommendation in writing to one or more specific service providers for a Prevention Program, an Early Intervention Program and/or a program providing treatment beyond early onset. Distributing a list of community resources to an individual does not constitute a referral under this subdivision.

(5) For the information reported under subdivisions (1) through (4) of this section, disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services by:

(A) The following age groups:

1. 0-15 (children/youth)
2. 16-25 (transition age youth)
3. 26-59 (adult)
4. ages 60+ (older adults)
5. Number of respondents who declined to answer the question

(B) Race by the following categories:

1. American Indian or Alaska Native
2. Asian

3. Black or African American
4. Native Hawaiian or other Pacific Islander
5. White
6. Other
7. More than one race
8. Number of respondents who declined to answer the question

(C) Ethnicity by the following categories:
1. Hispanic or Latino as follows
   a. Caribbean
   b. Central American
   c. Mexican/Mexican-American/Chicano
   d. Puerto Rican
   e. South American
   f. Other
   g. Number of respondents who declined to answer the question
2. Non-Hispanic or Non-Latino as follows
   a. African
   b. Asian Indian/South Asian
   c. Cambodian
   d. Chinese
   e. Eastern European
   f. European
   g. Filipino
   h. Japanese
   i. Korean
   j. Middle Eastern
   k. Vietnamese
   l. Other
   m. Number of respondents who declined to answer the question
3. More than one ethnicity
4. Number of respondents who declined to answer the question

(D) Primary language used listed by threshold languages for the individual county

(E) Sexual orientation,
1. Gay or Lesbian
2. Heterosexual or Straight
3. Bisexual
4. Questioning or unsure of sexual orientation
5. Queer
6. Another sexual orientation
7. Number of respondents who declined to answer the question

(F) Disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness
1. Yes, report the number that apply in each domain of disability(ies)
   a. Communication domain separately by each of the following

(i) Difficulty seeing,
(ii) Difficulty hearing, or having speech understood
(iii) Other (specify)

b. Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)
c. Physical/mobility domain
d. Chronic health condition (including, but not limited to, chronic pain)
e. Other (specify)

2. No
3. Number of respondents who declined to answer the question

(G) Veteran status,
1. Yes
2. No
3. Number of respondents who declined to answer the question

(H) Gender
1. Assigned sex at birth:
a. Male
b. Female
c. Number of respondents who declined to answer the question
2. Current gender identity:
a. Male
b. Female
c. Transgender
d. Genderqueer
e. Questioning or unsure of gender identity
f. Another gender identity
g. Number of respondents who declined to answer the question

(6) Any other data the County considers relevant, for example, data for additional demographic groups that are particularly prevalent in the County, at elevated risk of or with high rates of mental illness, unserved or underserved, and/or the focus of one or more Prevention and Early Intervention funded services.

(7) For Stigma and Discrimination Reduction Programs and Suicide Prevention Programs, the County may report available numbers of individuals reached, including demographic breakdowns. An example would be the number of individuals who received training and education or who clicked on a web site.

(8) For all programs and Strategies, the County may report implementation challenges, successes, lessons learned, and relevant examples.

(c) For a program serving children or youth younger than 18 years of age, the demographic information required under subdivision (b)(5) of this section relating to children or youth younger than 18 years of age shall be collected and reported only to the extent permissible by California Education Code,

Family Educational Rights and Privacy Act (FERPA), Health Insurance Portability and Accountability Act of 1996 (HIPAA), California Information Practices Act, and other applicable state and federal privacy laws.

(d) Except for sexual orientation, current gender identity, and veteran status, a county shall collect the demographic information required under subdivision(b)(5) of this section from a minor younger than 12 years of age. Information that cannot be obtained directly from the minor may be obtained from the minor's parent, legal guardian, or other authorized source.

(e) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, may report the demographic information required under subdivision (b)(5) of this section for the County's entire Prevention and Early Intervention Component instead of by each Program or Strategy.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5845(d)(6), and 5847, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Amend Section 3560.020 as follows:

Section 3560.020. Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report.

(a) The County shall submit the Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report to the Mental Health Services Oversight and Accountability Commission every three years as part of ~~the~~ a Three-Year Program and Expenditure Plan or Annual Update. The Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report answers questions about the impacts of Prevention and Early Intervention Component Programs on individuals with risk or early onset of serious mental illness and on the mental health and related systems.

(1) The first Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report is due to the Mental Health Services Oversight and Accountability Commission ~~on or before December 30, 2018~~ as part of ~~the~~ a Three-Year Program and Expenditure Plan or Annual Update within 30 calendar days of Board of Supervisors approval but no later than June 30, 2019 whichever occurs first. ~~for fiscal years 2017/18 through 2019/20~~. The first Three-Year Prevention and Early Intervention Evaluation Report shall report the required evaluations from fiscal year 2017-2018 and from fiscal year 2016-2017 if available. Each subsequent ~~The~~ Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report shall be due within 30 calendar days of Board of Supervisors approval but no later than ~~December 30th~~ June 30th every ~~three years~~ third year thereafter whichever occurs first, as part of a Three-Year Program and Expenditure Plan or Annual Update and shall report on the evaluation(s) for the three prior fiscal years ~~prior to the due date~~.

(2) The County shall exclude from the Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing privacy and security

regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.

(A) When the County has excluded information pursuant subdivision (2) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:

1. A supplemental Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report that contains all of the information including the information that was excluded pursuant to subdivision (2). This supplemental report shall be marked "confidential."
2. A supplement to the Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report that contains the information that was excluded pursuant to subdivision (2). This supplement to the report shall be marked "confidential."

(b) The Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report shall describe the evaluation of each Prevention and Early Intervention Component Program and two Strategies: Access and Linkage to Treatment and Improving Timely Access to Services for Underserved Populations. The Report shall include the following:

(1) The name of each Program for which the county is reporting

(2) The outcomes and indicators selected for each Prevention, Early Intervention, Stigma and Discrimination Reduction, or Suicide Prevention Program

(3) The approaches used to select the outcomes and indicators, collect data, and determine results for the evaluation of each Program and the Access and Linkage to Treatment and Improving Timely Access to Services for Underserved Populations Strategies

(4) How often the data were collected for the evaluation of each Program and for the Access and Linkage to Treatment and Improving Timely Access to Services for Underserved Populations Strategies

(c) The Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report shall provide results and analysis of results for all required evaluations set forth in Section 3750 for the three fiscal years prior to the due date.

(d) The County may also include in the Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report any additional evaluation data on selected outcomes and indicators, including evaluation results related to the impact of Prevention and Early Intervention Component Programs on mental health and related systems.

(e) The County shall include the same information for the previous fiscal year that otherwise would be reported in the Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report in response to requirements specified in 3560.010(b).

(f) The County may report any other available evaluation results in the County's Annual Updates.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5845(d)(6), and 5847, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Article 7. Prevention and Early Intervention

Amend Section 3705 as follows:

Section 3705. Prevention and Early Intervention Component General Requirements.

(a) The County shall include in its Prevention and Early Intervention Component:
  (1) At least one Early Intervention Program as defined in Section 3710.
  (2) At least one Outreach for Increasing Recognition of Early Signs of Mental Illness Program as defined in Section 3715.
  (3) At least one Prevention Program as defined in Section 3720
    (A) Small counties may opt out of the requirement to have at least one Prevention Program if:
      1. The Small County obtains a ~~declaration~~ resolution from the Board of Supervisors that the County cannot meet this requirement.
    (B) A Small County that opts out of the requirement in (a)(3) above shall include in its Three-year Program and Expenditure Plan and/or Annual Update documentation describing the rationale for the County's decision and how the County ensured meaningful stakeholder involvement in the decision to opt out.
  (4) At least one Access and Linkage to Treatment Program as defined in Section 3726
    (A) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, may opt out of the requirement to have at least one Access and Linkage to Treatment Program if:
      1. The County obtains a resolution from the Board of Supervisors that the County cannot meet this requirement.
    (B) A County that opts out of the requirement in (a)(4) above shall include in its Three-year Program and Expenditure Plan and/or Annual Update documentation describing the rationale for the County's decision and how the County ensured meaningful stakeholder involvement in the decision to opt out.
  (5) At least one Stigma and Discrimination Reduction Program as defined in Section 3725
  (6) The Strategies defined in Section 3735.
(b) The County may include in its Prevention and Early Intervention Component:
  (1) One or more Suicide Prevention Programs as defined in Section 3730.
(c) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, may satisfy the requirements in subdivisions (a)(1) through (a)(5) of this Section by combining and/or integrating the Early Intervention Program, the Outreach for Increasing Recognition of Early Signs of Mental Illness Program, the Prevention Program, the Access and Linkage to Treatment Program, and the Stigma and Discrimination Reduction Program.
  (1) A county that utilizes this provision shall not also opt-out of the requirement to have at least one Prevention Program under subdivision (a)(3) or of the requirement to have at least one Access and Linkage to Treatment Program under subdivision (a)(4).

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Amend Section 3726 as follows:

Section 3726. Access and Linkage to Treatment Program.

(a) The County shall offer at least one Access and Linkage to Treatment Program as defined in this section.
(b) "Access and Linkage to Treatment Program" means a set of related activities to connect children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.
    (1) Examples of Access and Linkage to Treatment Programs, include but are not limited to, Programs with a primary focus on screening, assessment, referral, telephone help lines, and mobile response.
(c) In addition to offering the required Access and Linkage to Treatment Program, the County is also required to offer Access and Linkage to Treatment as a Strategy within all Prevention and Early Intervention Programs.
(d) The County shall include all of the Strategies in each Access and Linkage to Treatment Program as referenced in Section 3735.
(e) An Access and Linkage to Treatment Program may be provided through other Mental Health Services Act components as long as it meets all of the requirements in this section.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5600.3 and 5840, Welfare and Institutions Code.

Amend Section 3735 as follows:
Section 3735. Prevention and Early Intervention Strategies.

(a) The County shall include all of the following Strategies as part of each Program listed in Sections 3710 through 3730 of Article 7:
    (1) Be designed and implemented to help create Access and Linkage to Treatment.
        (A) "Access and Linkage to Treatment" means connecting children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to~~,~~ care provided by county mental health programs.
    (2) Be designed, implemented, and promoted in ways that Improve Timely Access to Mental Health Services for Individuals and/or Families from Underserved Populations.
        (A) "Improving Timely Access to Services for Underserved Populations" means to increase the extent to which an individual or family from an underserved population as defined in Title 9 California Code of Regulations Section 3200.300 who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.
        (B) Services shall be provide in convenient, accessible, acceptable, culturally appropriate settings such as primary healthcare, schools, family resource centers, community-based

organizations, places of worship, shelters, and public settings unless a mental health setting enhances access to quality services and outcomes for underserved populations.

(C) In addition to offering the required Improve Timely Access to Services for Underserved Populations Strategy, the County may also offer Improve Timely Access to Services for Underserved Populations as a Program.

(3) Be designed, implemented, and promoted using Strategies that are Non-Stigmatizing and Non-Discriminatory

(A) "Strategies that are Non-Stigmatizing and Non-Discriminatory" means promoting, designing, and implementing Programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming, and positive.

(B) Non-Stigmatizing and Non-Discriminatory approaches include, but are not limited to, using positive, factual messages and approaches with a focus on recovery, wellness, and resilience; use of culturally appropriate language, practices, and concepts; efforts to acknowledge and combat multiple social stigmas that affect attitudes about mental illness and/or about seeking mental health services, including but not limited to race and sexual orientation; co-locating mental health services with other life resources; promoting positive attitudes and understanding of recovery among mental health providers; inclusion and welcoming of family members; and employment of peers in a range of roles.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Amend Section 3750 as follows:

Section 3750. Prevention and Early Intervention Component Evaluation.

(a) For each Early Intervention Program the County shall evaluate the reduction of prolonged suffering as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness by measuring reduced symptoms and/or improved recovery, including mental, emotional, and relational functioning. The County shall select, define, and measure appropriate indicators that are applicable to the Program.

(b) For each Prevention Program the County shall measure the reduction of prolonged suffering as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness by measuring a reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational functioning. The County shall select, define, and measure appropriate indicators that are applicable to the Program.

(c) For each Early Intervention and each Prevention Program that the County designates as intended to reduce any of the other Mental Health Services Act negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness, the County shall select, define, and measure appropriate indicators that the County selects that are applicable to the Program.

(d) For each Stigma and Discrimination Reduction Program referenced in Section 3725, the County shall select and use a validated method to measure one or more of the following:
  (1) Changes in attitudes, knowledge, and/or behavior related to mental illness that are applicable to the specific Program.
  (2) Changes in attitudes, knowledge, and/or behavior related to seeking mental health services that are applicable to the specific Program.

(e) If the County chooses to offer a Suicide Prevention Program referenced in Section 3730, the County shall select and use a validated method to measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness that are applicable to the specific Program.

(f) For each Strategy or Program to provide Access and Linkage to Treatment the County shall track:
  (1) Number of referrals as defined in subdivision (b)(3)(F) of section 3560.010 to treatment, and kind of treatment to which person was referred.
  (2) Number of persons who followed through on the referral as defined in subdivision (b)(3)(F) of section 3560.010 and engaged in treatment, defined as the number of individuals who participated at least once in the Program to which the person was referred.
    (A) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.
  (3) Duration of untreated mental illness.
    (A) Duration of untreated mental illness shall be measured for persons who are referred as defined in subdivision (b)(3)(F) of section 3560.010 to treatment and who have not previously received treatment as follows:
      1. The time between the self-reported and/or parent-or-family-reported onset of symptoms of mental illness and entry into treatment, defined as participating at least once in treatment to which the person was referred.
    (B) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.
  (4) The interval between the referral as defined in subdivision (b)(3)(F) of section 3560.010 and engagement in treatment, defined as participating at least once in the treatment to which referred.
    (A) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.

(g) For each Strategy or Program to Improve Timely Access to Services for Underserved Populations the County shall measure:
  (1) Number of referrals as defined in subdivision (b)(4)(G) of section 3560.010 of members of underserved populations to a Prevention Program, an Early Intervention Program, and/or treatment beyond early onset.

(2) Number of persons who followed through on the referral as defined in subdivision (b)(4)(G) of section 3560.010 and engaged in services, defined as the number of individuals who participated at least once in the Program to which the person was referred.
  (A) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.
(3) Timeliness of care.
  (A) Timeliness of care for individuals from underserved populations with a mental illness is measured by the interval between referral as defined in subdivision (b)(4)(G) of section 3560.010 and engagement in services, defined as participating at least once in the service to which referred.

(h) The County shall design the evaluations to be culturally competent and shall include the perspective of diverse people with lived experience of mental illness, including their family members, as applicable.

(i) In addition, to the required evaluations listed in this section, the County may also, as relevant and applicable, define and measure the impact of Programs funded by Prevention and Early Intervention funds on the mental health and related systems, including, but not limited to education, physical healthcare, law enforcement and justice, social services, homeless shelters and other services, and community supports specific to age, racial, ethnic, and cultural groups. Examples of system outcomes include, but are not limited to, increased provision of services by ethnic and cultural community organizations, hours of operation, integration of services including co-location, involvement of clients and families in key decisions, identification and response to co-occurring substance-use disorders, staff knowledge and application of recovery principles, collaboration with diverse community partners, or funds leveraged.

(j) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, is exempt from the evaluation requirements in this section for one year from the effective date of this section.

(k) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, electing to follow subdivision (c) of section 3705 may satisfy the requirements of subdivisions (a) through (g) of this section by selecting, defining, and measuring appropriate indicators that the County selects to evaluate the negative outcomes referenced in Welfare and Institutions Code section 5840, subdivision (d), identified in the County's Three-year Program and Expenditure Plan and/or Annual Update pursuant to subdivision (o)(2) of section 3755.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840 and 5847, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Amend Section 3755 as follows:

Section 3755. Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update.

(a) The requirements set forth in this section shall apply to the Annual Update due for the fiscal year 2016-17 and each Annual Update and/or Three-Year Program and Expenditure Plan thereafter.

(b) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan or Annual Update shall include the following general information:

(1) A description of how the County ensured that staff and stakeholders involved in the Community Program Planning process required by Title 9 California Code of Regulations, Section 3300, were informed about and understood the purpose and requirements of the Prevention and Early Intervention Component.

(2) A description of the County's plan to involve community stakeholders meaningfully in all phases of the Prevention and Early Intervention Component of the Mental Health Services Act, including program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations.

(3) A brief description, with specific examples of how each Program and/or Strategy funded by Prevention and Early Intervention funds will reflect and be consistent with all applicable Mental Health Services Act General Standards set forth in Title 9 California Code of Regulations, Section 3320.

(c) Except as provided in subdivision (o), t~~T~~he Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Early Intervention Program as defined in Section 3710 including, but not limited to:

(1) The Program name

(2) Identification of the target population for the specific Program including:

(A) Demographics relevant to the intended target population for the specific Program, including, but not limited to, age, race/ethnicity, gender or gender identity, primary language used, military status, and sexual orientation.

(B) The mental illness or illnesses for which there is early onset.

(C) Brief description of how each participant's early onset of a potentially serious mental illness will be determined.

(3) Identification of the type(s) of problem(s) and need(s) for which the Program will be directed and the activities to be included in the Program that are intended to bring about mental health and related functional outcomes including reduction of the negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) for individuals with early onset of potentially serious mental illness.

(4) The Mental Health Services Act negative outcomes as a consequence of untreated mental illness referenced in Welfare and Institutions Code Section 5840, subdivision (d) that the Program is expected to affect, including the reduction of prolonged suffering as a consequence of untreated mental illness, as defined in Section 3750, subdivision (a).

(A) List the mental health indicators that the County will use to measure reduction of prolonged suffering as referenced in Section 3750, subdivision (a).

(B) For any other specified Mental Health Services Act negative outcome as a consequence of untreated mental illness, as referenced in Section 3750, subdivision (c), list the indicators that the County will use to measure the intended reductions.

(C) Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence.

(5) Specify how the Early Intervention Program is likely to reduce the relevant Mental Health Services Act negative outcomes as referenced in Welfare and Institutions Code Section 5840, subdivision (d) by providing the following information:

(A) If the County used the evidence-based standard or promising practice standard to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.

(B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes for the intended population(s) and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.

(d) Except as provided in subdivision (o), t~~T~~he Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of the Prevention Program including but not limited to the following information:

(1) The Program name

(2) Identification of the target population for the specific Program, including:

(A) Participants' risk of a potentially serious mental illness, either based on individual risk or membership in a group or population with greater than average risk of a serious mental illness, i.e. the condition, experience, or behavior associated with greater than average risk.

(B) How the risk of a potentially serious mental illness will be defined and determined, i.e. what criteria and process the County will use to establish that the intended beneficiaries of the Program have a greater than average risk of developing a potentially severe mental illness.

(C) Demographics relevant to the intended target population for the specific Program including but not limited to age, race/ethnicity, gender or gender identity, sexual orientation, primary language used, and military status.

(3) Specify the type of problem(s) and need(s) for which the Prevention Program will be directed and the activities to be included in the Program that are intended to bring about mental health and related functional outcomes including reduction of the negative outcomes referenced in

Welfare and Institutions Code Section 5840, subdivision (d) for individuals with greater than average risk of potentially serious mental illness.

(4) Specify any Mental Health Services Act negative outcomes as a consequence of untreated mental illness as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that the Program is expected to affect, including reduction of prolonged suffering, as defined in Section 3750, subdivision (b).
   (A) List the mental health indicators that the County will use to measure reduction of prolonged suffering as referenced in Section 3750, subdivision (b).
   (B) If the County intends the Program to reduce any other specified Mental Health Services Act negative outcome as a consequence of untreated mental illness as referenced in Section 3750, subdivision (c), list the indicators that the County will use to measure the intended reductions.
   (C) Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence.

(5) Specify how the Prevention Program is likely to bring about reduction of relevant Mental Health Services Act negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) for the intended population by providing the following information:
   (A) If the County used the evidence-based standard or promising practice standard to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.
   (B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes for the intended population(s) and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.

(e) Except as provided in subdivision (o), t~~T~~he Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Outreach for Increasing Recognition of Early Signs of Mental Illness Program and for any Strategy within a Program, including, but not limited to:
   (1) The Program name
   (2) Identify the types and settings of potential responders the Program intends to reach.
      (A) Describe briefly the potential responders' setting(s), as referenced in Section 3750, subdivisions (d)(3)(A), and the opportunity the potential responders will have to identify diverse individuals with signs and symptoms of potentially serious mental illness.

(3) Specify the methods to be used to reach out and engage potential responders and the methods to be used for potential responders and public mental health service providers to learn together about how to identify and respond supportively to signs and symptoms of potentially serious mental illness.

(f) Except as provided in subdivision (o), t~~T~~he Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Stigma and Discrimination Reduction Program, including, but not limited to:

(1) The Program name

(2) Identify whom the Program intends to influence.

(3) Specify the methods and activities to be used to change attitudes, knowledge, and/or behavior regarding being diagnosed with mental illness, having mental illness and/or seeking mental health services, consistent with requirements in Section 3750, subdivision (e), including timeframes for measurement.

(4) Specify how the proposed method is likely to bring about the selected outcomes by providing the following information:

(A) If the County used the evidence-based standard or promising practice standard, to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.

(B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes for the intended population and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.

(g) Except as provided in subdivision (o), t~~T~~he Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Suicide Prevention Program including, but not limited to:

(1) The Program name

(2) Specify the methods and activities to be used to change attitudes and behavior to prevent mental illness-related suicide.

(3) Indicate how the County will measure changes in attitude, knowledge, and /or behavior related to reducing mental illness-related suicide consistent with requirements in Section 3750, subdivision (f) including timeframes for measurement.

(4) Specify how the proposed method is likely to bring about suicide prevention outcomes selected by the County by providing the following information:

(A) If the County used the evidence-based standard or promising practice standard to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), explain how the practice's effectiveness has been demonstrated and explain how the

County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.

(B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.

(h) Except as provided in subdivision (o), t~~T~~he Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of the Access and Linkage to Treatment Program and Strategy within each Program including, but not limited to:

(1) Program name

(2) An explanation of how the Program and Strategy within each Program will create Access and Linkage to Treatment for individuals with serious mental illness as referenced in Section 3735, subdivision (a)(1)

(3) Explain how individuals will be identified as needing assessment or treatment for a serious mental illness or serious emotional disturbance that is beyond the scope of an Early Intervention Program.

(4) Explain how individuals, and, as applicable, their parents, caregivers, or other family members, will be linked to county mental health services, a primary care provider, or other mental health treatment.

(5) Explain how the Program will follow up with the referral to support engagement in treatment.

(6) Indicate if the County intends to measure outcomes in addition to those required in Section 3750, subdivision (f) and if so, specify what outcome(s) and how will it be measured, including timeframes for measurement.

(i) Except as provided in subdivision (o), t~~T~~he Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include for all Programs:

(1) Program name

(2) An explanation of how the Program will be implemented to help Improve Access to Services for Underserved Populations, as required in Section 3735, subdivision (a)(2)

(3) For each Program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations. If the County intends to locate the Program in a mental health setting, explain why this choice enhances access to quality services and outcomes for the specific underserved population.

(4) Indicate if the County intends to measure outcomes in addition to those required in Section 3750, subdivision (g) and, if so, what outcome(s) and how will it be measured, including timeframes for measurement.

(j) Except as provided in subdivision (o), t~~T~~he Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include for all Programs:

(1) The Program name

(2) An explanation of how the Program will use Strategies that are Non-Stigmatizing and Non-Discriminatory, including a description of the specific Strategies to be employed and the reasons the County believes they will be successful and meet intended outcomes.

(k) Except as provided in subdivision (o), t~~T~~he Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include for all Programs the following information for the fiscal year after the plan is submitted.

(1) Estimated number of children, adults, and seniors to be served in each Prevention Program and each Early Intervention Program.

(2) The County may also include estimates of the number of individuals who will be reached by Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Access and Linkage to Treatment Program, Suicide Prevention Programs, and Stigma and Discrimination Reduction Programs.

(l) Except as provided in subdivision (o), t~~T~~he Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include projected expenditures for each Program funded with Prevention and Early Intervention funds by fiscal year

(1) Projected expenditures by the following sources of funding:

(A) Estimated total mental health expenditures

(B) Prevention and Early Intervention funds

(C) Medi-Cal Federal Financial Participation

(D) 1991 Realignment

(E) Behavioral Subaccount

(F) Any other funding

(2) The County shall identify each Program funded with Prevention and Early Intervention funds as a Prevention Program, an Early Intervention Program, Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Stigma and Discrimination Reduction Program, Suicide Prevention Program, Access and Linkage to Treatment Program, or Program to Improve Timely Access to Services for Underserved Populations and shall estimate expected expenditures for each Program. If the Programs are combined, the County shall estimate the percentage of funds dedicated to each Program.

(A) The County shall estimate the amount of Prevention and Early Intervention funds for Administration of the Prevention and Early Intervention Component.

(m) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include the previous fiscal years' unexpended Prevention and Early Intervention funds and the amount of those funds that will be used to pay for the Programs listed in the Annual Update and/or Three-year Program and Expenditure Plan.

(n) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include an estimate of the amount of Prevention and Early Intervention funds voluntarily assigned by the County to California Mental Health Services Authority or any other organization in which counties are acting jointly.

(o) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, electing to follow subdivision (c) of section 3705 shall

include in the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update a description of the combine and/or integrated program including but not limited:

(1) Name of the combined and/or integrated program.

(2) Description of how the five required programs were combined and/or integrated.

(3) Identification of the negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) the combined and/or integrated program is intended to reduce.

(4) Description of how the combined and/or integrated program is likely to reduce the outcomes identified in part (3) above.

(5) Identification of the indicators that the County will use to measure the intended outcomes identified in part (3) above.

(6) Explanation of how the combined and/or integrated program will be implemented to help Improve Access to Services for Underserved Population, as required in Section 3735, subdivision (a)(2).

(7) Explanation of how the combined and/or integrated program will use Strategies that are Non-Stigmatizing and Non-Discriminatory, as required in Section 3735, subdivision (a)(3).

(8) Estimated numbers of children, adults, and seniors, respectively, to be served in the combined and/or integrated program.

(9) List of the projected expenditures for the combined and/or integrated program funded with Prevention and Early Intervention funds by fiscal year and by the following sources of funding:

(A) Estimated total mental health expenditures

(B) Prevention and Early Intervention funds

(C) Medi-Cal Federal Financial Participation

(D) 1991 Realignment

(E) Behavioral Subaccount

(F) Any other funding

(10) Estimated amount of Prevention and Early Intervention funds budgeted for Administration of the Prevention and Early Intervention Component.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5847, and 5848 Welfare and Institutions Code.

ENCLOSURE 2

Article 5. Reporting Requirements

Amend Section 3580 as follows:

Section 3580. Innovative Project Reports.

(a) For each approved Innovative Project, the County shall submit to the Mental Health Services Oversight and Accountability Commission the following reports, as applicable.

(1) For a continuing Innovative Project, an Annual Innovative Project Report as specified in Section 3580.010.

(A) The first Annual Innovative Project Report is due no later than December 31, 2017 ~~following the end of the fiscal year for which the County is reporting.~~ The County may submit the Annual Innovative Project Report as part of ~~the~~ a Three-Year Program and Expenditure Plan or Annual Update. ~~as long as the documents are submitted no later than December 31 pursuant to this subdivision.~~ Each Annual Innovative Project Report thereafter is due to the Mental Health Services Oversight and Accountability Commission as part of an Annual Update or Three-Year Program and Expenditure Plan within 30 calendar days of Board of Supervisors approval but no later than June 30 of the same fiscal year whichever occurs first.

(B) The County shall exclude from the Annual Innovative Project Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing privacy and security regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.

1. When the County has excluded information pursuant to subdivision (B) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:

a. A supplemental Annual Innovative Project Report that contains all of the information including the information that was excluded pursuant to subdivision (B). This supplemental report shall be marked “confidential”.
b. A supplement to the Annual Innovative Project Report that contains the information that was excluded pursuant to subdivision (B). This supplement to the report shall be marked “confidential”.

(2) Upon completion of an Innovative Project, a Final Innovative Project Report as specified in Section 3580.020.

(A) The County may submit the Final Innovative Project Report as part of the Three-Year Program and Expenditure Plan, Annual Update, or within six months from completion of the Innovative Project whichever is closest in time to the completion of the Innovative Project.

(B) The County shall exclude from the Final Innovative Project Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH)

and their implementing privacy and security regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.

1. When the County has excluded information pursuant to subdivision (B) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:
   a. A supplemental Final Innovative Project Report that contains all of the information including the information that was excluded pursuant to subdivision (B). This supplemental report shall be marked "confidential".
   b. A supplement to the Final Innovative Project Report that contains the information that was excluded pursuant to subdivision (B). This supplement to the report shall be marked "confidential".

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830 and 5847, Welfare and Institutions Code.

Adopt Section 3580.010 as follows:

Section 3580.010. Annual Innovative Project Report.

(a) The Annual Innovative Project Report shall include:
   (1) Name of the Innovative Project
   (2) Whether and what changes were made to the Innovative Project during the reporting period and the reasons for the changes.
   (3) Available evaluation data, including outcomes of the Innovative Project and information about which elements of the Project are contributing to outcomes.
   (4) Program information collected during the reporting period, including for applicable Innovative Projects that serve individuals, number of participants served by:
      (A) Age by the following categories:
         1. 0-15 (children/youth)
         2. 16-25 (transition age youth)
         3. 26-59 (adult)
         4. ages 60+ (older adults)
         5. Number of respondents who declined to answer the question
      (B) Race by the following categories:
         1. American Indian or Alaska Native
         2. Asian
         3. Black or African American
         4. Native Hawaiian or other Pacific Islander
         5. White
         6. Other
         7. More than one race
         8. Number of respondents who declined to answer the question
      (C) Ethnicity by the following categories:

1. Hispanic or Latino as follows
    a. Caribbean
    b. Central American
    c. Mexican/Mexican-American/Chicano
    d. Puerto Rican
    e. South American
    f. Other
    g. Number of respondents who declined to answer the question
2. Non-Hispanic or Non-Latino as follows
    a. African
    b. Asian Indian/South Asian
    c. Cambodian
    d. Chinese
    e. Eastern European
    f. European
    g. Filipino
    h. Japanese
    i. Korean
    j. Middle Eastern
    k. Vietnamese
    l. Other
    m. Number of respondents who declined to answer the question
3. More than one ethnicity
4. Number of respondents who declined to answer the question

(D) Primary language used by threshold languages for the individual county

(E) Sexual orientation,
1. Gay or Lesbian
2. Heterosexual or Straight
3. Bisexual
4. Questioning or unsure of sexual orientation
5. Queer
6. Another sexual orientation
7. Number of respondents who declined to answer the question

(F) A Disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.
1. Yes, report the number that apply in each domain of disability(ies)
    a. Communication domain separately by each of the following
        (i) Difficulty seeing
        (ii) Difficulty hearing, or having speech understood
        (iii) Other (specify)
    b. Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)

c. Physical/mobility domain
d. Chronic health condition (including but not limited to chronic pain)
e. Other (specify)

2. No
3. Number of respondents who declined to answer the question

(G) Veteran status,
1. Yes
2. No
3. Number of respondents who declined to answer the question

(H) Gender
1. Assigned sex at birth
a. Male
b. Female
c. Number of respondents who declined to answer the question

2. Current gender identity
a. Male
b. Female
c. Transgender
d. Genderqueer
e. Questioning or unsure of gender identity
f. Another gender identity
g. Number of respondents who declined to answer the question

(5) Any other data the County considers relevant.

(b) For an Innovative Project serving children or youth younger than 18 years of age, the demographic information required under subdivision (a)(4) of this section relating to children or youth younger than 18 years of age shall be collected and reported only to the extent permissible by California Education Code, Family Educational Rights and Privacy Act (FERPA), Health Insurance Portability and Accountability Act of 1996 (HIPAA), California Information Practices Act, and other applicable state and federal privacy laws.

(c) Except for sexual orientation, current gender identity, and veteran status, a county shall collect the demographic information required under subdivision (a)(4) of this section from a minor younger than 12 years of age. Information that cannot be obtained directly from the minor may be obtained from the minor's parent, legal guardian, or other authorized source.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830, 5845(d)(6), and 5847, Welfare and Institutions Code.

ENCLOSURE 3

californiahealth+ advocates
ADVANCING THE MISSION OF COMMUNITY HEALTH CENTERS

(916) 503-9130
healthplusadvocates.org
1231 I Street, Suite 400, Sacramento, CA 95814

December 22, 2017

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

Re: Notice of Modification to the Prevention and Early Intervention and Innovation Regulations

Dear Mr. Ewing,

CaliforniaHealth+ Advocates would like to thank the Mental Health Services Oversight and Accountability Commission (OAC) and the Commissioners for their work in improving the reporting requirements under the PEI and Innovation regulations. We are very pleased to see that the OAC accepted our recommendations regarding the collection of demographic data. Collecting demographic data allows the OAC, and public, track who is receiving services offered under PEI and Innovation and ensure services are offered to *all* Californians, regardless of race, ethnicity, and primary language.

California Health+ Advocates represent more than 1,300 community clinics and health centers (CCHCs) that provide comprehensive, high quality care to 6.5 million people – 1 out of every 6 Californians. More than 35% of CCHC patients' primary language is non-English, and 70% of patients are persons of color with a diverse array of racial and ethnic backgrounds. CCHCs are proud of their roots in the community-based wellness model, which ensures services are culturally relevant and provided in the languages spoken by patients. We believe that all providers of Prevention and Early Intervention and Innovation programs funded by the Mental Health Services Act should work to ensure that their interventions are available to California's full diverse population.

We would particularly like to thank the Commission for ensuring that counties can track the availability of their services to all populations by requiring that counties collect racial and ethnic demographic data for all PEI and Innovation-funded programs, including data for children under 12 years of age. We also appreciate the nuance in the OAC's decision to exempt children 12 and under from providing their sexual orientation data. Finally, we are pleased that the OAC will now be collecting data regarding the number of referrals made to non-county providers for behavioral health services under the Innovation and PEI programs. This is an important step that will allow the OAC, and behavioral health community, better understand the utilization of non-county programs, including those offered by CCHCs. This will help ensure that counties are utilizing existing resources in their communities to ensure better care for patients.

If you have any questions please feel free to contact Elizabeth Oseguera at 916-503-9130 or at liz@healthplusadvocates.org.

Respectfully,

Andie Martinez Patterson
Director of Government Affairs
California Health+ Advocates

Cc
Tina Wooton, Chair, Mental Health Services Oversight and Accountability Commission
John Boyd, Chair-elect and Vice-Chair, Mental Health Services Oversight and Accountability Commission

AGENDA ITEM 8

Action

January 25, 2018, Commission Meeting

The Triage Grant Program Evaluation Contracts

Summary: The Commission will consider authorizing the Executive Director to enter into one or more contracts to support a statewide evaluation of the Investment in Mental Health Wellness Act, also known as Senate Bill (SB) 82.

SB 82 was enacted in 2013. The Act is intended to strengthen and expand the county mental health services system by augmenting existing county crisis services and creating linkages to new services through additional funding for triage personnel.

In the first round of funding, counties conducted their own county-wide evaluations of program effectiveness. While this produced valuable information at the county level, the varied approaches used by counties resulted in data that could not be aggregated to tell a state-wide story of program effectiveness. In order to continuously improve the program and learn from the state-wide efforts underway to reduce hospitalizations, improve the client experience, and mitigate law enforcement expenditures for people experiencing a mental health crisis, staff recommended that the program include a common, centralized, state-wide evaluation.

At the July 27, 2017 Commission meeting, a state-wide evaluation strategy was approved for the second round of Triage grants. This item is a follow-up to that approval. The Commission will consider authorizing the Executive Director to enter into sole source contracts for state-wide evaluation of the second round of Triage grants.

Presenter: Norma Pate, Deputy Director; Tom Orrock, Chief of Commission Operations and Grants

Enclosures: None

Handouts: A Power Point will be presented at the meeting.

Proposed Motion: The Commission authorizes the Executive Director to enter into one or more contracts for a total amount not to exceed $10,000,000.00 to assist the Commission in conducting statewide evaluation of the second round of SB 82 Triage grant programs.

AGENDA ITEM 9

Action

January 25, 2018 Commission Meeting

Legislative Priorities

Summary: The Commission will consider legislative priorities for the current legislative session. In 2016 and 2017 the Commission identified legislative priorities in the form of bills the Commission would sponsor and/or support. Additionally, in the past the Commission has directed staff to advocate on budget items, including funds for stakeholder advocacy.

The Commission may wish to consider authorizing the Executive Director to provide letters of support for the following legislation:

- **Senate Bill 215 (Beall): Diversion - Mental Health Disorders:** This bill will allow pretrial diversion of misdemeanor and realigned felony charges for defendants whose mental illness played a significant role in the commission of the charged offense. This bill is consistent with the Commission's recommendations in the recent report on Criminal Justice.

- **Senate Bill 688 (Moorlach): Mental Health Services Act – revenue and expenditure reports:** This bill will ensure consistency and transparency in the counties fiscal reporting, and allows for further evaluation and analysis of the County annual Revenue and Expenditure Reports.

- **Senate Bill 906 (Beall & Anderson): Peer Provider Certification:** This bill will require Department of Health Care Service to establish a certification program for peer providers. The program will define the range of responsibilities and practice guidelines for peer support specialist, specify required training and continuing education requirements, determine clinical supervision requirements, and establish a code of ethics and process for revocation of certification.

The Commission may wish to consider authorizing the Executive Director to sponsor the following legislation:

- **Workplace Mental Health:** Legislation to authorize the Mental Health Services Oversight and Accountability Commission to form an advisory group and to establish a voluntary standard for workplace mental health.

  The Commission will receive presentation from Donna Hardaker, Manager of Workplace Mental Health and Peer Relations, Sutter

Health on potential strategies to establish or promote a workplace mental health initiative.

Presenter: Toby Ewing, Executive Director, Mental Health Services Oversight and Accountability Commission

Enclosures: Senate Bill 215 (Beall), Senate Bill 688 (Moorlach), and Senate Bill 906 (Beall & Anderson)

Handout: None

Proposed Motion: The MHSOAC authorizes the Executive Director to pursue discussions with the Legislature consistent with the direction given by the Commission.

AMENDED IN SENATE JANUARY 9, 2018

AMENDED IN SENATE JANUARY 3, 2018

AMENDED IN SENATE MARCH 6, 2017

SENATE BILL No. 215

Introduced by Senator Beall
(Coauthors: Senators *Bradford,* Hertzberg, Wieckowski, and Wiener)

February 1, 2017

An act to add Chapter 2.9D (commencing with Section 1001.82) to Title 6 of Part 2 of the Penal Code, relating to diversion.

LEGISLATIVE COUNSEL'S DIGEST

SB 215, as amended, Beall. Diversion: mental disorders.

Existing law authorizes a court, with the consent of the defendant and a waiver of the defendant's speedy trial right, to postpone prosecution of a misdemeanor and place the defendant in a pretrial diversion program if the defendant is suffering from sexual trauma, a traumatic brain injury, post-traumatic stress disorder, substance abuse, or mental health problems as a result of his or her military service. Existing law authorizes the defendant to be referred to services for treatment and requires the responsible agencies to report to the court and the prosecution not less than every 6 months.

This bill would authorize a court, with the consent of the defendant and a waiver of the defendant's speedy trial right, to postpone prosecution of a misdemeanor or a felony punishable in a county jail, and place the defendant in a pretrial diversion program for up to 2 years if the court is satisfied the defendant suffers from a mental disorder, that the defendant's mental disorder played a significant role in the

commission of the charged offense, and that the defendant would benefit from mental health treatment. For specified offenses, the bill would condition granting diversion on the consent of the prosecution. *Specified driving-under-the-influence offenses would not be eligible for diversion under these provisions.* The bill would require the defense to arrange, to the satisfaction of the court, for a program of mental health treatment utilizing existing inpatient or outpatient mental health resources. The bill would require the divertee's mental health provider to provide reports on the defendant's progress to the court, the defense, and the prosecution not less than every month if the offense is a felony, and every 3 months if the offense is a misdemeanor, as specified. By increasing the duties of local prosecutors and public defenders, this bill would impose a state-mandated local program. The bill would require, upon successful completion of the diversion program, that the charges be dismissed and the records of the arrest be restricted, as specified, and that the arrest be deemed never to have occurred, except as provided. The bill would state findings and declarations by the Legislature regarding the need for the diversion program.

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

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

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

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

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

(a) Despite never being designed for the treatment or housing of those with mental health needs, jails have become the de facto mental health facilities in many communities across the country.

(b) Untreated mental health conditions frequently result in chronic homelessness and an inability to find stable employment or housing, increasing the likelihood that those suffering from mental illness come into contact with law enforcement.

(c) For many people suffering from mental disorders, incarceration only serves to aggravate preexisting conditions and does little to deter future lawlessness.

(d) For people who commit offenses as a direct consequence of a mental disorder, diversion into treatment is often not only more cost effective, but also more likely to protect public safety by reducing the likelihood that a person suffering from a mental health disorder reoffends in the future.

(e) Courts, as one of the first points of contact between the mentally ill and the state, can serve a useful function in identifying defendants with mental disorders and connecting them to existing services, thereby reducing recidivism.

SEC. 2. Chapter 2.9D (commencing with Section 1001.82) is added to Title 6 of Part 2 of the Penal Code, to read:

Chapter 2.9D. Diversion of Low-Level Offenders Whose Offense is a Product of Mental Illness

1001.82. (a) (1) Notwithstanding any other law, except as specified in paragraph (2), in any case before the court on an accusatory pleading alleging the commission of a misdemeanor offense or felony offense punishable in a county jail pursuant to subdivision (h) of Section 1170, the court may, after considering the positions of the defense and prosecution, grant pretrial diversion to a defendant pursuant to this section if he or she meets all of the requirements specified in subdivision (b).

(2) Diversion is not available under this section without the consent of the prosecution for any of the following offenses:

(A) Any felony, with the exception of an offense specified in Title 13 (commencing with Section 450) or Title 14 (commencing with Section 594) of Part 1 of this code, Division 10 (commencing with Section 11000) of the Health and Safety Code, or Section 10851 of the Vehicle Code, including a conspiracy to commit these offenses or acting as an accessory to their commission.

(B) Any offense involving the unlawful use or unlawful possession of a firearm.

(C) A violation of Section 192 or 192.5.

(D) An offense for which a person, if convicted, would be required to register pursuant to Section 290, except for a violation of Section 314.

~~(E) A violation of Section 23152 or 23153 of the Vehicle Code.~~

~~(F)~~

(E) A violent felony, as defined in subdivision (c) of Section 667.5.

~~(G)~~

(F) A violation of Section 273a, 273.5, 368, 597, or 646.9.

~~(H)~~

(G) An offense resulting in damages of more than five thousand dollars ($5,000).

~~(I)~~

(H) An offense that occurs within 10 years of three separate referrals to diversion pursuant to this section. A grant of diversion on multiple charges filed under the same case number, or stemming from the same incident, shall constitute a single referral to diversion under this section.

(3) A violation of Section 23152 or 23153 of the Vehicle Code is not eligible for diversion pursuant to this section.

~~(3)~~

(4) It is the intent of the Legislature that the consent of the prosecution be required prior to a court granting diversion for any offense listed in subparagraphs (A) to ~~(I),~~ *(H),* inclusive, of paragraph (2). If the provisions of paragraph (2) related to the consent of the prosecutor are invalidated for any reason, the offenses listed in subparagraphs (A) to ~~(I),~~ *(H),* inclusive, of paragraph (2) shall not be eligible for diversion pursuant to this section.

(b) Pretrial diversion may be granted pursuant to this section if all of the following criteria are met:

(1) The court is satisfied that the defendant suffers from a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including, but not limited to, bipolar disorder, schizophrenia, or post-traumatic stress disorder, but excluding antisocial personality disorder, borderline personality disorder, or pedophilia. Evidence of the defendant's mental disorder shall be provided by the defense and shall include a diagnosis by a qualified expert. In opining that a defendant suffers from a qualifying disorder, the expert may rely on an examination of the defendant, medical records, evidence that the defendant receives federal supplemental security income benefits, arrest reports, or any other reliable evidence.

(2) The court is satisfied that the defendant's mental disorder played a significant role in the commission of the charged offense. A court may conclude that a defendant's mental disorder played a significant role in the commission of the charged offense if, after reviewing any relevant and credible evidence, including, but not limited to, police reports, preliminary hearing transcripts, witness statements, statements by the defendant's mental health treatment provider, medical records, reports by qualified medical experts, or evidence that the defendant displayed symptoms consistent with the relevant mental disorder at or near the time of the offense, the court concludes that the defendant's mental disorder substantially contributed to the defendant's involvement in the commission of the offense.

(3) The court is satisfied that the defendant would benefit from mental health treatment.

(4) The defendant consents to diversion and waives his or her right to a speedy trial.

(c) As used in this chapter, "pretrial diversion" means the postponement of prosecution, either temporarily or permanently, at any point in the judicial process from the point at which the accused is charged until adjudication to allow the defendant to undergo mental health treatment, subject to the following:

(1) The defense shall arrange, to the satisfaction of the court, for a program of mental health treatment utilizing existing inpatient or outpatient mental health resources. Before approving a proposed treatment program, the court shall consider the requests of the defense, the requests of the prosecution, and the needs of the divertee and the community. The treatment may be procured using private or public funds, and a referral may be made to a county mental health agency, existing collaborative courts, or assisted outpatient treatment only if that agency has agreed to accept responsibility for the treatment of the defendant, and mental health services are provided only to the extent that resources are available and the defendant is eligible for those services. Reports shall be provided to the court, the defense, and the prosecutor by the divertee's mental health provider on the divertee's progress in treatment not less than every month if the offense is a felony, and every three months if the offense is a misdemeanor. A court shall consider setting more frequent progress report dates upon request

of the prosecution or the defense, or upon the recommendation of the divertee's mental health treatment provider.

(2) If it appears to the court that the divertee is performing unsatisfactorily in the assigned program, or that the divertee is not benefiting from the treatment and services provided pursuant to the diversion program, the court shall, after notice to the divertee, defense counsel, and the prosecution, hold a hearing to determine whether the criminal proceedings should be reinstituted or whether the treatment program should be modified.

(3) The period during which criminal proceedings against the defendant may be diverted shall be no longer than two years.

~~(4) If it would be required as a condition of probation for the diverted offense, a grant of diversion pursuant to this section shall include a requirement that the divertee comply, prior to January 1, 2019, and on and after January 1, 2026, with the requirements of paragraph (1) of subdivision (f) of Section 23575 of the Vehicle Code.~~

~~(5)~~

(4) Upon request, the court shall conduct a hearing to determine whether restitution within the meaning of Section 1202.4 is owed to any victim as a result of the diverted offense and, if owed, order its payment. However, a defendant's inability to pay restitution due to indigence or mental disorder shall not be grounds for denial of diversion or a finding that the defendant has failed to comply with the terms of diversion.

(d) If the divertee has performed satisfactorily during the period of diversion, at the end of the period of diversion, the criminal charges shall be dismissed. A court may conclude that a divertee has performed satisfactorily if, in the court's judgment, the divertee has substantially complied with the requirements of the treatment program, has avoided significant new violations of law unrelated to the defendant's mental health condition, and has a plan in place for long-term mental health care. Upon dismissal of the charges, a record shall be filed with the Department of Justice indicating the disposition of the case diverted pursuant to this section. Upon successful completion of a diversion program, the arrest upon which the diversion was based shall be deemed never to have occurred, and the court shall order access to the record of the arrest restricted in accordance with Section 1001.9, except as specified in subdivisions (e) and (f). The divertee who successfully completes

the diversion program may indicate in response to any question concerning his or her prior criminal record that he or she was not arrested or diverted for the offense, except as specified in subdivision (e).

(e) Regardless of his or her successful completion of diversion, the arrest upon which the diversion was based may be disclosed by the Department of Justice in response to any peace officer application request. Notwithstanding subdivision (d), this section does not relieve the divertee who successfully completes diversion pursuant to this section of his or her obligation to disclose the arrest in a response to any direct question contained in any questionnaire or application for a position as a peace officer, as defined in Section 830. The divertee shall be advised of the requirements of this subdivision upon the successful completion of diversion.

(f) A finding that the defendant suffers from a mental disorder, any progress reports concerning the defendant's treatment, or any other records created as a result of diversion pursuant to this section or for use at a hearing on the defendant's eligibility for diversion under this section may not be used in any other proceeding without the defendant's consent. However, when determining whether to exercise its discretion to grant diversion under this section, a court may consider previous records of arrests for which the defendant was granted diversion under this section.

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

O

AMENDED IN SENATE JANUARY 3, 2018

SENATE BILL No. 688

Introduced by Senator Moorlach

February 17, 2017

An act to amend Section ~~5892~~ *5899* of the Welfare and Institutions Code, relating to mental health services.

LEGISLATIVE COUNSEL'S DIGEST

SB 688, as amended, Moorlach. Mental Health Services ~~Fund: research and evaluation.~~ *Act: revenue and expenditure reports.*

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health ~~programs. Existing law requires the State Department of Health Care Services to, among other things, implement specified mental health services through contracts with county mental health programs or counties acting jointly.~~ *programs and establishes the Mental Health Services Oversight and Accountability Commission to oversee those programs. Existing law requires the State Department of Health Care Services, in consultation with the commission and the County Behavioral Health Directors Association of California, to develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report, which gathers specified information on mental health spending as a result of the MHSA, including the expenditures of funds distributed to each county. Existing law requires counties to electronically submit the report to the department and the commission. Existing law authorizes the Legislature to add provisions to clarify procedures and terms of the MHSA by majority vote.*

~~Existing law requires, prior to making allocations to specified programs and services, that funds be reserved for administrative costs for the department, among other specified entities, to implement duties pursuant to programs under the act, as specified. Existing law prohibits those costs from exceeding 5% of the total of annual revenues received for the Mental Health Services Fund. Existing law makes those administrative funds subject to appropriation in the annual Budget Act.~~

~~Existing law requires the amounts allocated for administration to include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in specified provisions.~~

~~This bill would amend the act by requiring the amounts allocated for administration to include amounts sufficient for the department to establish a contract and an interagency data sharing agreement with the University of California to ensure adequate research and evaluation as described above. The bill would state the intent of the Legislature that the department model this research and this evaluation on the California Child Welfare Indicators Project, as defined. The bill would make these provisions apply to the university only to the extent that the Regents of the University of California, by resolution, make any of these provisions applicable to the university.~~

~~Existing law authorizes the act to be amended by a ⅔ vote of the Legislature if the amendments are consistent with, and further the intent of, the act. Existing law authorizes the Legislature to add provisions to clarify procedures and terms of the act by majority vote.~~

~~By amending the provisions of the act, this bill would require a ⅔ vote of the Legislature.~~

This bill would additionally require counties to prepare the reports in accordance with generally accepted accounting principles and to electronically submit the report in a machine-readable format. By imposing a higher level of service on counties, the bill would impose a state-mandated local program.

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

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

Vote: ~~⅔~~ *majority*. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

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

SECTION 1. Section 5899 of the Welfare and Institutions Code is amended to read:

5899. (a) The State Department of Health Care Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the County Behavioral Health Directors Association of California, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report. The instructions shall include a requirement that the county certify the accuracy of this report. ~~This report shall be submitted electronically~~ *Each county shall prepare the report in accordance with generally accepted accounting principles, and shall electronically submit the report in a machine-readable format* to the department and to the Mental Health Services Oversight and Accountability Commission. The department and the commission shall annually post each county's report on its Internet Web site in a timely manner.

(b) The department, in consultation with the commission and the County Behavioral Health Directors Association of California, shall revise the instructions described in subdivision (a) by July 1, 2017, and as needed thereafter, to improve the timely and accurate submission of county revenue and expenditure data.

(c) The purpose of the Annual Mental Health Services Act Revenue and Expenditure Report is as follows:

(1) Identify the expenditures of Mental Health Services Act (MHSA) funds that were distributed to each county.

(2) Quantify the amount of additional funds generated for the mental health system as a result of the MHSA.

(3) Identify unexpended funds, and interest earned on MHSA funds.

(4) Determine reversion amounts, if applicable, from prior fiscal year distributions.

(d) This report is intended to provide information that allows for the evaluation of all of the following:

(1) Children's systems of care.

(2) Prevention and early intervention strategies.

(3) Innovative projects.
(4) Workforce education and training.
(5) Adults and older adults systems of care.
(6) Capital facilities and technology needs.

(e) If a county does not submit the annual revenue and expenditure report described in subdivision (a) by the required deadline, the department may withhold MHSA funds until the reports are submitted.

(f) A county shall also report the amount of MHSA funds that were spent on mental health services for veterans.

(g) By October 1, 2018, and by October 1 of each subsequent year, the department shall, in consultation with counties, publish on its Internet Web site a report detailing funds subject to reversion by county and by originally allocated purpose. The report also shall include the date on which the funds will revert to the Mental Health Services Fund.

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

~~SECTION 1. Section 5892 of the Welfare and Institutions Code is amended to read:~~

~~5892. (a) In order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows:~~

~~(1) In 2005–06, 2006–07, and in 2007–08, 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.~~

~~(2) In 2005–06, 2006–07, and in 2007–08, 10 percent for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the County Behavioral Health Directors Association of California to implement plans developed pursuant to Section 5847.~~

~~(3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840) of this division.~~

~~(4) The expenditure for prevention and early intervention may be increased in any county in which the department determines~~

~~that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase.~~

~~(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care.~~

~~(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division, shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.~~

~~(b) In any year after 2007–08, programs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section.~~

~~(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division.~~

~~(d) Prior to making the allocations pursuant to subdivisions (a), (b), and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health,~~

~~and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient for the State Department of Health Care Services to establish a contract and an interagency data sharing agreement with the University of California to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. It is the intent of the Legislature that the State Department of Health Care Services model this research and this evaluation based on the California Child Welfare Indicators Project, a collaborative arrangement between the University of California and the State Department of Social Services that provides policymakers, child welfare workers, researchers, and the public with access to customizable information on California's child welfare system. The amount of funds available for the purposes of this subdivision in any fiscal year is subject to appropriation in the annual Budget Act.~~

~~(e) In 2004–05, funds shall be allocated as follows:~~

~~(1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section 5820) of this division.~~

~~(2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).~~

~~(3) Five percent for local planning in the manner specified in subdivision (c).~~

~~(4) Five percent for state implementation in the manner specified in subdivision (d).~~

~~(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future years.~~

~~(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.~~

~~(h) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county that have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years, provided however, that funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the fund.~~

~~(i) If there are still additional revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the commission's adopted plan that furthers the purposes of this act.~~

~~SEC. 2. This act shall apply to the University of California only to the extent that the Regents of the University of California, by resolution, make any of these provisions applicable to the university.~~

O

SENATE BILL No. 906

Introduced by Senators Beall and Anderson
(Coauthors: Senators Hertzberg and Pan)

January 17, 2018

An act to add Article 1.4 (commencing with Section 14045.10) to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 906, as introduced, Beall. Medi-Cal: mental health services: peer, parent, transition-age, and family support specialist certification.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing law provides for a schedule of benefits under the Medi-Cal program and provides for various services, including various behavioral and mental health services.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. The act also requires funds to be reserved for the costs for the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development (OSHPD), the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to certain programs provided for by the act, subject to appropriation in the annual Budget Act. The act provides that it may be amended by the Legislature

by a ⅔ vote of each house as long as the amendment is consistent with, and furthers the intent of, the act, and that the Legislature may also clarify procedures and terms of the act by majority vote.

This bill would require the State Department of Health Care Services to establish, no later than July 1, 2019, a statewide peer, parent, transition-age, and family support specialist certification program, as a part of the state's comprehensive mental health and substance use disorder delivery system and the Medi-Cal program. The bill would include 4 certification categories: adult peer support specialists, transition-age youth peer support specialists, family peer support specialists, and parent peer support specialists. The certification program's components would include, among others, defining responsibilities and practice guidelines, determining curriculum and core competencies, specifying training and continuing education requirements, establishing a code of ethics, and determining a certification revocation process. The bill would require an applicant for the certification as a peer, parent, transition-age, or family support specialist to meet specified requirements, including successful completion of the curriculum and training requirements.

This bill would require the department to collaborate with OSHPD and interested stakeholders in developing the certification program, and would authorize the department to contract to obtain technical assistance pursuant to a specified joint state-county decisionmaking process. The bill would authorize the department to use funding provided through the MHSA and designated funds administered by OSHPD to develop and administer the certification program, and would authorize the use of these MHSA funds to serve as the state's share of funding to develop and administer the certification program for the purpose of claiming federal financial participation under the Medicaid Program.

This bill would authorize the department to establish a certification fee schedule and to require remittance of fees as contained in the schedule, for the purpose of supporting the department's activities associated with the ongoing state administration of the certification program. The bill would require the department to utilize the other funding resources made available under the bill before determining the need for the certification fee schedule and requiring the remittance of fees. The bill would declare the intent of the Legislature that the certification fees charged by the department be reasonable and reflect the expenditures directly applicable to the ongoing state administration of the certification program.

This bill would require the department to amend the Medicaid state plan to include a certified peer, parent, transition-age, and family support specialist as a provider type for purposes of the Medi-Cal program and to include peer support specialist services as a distinct service type for purposes of the Medi-Cal program. The bill would require Medi-Cal reimbursement for peer support specialist services to be implemented only if and to the extent that federal financial participation is available and the department obtains all necessary federal approvals. The bill would authorize the department to enter into exclusive or nonexclusive contracts on a bid or negotiated basis, as specified, on a statewide or more limited geographic basis. This bill also would authorize the department to implement, interpret, or make specific its provisions by means of plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action, until regulations are adopted. The bill would require the department to adopt regulations by July 1, 2021, and, commencing July 1, 2019, would require the department to provide semiannual status reports to the Legislature until regulations have been adopted.

This bill would declare that it clarifies terms and procedures under the Mental Health Services Act.

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

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

SECTION 1. Article 1.4 (commencing with Section 14045.10) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 1.4. Peer, Parent, Transition-Age, and Family Support Specialist Certification Program

14045.10. This article shall be known, and may be cited, as the Peer, Parent, Transition-Age, and Family Support Specialist Certification Program Act of 2018.

14045.11. The Legislature finds and declares all of the following:

(a) With the enactment of the Mental Health Services Act in 2004, support to include peer providers identified as consumers,

parents, and family members for the provision of services has been on the rise.

(b) There are over 6,000 peer providers in California who provide individualized support, coaching, facilitation, and education to clients with mental health care needs and substance use disorder, in a variety of settings, yet no statewide scope of practice, standardized curriculum, training standards, supervision standards, or certification protocol is available.

(c) The United States Department of Veterans Affairs and over 30 states utilize standardized curricula and certification protocols for peer support services.

(d) The federal Centers for Medicare and Medicaid Services (CMS) recognizes peer support services as an evidence-based model of care and notes it is an important component in a state's delivery of effective mental health and substance use disorder treatment. The CMS encourages states to offer peer support services as a component of a comprehensive mental health and substance use disorder delivery system, and federal financial participation is available for this purpose.

(e) A substantial number of research studies demonstrate that peer supports improve client functioning, increase client satisfaction, reduce family burden, alleviate depression and other symptoms, reduce hospitalizations and hospital days, increase client activation, and enhance client self-advocacy.

(f) Certification at the state level can incentivize the public mental health system and the Medi-Cal program, including the Drug Medi-Cal program, to increase the number, diversity, and availability of peer providers and peer-driven services.

14045.12. It is the intent of the Legislature that the peer, parent, transition-age, and family support specialist certification program, established under this article, achieve all of the following:

(a) Establish the ongoing provision of peer support services for beneficiaries experiencing mental health care needs, substance use disorder needs, or both by certified peer support specialists.

(b) Provide support, coaching, facilitation, and education to beneficiaries with mental health needs, substance use disorder needs, or both, and to families or significant support persons.

(c) Provide increased family support, building on the strengths of families and helping them achieve desired outcomes.

(d) Provide a part of a wraparound continuum of services, in conjunction with other community mental health services and other substance use disorder services.

(e) Collaborate with others providing care or support to the beneficiary or family.

(f) Assist parents, when applicable, in developing coping mechanisms and problem-solving skills.

(g) Provide an individualized focus on the beneficiary, the family, or both, as needed.

(h) Encourage employment under the peer, parent, transition-age, and family support specialist certification program to reflect the culture, ethnicity, sexual orientation, gender identity, mental health service experiences, and substance use disorder experiences of the people whom they serve.

(i) Promote socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

14045.13. For purposes of this article, the following definitions shall apply:

(a) "Adult peer support specialist" means a person who is 18 years of age or older and who has self-identified as having lived experience of recovery from mental illness, substance use disorder, or both, and the skills learned in formal trainings to deliver peer support services in a behavioral setting to promote mind-body recovery and resiliency for adults.

(b) "Certification" means, as it pertains to the peer, parent, transition-age, and family support specialist certification program, all federal and state requirements have been satisfied, federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available, and all necessary federal approvals have been obtained.

(c) "Certified" means all federal and state requirements have been satisfied by an individual who is seeking designation under this article, including completion of curriculum and training requirements, testing, and agreement to uphold and abide by the code of ethics.

(d) "Certification examination" means the competency testing requirements, as approved by the department, an individual is required to successfully complete as a condition of becoming certified under this article. Each training program approved by the

department may develop a unique competency examination for each category of peer, parent, transition-age, and family support specialist listed in subdivision (b) of Section 14045.14. Each certification examination shall include core curriculum elements.

(e) "Code of ethics" means the professional standards each certified peer, parent, transition-age, and family support specialist listed in subdivision (b) of Section 14045.14 is required to agree to uphold and abide by. These professional standards shall include principles, expected behavior and conduct of the certificate holder in an agreed-upon statement that is required to be provided to the applicant and acknowledged by signing with his or her personal signature prior to being granted certification under this article.

(f) "Core competencies" are the foundational and essential competencies required by each category of peer, parent, transition-age, and family support specialists listed in subdivision (b) of Section 14045.14 who provide peer support services.

(g) "Cultural competence" means a set of congruent behaviors, attitudes, and policies that come together in a system or agency that enables that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates, at all levels, the importance of language and culture, intersecting identities, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs to provide services in a culturally competent manner.

(h) "Department" means the State Department of Health Care Services.

(i) "Family peer support specialist" means a person with lived experience as a self-identified family member of an individual experiencing mental illness, substance use disorder, or both, and the skills learned in formal trainings to assist and empower families of individuals experiencing mental illness, substance use disorder, or both. For the purposes of this subdivision, "family member" includes a sibling or kinship caregiver, and their partners.

(j) "Parent" means a person who is parenting or has parented a child or individual experiencing mental illness, substance use disorder, or both, and who can articulate his or her understanding of his or her experience with another parent or caregiver. This

person may be a birth parent, adoptive parent, or family member standing in for an absent parent.

(k) "Parent peer support specialist" means a parent with formal training to assist and empower families parenting a child or individual experiencing mental illness, substance use disorder, or both.

(*l*) "Peer support specialist services" means culturally competent services that promote engagement, socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, identification of strengths, and maintenance of skills learned in other support services. Peer support specialist services shall include, but are not limited to, support, coaching, facilitation, or education to Medi-Cal beneficiaries that is individualized to the beneficiary and is conducted by a certified adult peer support specialist, a certified transition-age youth peer support specialist, a certified family peer support specialist, or a certified parent peer support specialist.

(m) "Recovery" means a process of change through which an individual improves his or her health and wellness, lives a self-directed life, and strives to reach his or her full potential. This process of change recognizes cultural diversity and inclusion, and honors the different routes to resilience and recovery based on the individual and his or her cultural community.

(n) "Transition-age youth peer support specialist" means a person who is 18 years of age or older and who has self-identified as having lived experience of recovery from mental illness, substance use disorder, or both, and the skills learned in formal trainings to deliver peer support services in a behavioral setting to promote mind-body recovery and resiliency for transition-age youth, including adolescents and young adults.

14045.14. No later than July 1, 2019, the department, as the sole state Medicaid agency, shall establish a peer, parent, transition-age, and family support specialist certification program that, at a minimum, shall do all of the following:

(a) Establish a certifying body, either within the department, through contract, or through an interagency agreement, to provide for the certification of peer, parent, transition-age, and family support specialists as described in this article.

(b) Provide for a statewide certification for each of the following categories of peer support specialists, as contained in federal

guidance issued by the Centers for Medicare and Medicaid Services, State Medicaid Director Letter (SMDL) #07-011:

(1) Adult peer support specialists, who may serve individuals across the lifespan.

(2) Transition-age youth peer support specialists.

(3) Family peer support specialists.

(4) Parent peer support specialists.

(c) Define the range of responsibilities and practice guidelines for the categories of peer support specialists listed in subdivision (b), by utilizing best practice materials published by the federal Substance Abuse and Mental Health Services Administration, the federal Department of Veterans Affairs, and related notable experts in the field as a basis for development.

(d) Determine curriculum and core competencies, including curriculum that may be offered in areas of specialization, such as older adults, veterans, family support, forensics, whole health, juvenile justice, youth in foster care, sexual orientation, gender identity, and any other areas of specialization identified by the department. Specialized curriculum shall be determined for each of the categories of peer, parent, transition-age, and family support specialists listed in subdivision (b). Core competencies-based curriculum shall include, at a minimum, all of the following elements:

(1) The concepts of hope, recovery, and wellness.

(2) The role of advocacy.

(3) The role of consumers and family members.

(4) Psychiatric rehabilitation skills and service delivery, and addiction recovery principles, including defined practices.

(5) Cultural competence training.

(6) Trauma-informed care.

(7) Group facilitation skills.

(8) Self-awareness and self-care.

(9) Cooccurring disorders of mental health and substance use.

(10) Conflict resolution.

(11) Professional boundaries and ethics.

(12) Safety and crisis planning.

(13) Navigation of, and referral to, other services.

(14) Documentation skills and standards.

(15) Study and test-taking skills.

(e) Specify training requirements, including core-competencies-based training and specialized training necessary to become certified under this article, allowing for multiple qualified training entities, and requiring training to include people with lived experience as consumers and family members.

(f) Specify required continuing education requirements for certification.

(g) Determine clinical supervision requirements for personnel certified under this article, that shall require, at a minimum, personnel certified pursuant to this article to work under the direction of a mental health rehabilitation specialist, as defined in Section 782.35 of Title 9 of the California Code of Regulations, or substance use disorder professional. A licensed mental health professional, as defined in Section 782.26 of Title 9 of the California Code of Regulations, may also provide supervision.

(h) Establish a code of ethics.

(i) Determine the process for certification renewal.

(j) Determine a process for revocation of certification.

(k) Determine a process for allowing existing personnel employed in the peer support field to obtain certification under this article, at their option.

14045.15. In order to be certified as an adult peer support specialist, an individual shall, at a minimum, satisfy all of the following requirements:

(a) Be at least 18 years of age.

(b) Have or have had a primary diagnosis of mental illness, substance use disorder, or both, which is self-disclosed.

(c) Have received or is receiving mental health services, substance use disorder services, or both.

(d) Be willing to share his or her experience of recovery.

(e) Demonstrate leadership and advocacy skills.

(f) Have a strong dedication to recovery.

(g) Agree to uphold and abide by a code of ethics. A copy of the code of ethics shall be signed by the applicant.

(h) Successful completion of the curriculum and training requirements for an adult peer support specialist.

(i) Pass a certification examination approved by the department for an adult peer support specialist.

(j) Successful completion of any required continuing education, training, and recertification requirements.

14045.16. In order to be certified as a transition-age youth peer support specialist, an individual shall, at a minimum, satisfy all of the following requirements:

(a) Be at least 18 years of age.

(b) Have or have had a primary diagnosis of mental illness, substance use disorder, or both, which is self-disclosed.

(c) Have received or is receiving mental health services, substance use disorder addiction services, or both.

(d) Be willing to share his or her experience of recovery.

(e) Demonstrate leadership and advocacy skills.

(f) Have a strong dedication to recovery.

(g) Agree to uphold and abide by a code of ethics. A copy of the code of ethics shall be signed by the applicant.

(h) Successful completion of the curriculum and training requirements for a transition-age youth peer support specialist.

(i) Pass a certification examination approved by the department for a transition-age youth peer support specialist.

(j) Successful completion of any required continuing education, training, and recertification requirements.

14045.17. In order to be certified as a family peer support specialist, an individual shall, at a minimum, satisfy all of the following requirements:

(a) Be at least 18 years of age.

(b) Be self-identified as a family member of an individual experiencing mental illness, substance use disorder, or both.

(c) Be willing to share his or her experience.

(d) Demonstrate leadership and advocacy skills.

(e) Have a strong dedication to recovery.

(f) Agree to uphold and abide by a code of ethics. A copy of the code of ethics shall be signed by the applicant.

(g) Successful completion of the curriculum and training requirements for a family peer support specialist.

(h) Pass a certification examination approved by the department for a family peer support specialist.

(i) Successful completion of any required continuing education, training, and recertification requirements.

14045.18. In order to be certified as a parent peer support specialist, an individual shall, at a minimum, satisfy all of the following requirements:

(a) Be at least 18 years of age.

(b) Be self-identified as a parent, as defined in Section 14045.13.
(c) Be willing to share his or her experience.
(d) Demonstrate leadership and advocacy skills.
(e) Have a strong dedication to recovery.
(f) Agree to uphold and abide by a code of ethics. A copy of the code of ethics shall be signed by the applicant.
(g) Successful completion of the curriculum and training requirements for a parent peer support specialist.
(h) Pass a certification examination approved by the department for a parent peer support specialist.
(i) Successful completion of any required continuing education, training, and recertification requirements.

14045.19. This article shall not be construed to imply that an individual who is certified pursuant to this article is qualified to, or authorize that individual to, diagnose an illness, prescribe medication, or provide clinical services.

14045.20. The department shall closely collaborate with the Office of Statewide Health Planning and Development (OSHPD) and its associated workforce collaborative, and regularly consult with interested stakeholders, including peer support and family organizations, mental health and substance use disorder services providers and organizations, the County Behavioral Health Directors Association of California, health plans participating in the Medi-Cal managed care program, the California Behavioral Health Planning Council, and other interested parties in developing, implementing, and administering the peer, parent, transition-age, and family support specialist certification program established pursuant to this article. This consultation shall initially include, at a minimum, bimonthly stakeholder meetings, which may also include technical workgroup meetings. The department may seek private funds from a nonprofit organization or foundation for this purpose.

14045.21. The department may contract to obtain technical assistance for the development of the peer, parent, transition-age, and family support specialist certification program, as provided in Section 4061.

14045.22. (a) The department shall amend its Medicaid state plan to do both of the following:
(1) Include each category of peer, parent, transition-age, and family support specialist listed in subdivision (b) of Section

14045.14 certified pursuant to this article as a provider type for purposes of this chapter.

(2) Include peer support specialist services as a distinct service type for purposes of this chapter, which may be provided to eligible Medi-Cal beneficiaries who are enrolled in either a Medi-Cal managed mental health care plan or a Medi-Cal managed care health plan.

(b) The department may seek any federal waivers or other state plan amendments as necessary to implement the certification program provided for under this article.

(c) Medi-Cal reimbursement for peer support specialist services shall be implemented only if and to the extent that federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) is available and all necessary federal approvals have been obtained.

14045.23. To facilitate early intervention for mental health services, community health workers may partner with peer, parent, transition-age, and family support specialists for engagement, outreach, and education.

14045.24. It is not the intent of the Legislature in enacting this article to modify the Medicaid state plan in any manner that would otherwise change or nullify the requirements, billing, or reimbursement of the "other qualified provider" provider type, as currently authorized by the Medicaid state plan.

14045.25. The department may utilize Mental Health Services Act funds under subdivision (d) of Section 5892 and any designated Workforce Education and Training Program resources, including funding, as administered by OSHPD pursuant to Section 5820, to develop and administer the peer, parent, transition-age, and family support specialist certification program. Further, these Mental Health Service Act funds may then serve as the state's share of funding to develop and administer the peer, parent, transition-age, and family support specialist certification program and shall be available for purposes of claiming federal financial participation under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) once all necessary federal approvals have been obtained.

14045.26. The department may establish a certification fee schedule and may require remittance as contained in the certification fee schedule for the purpose of supporting the

department's activities associated with the ongoing state administration of the peer, parent, transition-age, and family support specialist certification program. The department shall utilize all funding resources as made available in Section 14045.25 first, prior to determining the need for the certification fee schedule and requiring the remittance of fees. It is the intent of the Legislature that any certification fees charged by the department be reasonable and reflect the expenditures directly applicable to the ongoing state administration of the peer, parent, transition-age, and family support specialist certification program.

14045.27. For the purposes of implementing this article, the department may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for the purpose of obtaining subject matter expertise or other technical assistance. Contracts may be statewide or on a more limited geographic basis.

14045.28. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this article by means of plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action, until the time regulations are adopted. The department shall adopt regulations by July 1, 2021, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Commencing July 1, 2019, the department shall provide semiannual status reports to the Legislature, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

SEC. 2. The Legislature finds and declares that this act clarifies procedures and terms of the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.

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AGENDA ITEM 10

Information

January 25, 2018 Commission Meeting

Statewide Suicide Prevention Strategic Plan

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will hear a draft work plan for development of a Statewide Suicide Prevention Strategic Plan. Under Section 18 of Assembly Bill 114 (Chapter 38, Statutes of 2017), the Legislature appropriated $100,000 to the MHSOAC to support development of the Plan. These funds must be expended or encumbered by June 30, 2018.

This work plan will be presented to the project subcommittee for discussion and further development.

Presenters: Brian R. Sala, Ph.D., Deputy Director for Evaluation and Program Operations**,** and Ashley Mills, Senior Researcher and Project Lead.

Enclosures (1): (1) Section 18, Assembly Bill 114 (Chapter 38, Statutes of 2017), Section 18.

Handouts (2): (1) Draft Project Work Plan; (2) PowerPoint Presentation.

AGENDA ITEM 10

Information

January 25, 2018 Commission Meeting

Statewide Suicide Prevention Strategic Plan

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will hear a proposed work plan for development of a Statewide Suicide Prevention Strategic Plan. Under Section 18 of Assembly Bill 114 (Chapter 38, Statutes of 2017), the Legislature appropriated $100,000 to the MHSOAC to support development of the Plan. These funds must be expended or encumbered by June 30, 2018.

Presenters: Brian R. Sala, Ph.D., Deputy Director for Evaluation and Program Operations**,** and Ashley Mills, Senior Researcher and Project Lead.

Enclosures (1): (1) Section 18, Assembly Bill 114 (Chapter 38, Statutes of 2017), Section 18.

Handouts (2): (1) Proposed Project Work Plan; (2) PowerPoint Presentation.

Assembly Bill No. 114

CHAPTER 38

An act to amend Sections 1627, 1630, 102247, 103605, 103625, and 127662 of, to add Section 1629.5 to, and to repeal and add Section 127665 of, the Health and Safety Code, and to amend Sections 5892 and 5899 of, and to add Sections 5892.1 and 5899.1 to, the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor July 10, 2017. Filed with Secretary of State July 10, 2017.]

LEGISLATIVE COUNSEL'S DIGEST

AB 114, Committee on Budget. Public health.

Existing law requests the University of California to establish and administer the Umbilical Cord Blood Collection Program, until January 1, 2018, for the purpose of collecting units of umbilical cord blood for public use, as defined, in transplantation and providing nonclinical units for specified research.

This bill would extend the provisions of the program until January 1, 2023. The bill would also require the University of California, by January 1, 2022, if it elects to administer the program, to provide a report to the Assembly and Senate Committees on Health that addresses various topics relating to the program, including, among other things, the number of cord blood units collected and registered under the program, disaggregated by race and ethnicity.

Until January 1, 2018, existing law requires an applicant to pay an $18 fee for a certified copy of a birth certificate, except as specified. Existing law requires $2 of the $18 fee to be paid to the Umbilical Cord Blood Collection Program Fund. Moneys in the fund are available, upon appropriation by the Legislature, for purposes of the Umbilical Cord Blood Collection Program.

This bill would extend until January 1, 2023, the requirement that an applicant pay an $18 fee for a certified copy of a birth certificate and the requirement that $2 of that $18 fee be paid to the Umbilical Cord Blood Collection Program Fund. The bill would make conforming changes to related provisions.

Under existing law, the University of California has established the California Health Benefit Review Program pursuant to a request by the Legislature. Under existing law, specified members of the Legislature are authorized to request analysis by the university of legislation that proposes to mandate a health benefit or service or proposes to repeal a mandated health benefit or service, as defined. Under existing law, the university is

Page 2 Omitted

findings and declarations stating that the provisions of this bill are consistent with, and further the intent of, the act.

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

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

This bill would appropriate $100,000 from the Mental Health Services Fund to the Mental Health Services Oversight and Accountability Commission to develop a statewide suicide prevention plan.

This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.

Appropriation: yes.

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

SECTION 1. Section 1627 of the Health and Safety Code is amended to read:

1627. (a) (1) On or before July 1, 2011, the University of California is requested to develop a plan to establish and administer the Umbilical Cord Blood Collection Program for the purpose of collecting units of umbilical cord blood for public use in transplantation and providing nonclinical units for research pertaining to biology and new clinical utilization of stem cells derived from the blood and tissue of the placenta and umbilical cord. The program shall conclude no later than January 1, 2023.

(2) For purposes of this article, "public use" means both of the following:

(A) The collection of umbilical cord blood units from genetically diverse donors that will be owned by the University of California. This inventory shall be accessible by the National Registry and by qualified California-based and other United States and international registries and transplant centers to increase the likelihood of providing suitably matched donor cord blood units to patients or research participants who are in need of a transplant.

(B) Cord blood units with a lower number of cells than deemed necessary for clinical transplantation and units that meet clinical requirements, but for other reasons are unsuitable, unlikely to be transplanted, or otherwise unnecessary for clinical use, may be made available for research.

(b) (1) In order to implement the collection goals of this program, the University of California may, commensurate with available funds appropriated to the University of California for this program, contract with one or more selected applicant entities that have demonstrated the competence to collect and ship cord blood units in compliance with federal guidelines and regulations.

Pages 4-17 Omitted

(1) Children's systems of care.
(2) Prevention and early intervention strategies.
(3) Innovative projects.
(4) Workforce education and training.
(5) Adults and older adults systems of care.
(6) Capital facilities and technology needs.

(e) If a county does not submit the annual revenue and expenditure report described in subdivision (a) by the required deadline, the department may withhold MHSA funds until the reports are submitted.

(f) By October 1, 2018, and by October 1 of each subsequent year, the department shall, in consultation with counties, publish on its Internet Web site a report detailing funds subject to reversion by county and by originally allocated purpose. The report also shall include the date on which the funds will revert to the Mental Health Services Fund.

SEC. 16. Section 5899.1 is added to the Welfare and Institutions Code, to read:

5899.1. (a) On or after July 1, 2017, funds subject to reversion pursuant to subdivision (h) of Section 5892 shall be reallocated to other counties for the purposes for which the unspent funds were initially allocated to the original county.

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this section, Section 5892.1, and subdivision (h) of Section 5892, by means of all-county letters or other similar instructions, until applicable regulations are adopted in accordance with Section 5898, or until July 1, 2019, whichever occurs first. The all-county letters or other similar instructions shall be issued only after the department provides the opportunity for public participation and comments.

SEC. 17. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 18. The sum of one hundred thousand dollars ($100,000) is hereby appropriated from the Mental Health Services Fund to the Mental Health Services Oversight and Accountability Commission for the purpose of developing a strategic statewide suicide prevention plan. These funds shall be available for encumbrance or expenditure until June 30, 2018.

SEC. 19. The Legislature finds and declares that this act is consistent with, and furthers the intent of, the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.

SEC. 20. This act is a bill providing for appropriations related to the Budget Bill within the meaning of subdivision (e) of Section 12 of Article IV of the California Constitution, has been identified as related to the budget in the Budget Bill, and shall take effect immediately.

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