Commission Packet

Commission Meeting
April 26, 2018

Hilton Anaheim
777 W Convention Way
Anaheim, CA 92802

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

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

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

April 26, 2018
9:00 AM – 4:00 PM

Hilton Anaheim
777 W Convention Way
Anaheim, CA 92802

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.

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Approximate Times

9:00 AM **Convene and Welcome**
Chair John Boyd, Psy.D., will convene the Mental Health Services Oversight and Accountability Commission Meeting. Roll call will be taken.

9:05 AM **Consumer Engagement**
Elyn Saks will open the Commission meeting with her story of recovery and resilience.

9:40 AM **Action**
1: Approve March 22, 2018 MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the March 22, 2018 meeting.

- Public Comment
- Vote

9:45 AM **Action**
2: Los Angeles County Innovation Plans
Presenters:

- Jonathan Sherin, M.D., Ph.D., Los Angeles County Director
- Debbie Innes-Gomberg, Ph.D., Los Angeles County Deputy Director
- Marc Heiser, M.D., Los Angeles County Psychiatry Specialist

The Commission will consider approval of $2,499,102 to support the Los Angeles Mobile Transcranial Magnetic Stimulation Innovation Projects, and $9,874,886 for the Peer Support Specialist Full Service Partnership Innovation Project.

- Public Comment
- Vote

10:45 AM **Action**
3: Orange County and Modoc County Innovation Plans
Presenters:

- Jeffrey A. Nagel, Ph.D., Orange County Director
- Sharon Ishikawa, Ph.D., Orange County MHSA Coordinator
- Flor Yousefian Tehrani, Psy.D., LMFT, Orange County Program Manager
- Karen Stockton, Ph.D., Modoc County Director
- Rhonda Bandy, Ph.D., Modoc County MHSA Program Manager
- Guillermo Diaz, MBA, Modoc County Peer Specialist
- Adelaida B. More, Executive Director, Sunray's of Hope, Inc.
- Ronald Gilbert, Operations Manager, Sunray's of Hope, Inc.
- Karin Kalk, MA, Director, California Institute for Behavioral Health Solutions

The Commission will consider approval of $24,000,000 to support the Orange County Mental Health Technology Solutions Innovation Project, and $270,000 to support the Modoc County Mental Health Technology Suite Innovation Project. Both Innovation plans are part of the Technology Solutions Collaboration Project.

- Public Comment
- Vote

11:45 PM **General Public Comment**
Members of the public may briefly address the Commission on matters not on the agenda.

12:00 PM **Lunch Break**

1:15 PM **Information**
4: 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 Enclosed:
(1) The Motions Summary from the March 22, 2018 Commission Meeting; (2) Evaluation Dashboard; (3) Calendar of Commission activities; (4) Innovation Review Outline; (5) Innovation Dashboard; and (6) Department of Health Care Services Revenue and Expenditure Reports status update

1:30 PM **Information**
5: California State Auditor's February 2018 Report on the Mental Health Services Act
Presenter: Toby Ewing, Ph.D., Executive Director

The Commission will be presented with details regarding the State Auditor's February 2018 Report on the Mental Health Services Act.

- Public Comment

1:50 PM **Action**
6: Award Senate Bill 82 Children's Triage Program Grants
Presenters:

- Tom Orrock, Chief of Commission Operations and Grants
- Kristal Antonicelli, Project Lead

The Commission will consider the award of the Triage Program grants in response to the Request for Applicants released by the Commission in February 2018.

- Public Comment
- Vote

2:00 PM **Action**
7: Evaluation Contracts Approval
Presenter: Brian Sala, Ph.D., Deputy Director

The Commission will consider approval of one or more contracts in an amount not to exceed $1.4 million to support statewide evaluation of Mental Health Services Act programs.

- Public Comment
- Vote

2:20 PM **Action**

8: Approval of Innovation Funds for Community Planning of Innovation Projects

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

The Commission will consider whether to approve use of Innovation funds to support counties' community program planning for Innovation and San Diego County's request to use $100,000 of Innovation funds to support a human-centered design project for its community program planning for a future Innovation project.

- Public Comment
- Vote

2:50 PM **Information**

9: Draft Business Plan for Innovation Incubator

Presenters:

- Toby Ewing, Ph.D., Executive Director
- David Smith, Consultant, X-SECTOR LAB

The Commission will be presented with a draft business plan for the creation of an Innovation Incubator and an overview of the Innovation Summit.

- Public Comment

3:30 PM **Action**

10: Legislation

Presenters:

- Toby Ewing, Ph.D., Executive Director
- Norma Pate, Deputy Director

The Commission will consider whether to support legislation related to mental health services under the Mental Health Services Act.

- Public Comment
- Vote

3:45 PM **General Public Comment**

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

4:00 PM **Adjourn**

AGENDA ITEM 1

Action

April 26, 2018 Commission Meeting

Approve March 22, 2018 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the March 22, 2018 meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None.

Enclosures: (1) March 22, 2018 Commission Meeting Minutes.

Handouts: None.

Recommended Action: Approve March 22, 2018 Meeting Minutes.

Proposed Motion: The Commission approves the March 22, 2018 Meeting Minutes.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
March 22, 2018

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

866-817-6550; Code 3190377

Members Participating:

John Boyd, Psy.D., Chair
Khatera Aslami-Tamplen, Vice Chair
Mayra Alvarez
Jim Beall
Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
David Gordon
Mara Madrigal-Weiss
Gladys Mitchell

Members Absent:

Reneeta Anthony
Lynne Ashbeck
Sheriff Bill Brown
Wendy Carrillo
Larry Poaster
Tina Wooton

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Kristal Antonicelli, Health Program Specialist and RFA Lead
Tom Orrock, Chief, Commission Operations and Grants
Sharmil Shah, Psy.D., Chief, Program Operations

CONVENE AND WELCOME

Chair John Boyd called the meeting of the Mental Health Services Oversight and Accountability Commission to order at 9:23 a.m. and welcomed everyone.

Meeting Calendar

Chair Boyd stated that the April 26th meeting will be held in Anaheim and the May 24th meeting will be held in Sacramento. The Anaheim location will soon be announced.

Youth Participation

Chair Boyd stated the Commission made a commitment to include a young person around the table at every Commission meeting to learn the Commission process and to give their perspective on issues. He asked Smitha Gundavajhala to introduce herself.

Smitha Gundavajhala stated she is part of Young Minds Advocacy, an organization that focuses on children's mental health and improving access to quality mental health care for young people and their families. She studied public health at the University of California, Berkeley where she learned to advocate for college students and the mental health challenges they face. She stated she later learned that the challenges that college students face are emblematic of the larger challenges that young people face when it comes to accessing mental health care. She commended the Commission for their intentional efforts to include young people's voices in the conversation.

New Personnel

Sharmil Shah, Psy.D., Chief, Program Operations, introduced two new staff members: Jeff Kukral, Plan Review team, and Kara Chung, Prevention and Early Intervention team.

CONSUMER ENGAGEMENT

Chair Boyd suggested at the February Commission meeting that future Commission meetings should begin with an individual with lived experience sharing their story. He stated the hope that this will be a part of Commission meetings hereafter. In keeping with that suggestion, the Commission has invited Jessie Wright to share her story.

Jessie Wright, National Alliance on Mental Illness (NAMI), shared her story of growing up with mental illness, dropping out of high school, getting into drugs, having experiences with law enforcement and first responders, being taken to the Sacramento Mental Health Center, being diagnosed as paranoid, schizophrenic, and manic depressive, and becoming homeless but not thinking anything was wrong with her. She stated she would take her medication but stop when she felt she was okay.

Ms. Wright stated her daughter began to take care of her siblings and mother from the time she was in fourth grade. She stated her daughter took her back to the Sacramento Mental Health Center in 2010. Ms. Wright was in grad school at the time. Her daughter is 44 years old today and is still her family's support. Family support is important.

In 2012, 12-Step Recovery took Ms. Wright to the hospital, where they put her on a different medication that she is still on today. Ms. Wright stated she had to get treatment, stay with that treatment, become medication compliant, and accept that she had a mental illness. She stated she still struggles with that acceptance today.

Ms. Wright stated she advocates for others, gets involved, and loves what she does. She stated her passion is to see others come out of denial, get into treatment, and begin the healing process. Recovery is a continuous process that lasts a lifetime.

Commissioner Comments

Commissioner Mitchell applauded Ms. Wright and stated she appreciated her resilience and the whole notion of hanging in there and obtaining a Master's Degree. She stated Jessie Wright is a model.

Vice Chair Aslami-Tamplen stated Jessie Wright's story is inspirational. In sharing it, Ms. Wright is spreading the message of hope that recovery is possible and that the journey is nonlinear. She stated sometimes there are setbacks but, with support and the right resources, recovery is possible for all.

Commissioner Madrigal-Weiss thanked Jessie Wright for keeping it real. She stated meetings contain a lot of paperwork and formalities, but if it is not kept real by hearing the everyday stories, Commissioners can get lost in the bureaucracy and business.

Roll Call

Filomena Yeroshek, Chief Counsel, called the roll and announced a quorum was not present. She suggested skipping Agenda Item 1, the approval of the meeting minutes, until later in the meeting and beginning with Agenda Item 2, Schools and Mental Health Panels. A quorum was established during the afternoon session.

[Note: Agenda item 1 was moved to the afternoon. These minutes reflect the Agenda Item 1 as listed on the agenda and not as taken in chronological order.]

ACTION

1: Approve February 8, 2018, and February 22, 2018, MHSOAC Meeting Minutes

Public Comment

Rory O'Brien, LGBTQ Program Coordinator, Mental Health America of Northern California (NorCal MHA), Project Coordinator, Out for Mental Health, referred to page 19 of the February 22, 2018, meeting minutes and stated the following statement is not correct: "phenotyping feature only be used with clients who have been provided with in-person consent counseling and that the counseling be an opt-in process." The correct statement that the speaker made was that the digital phenotyping feature be an opt-in process contingent upon the counseling not that the counseling be an opt-in.

Action: Vice Chair Aslami-Tamplen made a motion, seconded by Chair Boyd, that:

The Commission approves the February 8, 2018, and February 22, 2018, Meeting Minutes.

Motion carried 5 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Madrigal-Weiss, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

The following Commissioners abstained: Commissioners Bunch, Danovitch, and Gordon.

INFORMATION

2: Schools and Mental Health Panels

Commissioner Gordon stated today's panel sessions represent another stage in the journey towards building a system, which hopefully will join school and mental health systems together in partnership. He stated the hope that those partnerships will be more than just on paper and through grants but on the ground where services need to be available where children and families can most readily access them.

Commissioner Gordon stated parents ask him why services were not made available when kindergarten and first grade teachers noticed issues with their children, but instead took until fifth, sixth, or seventh grade for their children's situations to get bad enough that services were offered. He spoke against a fail-first system and stated the need to ensure that it is not.

Commissioner Gordon stated staff put together panels of outstanding leaders to discuss why Prevention and Early Intervention (PEI) is important and how it can be done at the local and state levels. He thanked the panel members in advance for their willingness to present and for their remarks.

Commissioner Gordon highlighted the consideration section of the Issue Brief, which was included in the meeting packet. He stated the questions at the end of the Issue Brief are worthy of consideration by the Commission. He invited the members of the Subcommittee to offer comments.

Commissioner Madrigal-Weiss stated the need to take action now while there is great interest.

Commissioner Mitchell stated she looked forward to making improvements with mental health in schools, especially at the earliest point of intervention. She stated more than anything relationships need to be built within schools. She stated programs and mental health providers can be brought in but there has to be trust so the work is done as a team to help children and families.

Panel 1: The Lived Experience of Childhood Trauma and Resilience

- Emmerald Evans, Founding Member of Seneca Family of Agencies Youth Advisory Board
- Jakaar Brandon, Transition Age Youth Advocate and Peer Counselor, Member of Seneca Family of Agencies

Jakaar Brandon

Jakaar Brandon, Transition Age Youth Advocate and Peer Counselor, Member of Seneca Family of Agencies, emphasized that, rather than his title, first, he is a human. He shared his story of living in group homes since the age of 12, taking medication at an early age, being in children's mental health since the age of four, and having seen many psychiatrists and psychologists who he felt never listened. He stated, at the age of 26, he finally has come to the point where he knows where he is going.

Mr. Brandon stated one of his recommendations is a change in the curriculum and training for all who work in schools. The Seneca Family of Agencies has a two-week training called New Employee Orientation (NEO), which is training from individuals who have had the same experience of group homes and trauma and who can explain their experiences and discuss them. He stated individuals with lived experience should do the training. Individuals with a Master's Degree do not necessarily understand. He stated counselors, therapists, and social workers at the schools need training along with the teachers and school staff so they can better understand the need.

Emmerald Evans

Emmerald Evans, Founding Member of the Seneca Family of Agencies Youth Advisory Board, stated she is 19 years old and a student at Sacramento State University. She shared her story of living in foster care and group homes from the age of six. That unstable and nonnurturing environment with inconsistent mental health services and resources led to behavioral issues and inconsistencies in her academics.

Ms. Evans stated, over time, she was blessed with key, lasting relationships, which enabled her to be resilient. She suggested that schools and communities provide spaces, forums, and groups for students to explore past experiences and ongoing needs. There should always be access to licensed mental health professionals in case of mental crises or life stresses. She stated administrators and staff should consistently develop a culture that eliminates the stigma of mental health and trauma, allowing students to feel safe and reach out for help and support from one another.

Ms. Evans stated one of the biggest things she wished she had when going through the foster care system is consistency and stabilization. Ms. Evans stated she had the same lawyer throughout her foster care experience, from 6 to 18 years of age, who loved and appreciated her. That consistency is what grounded her. She stated she did not know what her purpose was until she turned 18 and became a leader to someone else. She stated understanding childhood trauma and breaking the stigma about mental illness are important strategies to finding help for these individuals. These children may not know they need help, but individuals who have lived through it know. Compassion is needed.

Commissioner Questions

Chair Boyd asked if Ms. Gundavajhala would share her perspective. She stated her heart is both heavy and full hearing the previous speakers' experiences. She stated their bravery is huge – not only in how they have moved forward and upward from everything they went through, but also in surviving and being willing to share their stories today. Those stories will be an inspiration to many individuals who may be listening or are present at the meeting.

Ms. Gundavajhala stated Mr. Brandon spoke about the importance of training programs for teachers and faculty to equip them to recognize mental health challenges that would be informed by young people with trauma-lived experience. She asked why he thought it was important for young people with those experiences to be informing, leading, and driving the process at all levels.

Mr. Brandon stated it gives them more of a purpose that they can see. Individuals with mental and physical challenges who have lived through these experiences and who have been that troubled person on the front line growing up have a voice. Being involved in training programs and peer-led groups gives them a sense of self-worth and possibly a career out of something that they have lived.

Ms. Gundavajhala stated advocacy can be a form of healing and moving forward positively from pain and negative experiences. She stated teachers can often be squeezed between needing to serve students with all the performance expectations placed on them by administration. They are the individuals who interact with young people on a daily basis. She asked Mr. Brandon about his thoughts on restorative justice opportunities and programs for young people whose schools are not often equipped to recognize or handle their mental health challenges.

Mr. Brandon stated teachers who think a child acts out because he is bad do not allow a relationship to be built. Training should be given regardless of funding because it will help teachers to better understand young people and to build relationships. Teachers should have compassion as a human being that someone is going through something instead of immediately thinking that the child is going crazy and call law enforcement.

Commissioner Mitchell stated she heard Mr. Brandon say it would have helped to have individuals in the classroom who were empathetic to the situation and recognized that there was more going on there than just an out-of-control student. Mr. Brandon agreed.

Commissioner Mitchell stated hopefully an effective change can be made to the process that trains educators. She agreed that teachers have benchmarks to hit in the classroom and administrative tasks and that it is necessary to have someone in the classroom to help build that relationship from the point in which the mental health issues appear. Teachers see it more often than anyone because the child is with them all day. She stated she does not know what the answer is but it probably is somewhere in that training and the Commission doing something with the requirements of educators.

Commissioner Bunch agreed that training from individuals with lived experience is important. She stated she was particularly sad to hear that the panel members felt so unheard for so many years. She stated it is not just an issue of training so teachers and social workers know where individuals with lived experience are coming from, because they already do. What happens over time is that teachers and social workers get frustrated and disillusioned by the same systems that are letting individuals with lived experience down and they get desensitized.

Commissioner Bunch stated one of the things the Commission has to think about to intervene is how to support teachers and social workers and find ways to decrease vicarious trauma that is not being addressed and help them get past the barriers. She stated teachers and social works can have all the empathy in the world, but if there is no way for them to help, then the only way they can help themselves is to start to feel less.

Commissioner Gordon stated the Commission recently had an opportunity to visit the school in Richmond that had a Seneca Family of Agencies team that provided a support system around the teachers and other personnel. He asked Ms. Evans to share what

Seneca Family of Agencies does to make to make those supports and to provide consistency for students and faculty.

Ms. Evans stated she is familiar with that program but did not deal with Seneca Family of Agencies at school. She agreed that consistency is important. Consistency in the support and the person working with the young people helps to break down those barriers so the professionals see the young people as humans.

Commissioner Madrigal-Weiss asked Mr. Brandon for more detail on his suspensions. Mr. Brandon stated he has gone to approximately 60 percent of the schools in Vallejo.

Commissioner Madrigal-Weiss asked if the reason he was expelled from school was because of his behavior. Mr. Brandon stated it was.

Commissioner Madrigal-Weiss stated one of the reasons restorative justice and restorative practices are discussed is because it is about behavior and discipline. She stated schools are looking at doing things differently because behavior and mental health issues need to be considered. Schools cannot continue to expel students.

Commissioner Madrigal-Weiss stated she agreed that faculty and staff require training. School counselors, social workers, and psychologists need training, but the reality is that students spend more time with their instructors. Teachers need to understand things differently and respond differently. She stated, while teachers are already trained and are under pressure to meet academic standards, they do not need to understand all mental health issues. Teachers only need to be trained to ask the right questions, which align with trauma-informed practice.

Commissioner Madrigal-Weiss stated, when teachers stop asking what is wrong with a student and, instead, frame the question as what happened to the student, they will behave differently. Including persons with lived experience in a leadership position during those trainings is much more powerful than handing teachers a manual. She thanked the speakers for presenting today and for reminding the Commission that it needs to take that into consideration. There is a lot of work yet to do.

Commissioner Mitchell agreed. She stated the Commission's work is to somehow inform or educate teachers on these issues so they better recognize students with needs. She stated the need to insert the training into the requirements for teachers.

Commissioner Gordon stated the school in Richmond recognized that any training given to teachers or anyone else is in their past or is episodic. Teachers go to a training, go back to work, and the training is done. But the Richmond school created a team of individuals who work together to help teach each other the kinds of ways they should be responding to situations. He stated the teachers learn from each other. They have created a culture within the school that responded to young people in a way that was restorative rather than punitive. He stated it is that culture and that team at the school who are continually reinforcing that that will make a huge difference.

Ms. Gundavajhala stated the youth voice is the credibility and the expertise that teachers need to be effective, because young people are the population that teachers are trying to serve. She stated the need to continue the conversation on not just how to

make it easier for teachers to support young people, but also to continue to elevate what young people have to say about their own experiences as they move through their education. She thanked the panel members for being a part of that process.

Panel 2: Understanding Early Childhood Mental Health: Risks, Disparities, and Educational Outcomes

- Chandra Ghosh Ippen, Ph.D., Associate Director, Child Trauma Research Program, University of California, San Francisco
- Gustavo Loera, Ed.D., Mental Health and Education Research Consultant, Center for Reducing Health Disparities, University of California, Davis

Chandra Ghosh Ippen, Ph.D.

Chandra Ghosh Ippen, Ph.D., Associate Director, Child Trauma Research Program, University of California, San Francisco, stated she is a mental health professional working with children in the zero- to six-year-old range. She stated the need for a work force that is trained to identify and support families much earlier. She provided an overview, with a slide presentation, on understanding early childhood mental health risks, disparities, and educational outcomes.

Dr. Ghosh Ippen stated all teachers need to be taught to question if children are ADHD or if they do not focus so well and move around a lot because of trauma. It is not what is wrong with a child; it is what happened to a child. All behavior has meaning. The question is whether the meaning is being attended to. Schools do a lot for learning disorders but not if children are delayed in terms of emotion regulation.

Dr. Ghosh Ippen stated a child's history never goes away but, if a child can turn, process, and make meaning of their history, they can carry it differently. Positive experiences matter, such as competence-enhancing activities, safe environments, supportive relationships, and community support.

Dr. Ghosh Ippen stated it is important to recognize that trauma is powerful learning. It is not about what children remember, it is about what they learned about safety, feelings, and themselves. She stated, as a professional, she understands that she has to earn safety and trust with children. Everyday little interactions like telling a child they are worthy and they are safe bring about change.

Commissioner Questions and Discussion

Commissioner Mitchell asked how this presentation can be shown in schools because this is what educators need.

Commissioner Bunch suggested combining Dr. Ghosh Ippen's presentation with the presentations from Panel 1 and creating a program for schools.

Gustavo Loera, Ed.D.

Gustavo Loera, Ed.D., Mental Health and Education Research Consultant, Center for Reducing Health Disparities, University of California, Davis, provided an overview, with a slide presentation, on the importance of prevention, early detection, and timely

treatment of mental disorders. He stated the onset of mental disorders usually occur in childhood or adolescence; however, treatment typically does not occur until years later.

Dr. Loera stated that in his written statement, which is included in the meeting packet, he provided stories of youth whose mental health issues went undetected and untreated as children and who are now struggling as youth. He showed a presentation slide of "El Wango," a child in crisis. El Wango is translated as "baggy pants" because most of his clothes were hand-me-down clothes from other families. He stated El Wango's story illustrates the many risk factors and adversities that he and children like him face on a daily basis. His story is a reminder that failure to work with schools to identify and find effective school-based mental health programs that focus on early detection and appropriate treatment could lead to more severe mental and physical conditions.

Dr. Loera displayed a slide of a model that speaks of two best practices that he has been involved with: NAMI On-Campus Clubs and the California Health Occupations Students of America (Cal-HOSA). These programs are student-led organizations for middle schools and high schools that give children and adolescents a sense of belonging, recognize them as an asset to the community, and help them discover a meaningful purpose and role in their school and community life.

Dr. Loera returned to the slide of El Wango. He stated the slide speaks to the value of educating and training teachers. He stated El Wango was on a trajectory towards a mental disorder but there was one educator who saw beyond the risk factors and tapped into the strength of this individual. He stated this educator who cared and showed compassion and empathy is the reason why El Wango is testifying before the Commission this morning. He thanked the Commission for the opportunity.

Commissioner Questions and Discussion

Commissioner Alvarez asked the presenters to discuss what this moment in particular means for advancing trauma-informed approaches, not only for children and immigrant families, but listing that as an experience that can be applied to children more broadly.

Dr. Loera agreed that it is said that children are not wanting to go to school as a result of the fear of their parents being deported. Children struggling with depression will not ask for help for that reason. He stated only nine percent of farm workers and their families use services. He stated that is another population being forgotten. He stated the LGBTQ community has a double stigma and, if they are undocumented, it adds another layer of stress. There are a lot of stressors that are impacting their ability to seek services and what they see on the television every day does not make it any easier for them to do so.

Dr. Ghosh Ippen stated she has to explain to children as young as two and three years of age who are having nightmares because someone could take their parent away and what will happen if they do. They are anxious and they see the faces of their parents as they worry. Then they go school on days after there have been raids and it makes sense that they will look hyperactive. They are not going to focus. When thinking of the protective shield, it is not just the caregivers that are failing those children, it is society.

Panel 3: Enhancing Opportunities for Prevention and Early Intervention

- Heather Little, M.Ed., Health Policy and Program Manager, First 5 Association of California
- Natalie Woods Andrews, Ed.D., Director, Early Learning Department, Sacramento County Office of Education
- Ruben Reyes, Superintendent, Robla School District
- Ron Powell, Ph.D., Special Education Consultant, Early Childhood Mental Health Advocate

Heather Little

Heather Little, M.Ed., Health Policy and Program Manager, First 5 Association of California, provided an overview, with a slide presentation, on expanding early intervention systems in California. She stated, much like the Mental Health Services Act (MHSA), First 5 is a proposition-driven initiative, but, unlike the MHSA, First 5 dedicates 100 percent of its funding specifically to those early prevention, early identification, and early intervention years. She highlighted First 5's advocacy efforts and investments to help find solutions such as the Help Me Grow initiative to connect children to early mental health services. She stated there is not a single teacher, pediatrician, day care provider, or parent who does not want the best for the child in their care. She stated it is also a reality that there is no one single solution. She stated First 5 does not think they have every answer but it knows it is important to be part of the conversation and to bring individuals together.

Natalie Woods Andrews, Ed.D.

Natalie Woods Andrews, Ed.D., Director, Early Learning Department, Sacramento County Office of Education (SCOE), provided an overview, with a slide presentation, on enhancing opportunities for PEI. She stated there is a growing body of research that is focused on the importance of early identification and early intervention, and the importance of building strong relationships and ensuring that comprehensive supports are in place for young children and their families.

Dr. Woods Andrews stated the importance of collaboration and coordinated services for that collective impact to ensure the wellbeing of young children and their families. She stated the result of a 15-month process was to develop the Sacramento County Early Learning Roadmap with five priority areas focusing on comprehensive and coordinated work, which was included in the meeting packet.

Dr. Woods Andrews stated SCOE is working in collaboration with First 5 in launching Help Me Grow Sacramento County to implement comprehensive services and supports for children and their families.

Ruben Reyes

Ruben Reyes, Superintendent, Robla School District, continued the slide presentation and discussed the Robla School District demographics, the district's application for a homeless grant, and the district's Local Control Accountability Plan for student

achievement and interventions, school climate, and parent involvement. He highlighted the current district activities being implemented around student mental health and their social-emotional growth, such as tripling the number of social workers currently working in the district.

Superintendent Reyes stated everyone needs to be involved in supporting children in a variety of ways, including school secretaries, custodians, and kitchen workers. School districts must see parents as partners and vice versa. He highlighted the importance of creating outside partnerships with First 5, the SCOE, and other organizations to help bring resources. Partners help schools reach families and provide the kinds of services that are necessary to bring about the stability that families need.

Ron Powell, Ph.D.

Ron Powell, Ph.D., Special Education Consultant, Early Childhood Mental Health Advocate, stated he was the Administrator of the Desert/Mountain Special Education Local Plan Area (SELPA). He stated the Desert/Mountain SELPA is one of six SELPAs in San Bernardino County. He provided an overview, with a slide presentation, on enhancing opportunities for PEI. He stated San Bernardino County is possibly the most rural location in the nation and is certainly the largest SELPA in the state of California. The rural nature of the Desert/Mountain SELPA is what caused the SELPA to focus on mental health.

Dr. Powell stated, as a consortium of 15 school districts and multiple charter schools, the SELPA was faced with the prospect of having to provide mental health services to the children in its region. The SELPA serves children who needed mental health services, has 25 therapists, and provides school-based mental health services including screening, assessment, referral, and treatment in over 300 schools in every district within the region. The SELPA served 11,000 children last year.

Dr. Powell stated professionals cannot help what happens to a child, but they can control how it is responded to. He stated that response cannot be limited to the creation of new programs or the collaboration of individuals who just want to do a better job for children. Efforts must be directed toward the installation of safety nets all the way up the river, not just the children who are going off the waterfall. It is each individual's responsibility to be that one supportive, caring person in that child's life to make the difference and enable them to be resilient.

Commissioner Questions and Discussion

Commissioner Danovitch stated, if the desire is for teachers to care for students and children, then those teachers need to be cared for. The Commission has not had time to characterize the duress that teachers are under. He asked how to create a climate that can take care of the caretakers to give them trainings, resources, and supports to help children.

Dr. Powell agreed that there is a need to understand that teachers have triggers and those triggers come from their own trauma history. He stated it is not just the teacher, it is everyone on the campus. It is the bus driver who sets the mood at the first of the day to the janitors and the cafeteria workers and everyone all along the way. Training is

necessary in programs but teachers also need supports to continue to build them up when they need the help. That also needs to be a part of whatever is done.

Panel 4: Strengthening California's Response to Children's Mental Health Needs

- Curtiss Sarikey, MSW., Chief of Staff, Oakland Unified School District
- Ted Lempert, J.D., President, Children Now

Curtiss Sarikey

Curtiss Sarikey, MSW., Chief of Staff, Oakland Unified School District, stated this problem is of great magnitude. The solutions must be grounded in equity by incentivizing collaboration among funding agencies, fields, professional domains, providers, schools, and community organizations to support families and caregivers, ensuring quality relationships for children across settings, supporting all pathways leading to kindergarten, building capacity of adults caring for and educating children, and creating healing environments.

Mr. Sarikey suggested a cradle-to-career vision that crosses over all the siloes, funding streams, agencies, and professional domains that have been created, working together to scale social and emotional and academic development and embed it in all systems, convening the research and practice community to develop an integrated model of social and emotional learning that includes restorative practices, trauma-informed and healing practices, mental health, culturally specific practices, parent and student engagement, and a multi-tiered system of supports, identifying family engagement and partnership with parents as a key component of mental health PEI, supporting programs and models, and ensuring that families are part of developing this component at the policy and practice levels.

Ted Lempert

Ted Lempert, J.D., President, Children Now, and former Legislator and County Supervisor, stated the need to prioritize children, break down the silos, screen elementary children for oral health, speech, and vision, and ensure that there is an intervention. He suggested implementing home visiting across the state, adopting culturally appropriate screening, outreach, and referral processes for all children, developing a cross-agency council that brings together agencies at a state level, and working with counties that have successful PEI programs to better understand what works. Mr. Lempert stated this has already been done five decades ago. He stated he knows it can be done again for every child today.

Commissioner Questions and Discussion

Commissioner Mitchell thanked Mr. Lempert for reminding the Commission that there were screenings in the past. She agreed that it can be done today.

Commissioner Alvarez stated the recurring theme throughout the panels has been the need to take care of children where they are and to emphasize as a priority taking care

of children's overall wellbeing. That priority needs to be kept at the forefront. She stated the first panel opened up with Jakaar saying first and foremost he is human. She stated the need to think of children and parents as humans and ensure that they receive the services they need where they are as individuals.

Commissioner Gordon stated what he heard today was that it needs to be one system, that the siloes have to go away, and that the resources have to be filled with well-trained personnel. He stated the need for these well-trained individuals to have the capacity to build relationships among one another, the students, and their families and learn from one another. He stated the need for timely universal access where and when the clients need it.

Commissioner Gordon stated another thing he gained was that it is necessary to intervene not when it is convenient for health systems or bureaucratic systems but at the earliest possible point – not just at preschool or kindergarten but before signs of needs emerge. He stated the need to intervene at that point to head off possible issues and challenges as the child progresses that the system would otherwise have to deal with later in the child's life.

Commissioner Gordon stated the thing that most struck him today was the power of the voices of the youth and how much could be learned, but oftentimes individuals do not take the time to listen to them to help shape and frame approaches to these problems.

Commission Danovitch stated that underfunding is the elephant in the room.

Ms. Gundavajhala stated when schools and mental health are discussed, it is considered a point of intervention, but there are upstream and downstream approaches and the stream continues lifelong.

Public Comment

Anna Hasselblad, Public Policy Manager, United Ways of California, stated United Ways of California is a member of the Children's Health Coverage Coalition and is championing a state budget proposal to reinvest in funding for the coordination of the array of services through the Healthy Start Initiative, which promotes PEI interventions that are trauma-informed and culturally competent.

Poshi Walker, LGBTQ Program Director, NorCal MHA, Co-Director, Out for Mental Health, and the California LGBT Health and Human Services Network, expressed concern that sexual orientation and gender identity issues have not yet been addressed in this schools and mental health project. LGBTQ children are overrepresented in the foster care system. Children who are identified as or perceived to be LGBTQ receive more frequent discipline and a greater severity of discipline than their cisgender and straight counterparts. Negative comments in the educational cumulative file can follow a child, amplifying implicit bias.

Rory O'Brien, LGBTQ Program Coordinator, NorCal MHA, Project Coordinator, Out for Mental Health, urged discussing curriculum in schools and how to talk about mental health in the curriculum at a young age. Schools must be prepared to respond to the needs of all youth in their classes including, in particular, the need of youth to

understand themselves and their classmates. The speaker suggested that the Commission read the National Sexuality Education Standards and consider it in discussions with districts and counites.

Sandra Marley, client advocate, stated Parliament has government and opposition and opposition is looked on as being a very vital part of government. The speaker suggested tuning in to Channel 6 at 9:00 p.m. on Sunday about parliament with British Prime Minister Theresa May and the opposition and how they address each other. The speaker distributed a handout with questions about Senate Bill (SB) 906 such whether the individuals doing the criteria and exams have lived experience.

GENERAL PUBLIC COMMENT

Robb Layne, Director of Communications and External Affairs, California Behavioral Health Directors Association (CBHDA), discussed the CBHDA's strategy as an association around the AB 114, MHSA Reversion. The speaker stated the CBHDA is working with county partners to track and benchmark the Innovation dollars subject to the prior reversion. The CBHDA will continue to work with staff to create transparent deadlines, and to be a facilitator between counties, Commission staff, and Department of Health Care Services (DHCS) staff to meet the July 1, 2018, deadline.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), referred to the February 22, minutes where it was reported that the speaker looked forward to hearing a summary report-out on the Innovation Summit. The speaker stated it was not on today's agenda but hoped there will be a report in the future. The speaker suggested that, if there is not time to present the report during a Commission meeting, perhaps the report can be posted online for public review.

Joy Torres, NorCal MHA Advancing Client and Community Empowerment through Sustainable Solutions (ACCESS) Ambassador, spoke about the importance of treatment. Mental illness causes individuals to become isolated. The most deserving of the services are the severely mentally ill who are wandering the streets.

Susan Gallagher, Executive Director, NorCal MHA, suggested more focus on the peer support aspect and less on the diagnostic aspect and pathologizing some of these behaviors. The speaker highlighted the need for more services and supports for children who have parents who are incarcerated.

Sandra Marley referred to an article that came out in 2017 titled "Adult Bullying in the Workplace." The speaker furnished staff with copies for their review. The speaker stated the need to bring the older adult population into the conversation. Older adults cannot get out and advocate for themselves. The speaker expressed concern about the Los Angeles Innovation project and their passive phenotyping and plan to contract the data storage out. The speaker stated there is possibly not enough oversight on that project.

Andrea Crook, Advocacy Director, ACCESS California, NorCal MHA, stated this was the best Commission meeting she has attended. The speaker stated the need to do away with cultural competence and replace it with cultural humility. Cultural competence calls for expert knowledge, which is based on academic and institutional expertise, but expert knowledge comes from the individuals with the lived experience. The principles

of cultural humility are life-long learning, critical self-reflection, recognizing and challenging power imbalances, and institutional accountability. To sum it up in one word, it is about love.

LUNCH BREAK

Chair Boyd explained that the Commission will be going into closed session during the lunchbreak as part of the Commission's normal annual executive director performance review.

REPORT BACK FROM CLOSED SESSION

Chair Boyd reconvened the meeting after the lunchbreak and stated the Commission took no reportable action.

INFORMATION

3: Executive Director Report Out

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

Executive Director Ewing thanked the panelists and the public who attended the meeting. He agreed with Andrea Crook's comment that this was one of the best, most insightful, and most engaging presentations given about student mental health. He thanked the presenters for the guidance regarding the path the Commission will take to enhance the opportunities to serve children, youth, and young adults. He stated the purpose of these discussions is to create a shared understanding so that a policy path can be followed and recommendations can be formed that can be presented to the Governor and the Legislature that are consistent with the leadership that Senator Beall has shown in terms of his bill, SB 1019, youth mental health and substance use disorder services. He restated how exciting this morning's success was.

Executive Director Ewing presented his report as follows:

Personnel

In a temporary capacity, the Commission has retained a retired annuitant to replace Jennifer Whitney, the communications director, who has retired from state service. She will help the Commission build their communications strategy while a long-term director is found.

Budget

The budget process is in full swing. Pre-hearings are in progress; formal hearings will begin in a couple of weeks. Staff has been meeting with budget committees in both houses and has been speaking with the Department of Finance.

Project Update

Fiscal Reporting Tool

The Fiscal Reporting Tool has been updated. A beta version of the updated features has been shared with the counties. They have until tomorrow to provide comment. A

2.0 version of the tool should go live next week that will allow more recent data and, ideally, will allow the public to see cash on hand as of the end of the last fiscal year, which was eight months ago. It is not a cash-flow balance, but it does show the total dollars that counties have in their bank accounts up to the end of the prior fiscal year as a function of annualized revenue.

The reason that is important is because some counties are carrying about a 40 percent balance year over year. They are spending their money very quickly and annually. Other counties are carrying more than two years' worth of revenue on their balance sheet. They are sitting on the dollars for the first year or the second year and they are beginning to spend them only in the third year.

The auditor included in the audit report the level of fund balances as inconsistent with needs and made the argument that the mental health community has to do a better job of making these dollars available for services. That feature has been added to the tool and it should go live, ideally, next week.

Innovation Incubator

The Governor included $5 million in his budget to launch the Innovation Incubator, which was discussed as part of the strategy to enhance Innovation. In the budget proposal, the Governor asked the Commission to focus the Innovation Incubator on reducing criminal justice involvement of consumers in direct response to the large backlog of individuals who are declared incompetent to stand trial. This is consistent with the work that Commissioner Brown led in terms of community-based strategies for diversion and to improve access to care on the community side as a way to reduce the number of individuals who end up involved with the criminal justice system. Staff continues to speak with the budget and policy committees around unspent funds and how to prioritize those dollars consistent with the Governor's proposal.

The Commission has entered into a contract with a consultant to help design a business plan for the Innovation Incubator. Staff is working on a game plan including a series of meetings. There will be broader community meetings to discuss goals and objectives and more focused meetings with individuals around the world who have expertise in these models in order to develop a business plan and the governance on the operational side, such as how to fund this moving forward. There will be a series of larger open meetings and a series of focused meetings with individuals with technical expertise. Executive Director Ewing invited Commissioners to be involved in this planning effort.

Innovation Planning

Executive Director Ewing asked Dr. Shah to provide an update on her efforts to highlight where the counties are in terms of Innovation planning and the conversations that staff has had with the Legislature and with the auditors about delays in Innovation approvals. Staff is doing a better job tracking counties that have plans in place, counties that have come to the Commission for plans, and counties that have not submitted an Innovation proposal for several years.

Dr. Shah reviewed the Innovation Dashboard, which was included in the meeting packet. She referred to the Innovation Proposals to be Calendared chart and stated there are currently nine draft proposals that have been submitted by seven counties, which total $17 million in Innovation funds.

Dr. Shah referred to the Innovation Concepts being Developed chart and stated 13 Innovation concepts have been submitted by six counties and are being developed with staff support and technical assistance, which total approximately $42 million.

Dr. Shah referred to the Approved Innovation Plans chart and stated this chart tracks the number of Innovation plans that have been approved during the past five years including extensions. She stated 52 counties have presented an Innovation plan to the Commission since 2013, which is 88 percent of the counties, and seven counties have not presented an Innovation plan, which is 12 percent of the counties.

Dr. Shah stated an updated Innovation Dashboard will be included in the meeting packet every month.

Chair Boyd thanked Dr. Shah and her team for putting this together. He stated major strides have been made in this area and the Innovation Dashboard is one more tool that will increase transparency and engagement and help the Commission and staff pace and schedule the work.

Stakeholder Contracts

Staff expects to testify in April before the budget committees on the Commission's request to increase stakeholder funding in support of reducing criminal justice involvement of consumers and to increase stakeholder funding to support advocacy on behalf of the mental health needs of immigrants and refugees. Staff will work with the Chair to determine if the Chair or a Commissioner wants to testify to the budget committees to make the request.

Strategic Planning

There are three proposals in response to Chair Boyd's request that a strategic planning consultant be identified, with a fourth proposal imminent. The contract will be awarded once all vendor proposals have been reviewed.

Triage Grants

Today's agenda includes a presentation on the allocation of funds for triage. Staff is excited about the work that is happening in the triage program. There is a lot of interest in triage. Fundamentally, what was done last year was to shift triage as a funding strategy and move it towards a way to incentivize stronger collaboration and integration at the community level. There will be more to report after the procurement discussion because there will be a lot of interest in that.

INFORMATION

4: California State Auditor's February 2018 Report on the Mental Health Services Act

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

Chair Boyd tabled this item to the next Commission meeting. He stated the meeting packet contains detailed information about this item for Commissioners and public review.

Roll Call

Chair Boyd asked Chief Counsel Yeroshek to call roll. Chief Counsel Yeroshek called the roll and announced a quorum was achieved.

ACTION

5: Trinity County Innovation Plan

Presenters: Noel O'Neill, LMFT, Director; Marlinda Butler, MSW, MHSA Coordinator, Trinity County

Noel O'Neill, LMFT, Director, Trinity County, stated Marlinda Butler, MHSA Coordinator, Trinity County, wrote the proposed Trinity County Innovation Plan but was unable to be in attendance due to illness. He provided an overview, with a slide presentation, of assessing the local capacity to serve the consumer in crisis, establishing a vision for peer respite, and developing an Innovation plan for the Cedar Home Peer Respite project. He stated construction is now complete on the 1,800 square foot peer respite home. A peer respite in Trinity County not only reduces the need for out of county placements, it furthers the county's efforts to demonstrate the efficacy of peer support and to further embed recovery and resiliency programming as a cornerstone to successful behavioral health treatment within the county MHP system.

Commissioner Questions

Commissioner Danovitch asked about the measure and comparison used to answer the study question. Mr. O'Neill stated the measurement used over the last five years is the number of days of purchased hospital beds for psychiatric care. He stated, before the last Innovation project, the county was at 290 bed days purchased per year for two years prior to the project and is now averaging 173 bed days. He stated the county knows, because of this gap in service, that there are no locations available for an overnight stay in the community. He stated this number can be brought down even more.

Commissioner Danovitch asked if the county's hypothesis is to bring down that number. Mr. O'Neill stated it was.

Commissioner Danovitch asked about the mechanism to continue this going forward after the Innovation and evaluation period, if that number is brought down and is judged to be a success. Mr. O'Neill stated the county made an agreement with CHFFA that this

would be a 20-year project and it is greatly needed in the community. Trinity County is committed to it.

Public Comment

Adrienne Shilton, Government Affairs Director, Steinberg Institute, spoke in support of the proposed project.

Robb Layne spoke in support of the proposed project.

Chair Boyd stated the importance for counties to engage the youth voice around the state. He stated the Commission will be looking for that moving forward.

Ms. Gundavajhala thanked Mr. O'Neill for his presentation and acknowledged and appreciated the county's commitments to longevity and sustainability. Innovation should be considered more short-term and immediate while thinking about sustainability and ultimately how the community can continue to be involved in the process.
Ms. Gundavajhala encouraged the county to continue that community-based informatory process, especially when thinking about peers, and to think about a varied group of peers to reflect the varied experiences of the communities in the county.

Commissioner Discussion

Commissioner Danovitch stated he is supportive of the need for this but was concerned that it does not fit into his understanding of what the Innovation mechanism is supposed to be, which is a mechanism to study an Innovation and as a way of determining whether or not it works and then coming up with a way to sustain that. Innovation dollars are not supposed to fund fixed costs in programs.

Chair Boyd stated he also was conflicted. He agreed there should be a level of rigor and innovation around these types of issues. He stated he was more inclined to support it being that it is in a small rural community and understanding that on some level it does not necessarily meet all the things expected for Innovation. He asked Chief Counsel Yeroshek for her perspective.

Chief Counsel Yeroshek stated there is always challenge and conflict regarding the need. Every county that comes to present an Innovation plan talks about the need. She stated the definition of Innovation from a legal perspective is very broad. She stated this proposed Innovation plan fits within the minimum legal requirements. The question becomes if the Commission will accept the minimum requirements. She stated the Commission has been moving towards truly short-term testing of a new or adopted approach. Of concern is the fact that the county already has a commitment to continue the project for 20 years. The problem may be if the proposed project qualifies as a test and evaluates whether something works.

Chief Counsel Yeroshek summarized that the Commission has the discretion to approve the proposed project because it fits the minimum requirements from a legal perspective, but this is a challenge that the Commission has been dealing with for multiple years now.

Vice Chair Aslami-Tamplen stated she saw the proposed project as unique because of the frontier aspect of the county. Trinity County is a very rural county where it is not unusual to drive 100 miles to get any kind of service. She commended the county for their stakeholder process, listening to individuals with lived experience, making that space and commitment, leveraging the resources from CHFFA, and, in the process, involving national leaders to amplify the impact. She stated the proposed project is innovative, inspiring, and exciting to see.

Mr. O'Neill stated there are four MHSA core values. He stated his belief that the proposed project meets all four of the MHSA core values. He brought to the Commission's attention that counties come before the Commission asking for millions of dollars. Trinity County is asking for $89,000 to help support what the community believes to be an essential program.

Ms. Gundavajhala stated Commissioner Danovitch's comment brought up that one of the things that community programs often struggle with is communicating the value of what they do. She stated a lot of what allows these programs to continue to be supported, funded, built on, and improved is being able to communicate the value of what is happening in that program. She stated, although this may not be a traditional use of the word Innovation, what is innovative is the way of thinking about service provision.

Ms. Gundavajhala strongly urged the county in their implementation to document and be creative about documenting the strengths of this Innovation because what makes it challenging to standardize Innovation is that Innovation is nonstandard by definition. Creatively documenting strengths as they are observed will be valuable.

Chair Boyd stated, to be consistent and clear to counties and other key stakeholders, he explained that what Commissioner Danovitch discussed was the strong direction of this Commission and what he himself discussed was that the Commission is in the process of implementing and trying to live up to that standard. The Commission has more work to do on that. He stated the definition and standards heard from Commissioner Danovitch do ultimately reflect where the Commission is going.

Vice Chair Aslami-Tamplen stated the transformation the Commission is seeking and that the youth and the panel members discussed this morning is a peer-to-peer approach. That connection, relationship, and place to go makes a huge difference and is the heart of the MHSA. She commended Trinity County for taking leadership in looking at crisis as an opportunity for peers to make an impact on one another.

Chair Boyd stated this is a tough one. He applauded the work and the effort. The project barely meets minimal qualifications. Peers and use of peers are amazing; that is how transformation is happening. The struggle is that this has been done before.

Mr. O'Neill agreed that peer respite has been done, but it has been done in Los Angeles, Santa Cruz, Sonoma, and Alameda Counties. He noted that these are all urban areas. He stated it has never been done in a rural county with no crisis residential, no crisis stabilization, and no crisis unit. This is the resource that Trinity

County will have. The study question is can this resource ameliorate some of the mental health issues that the county deals with every day?

Action: Vice Chair Aslami-Tamplen made a motion, seconded by Commissioner Gordon, that:

The MHSOAC approves Trinity County's Innovation Project as follows:

Name: Cedar Home Peer Respite
Amount: $267,000
Program Length: Twenty-Seven (27) Months

Motion carried 7 yes, 1 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Bunch, Gordon, Madrigal-Weiss, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

The following Commissioner voted "No": Commissioner Danovitch.

ACTION

6: San Francisco County Innovation Plan

Presenters: Imo Momoh, MPA, Director; Tracey Helton, MPA, CATC, Program Manager, San Francisco County; Jose Orbeta, Peer Specialist, San Francisco County

Imo Momoh

Imo Momoh, MPA, Director, San Francisco County, provided an overview, with a slide presentation, of the need and goal, peer model, and community planning process of the Intensive Case Management/Full-Service Partnership (ICM/FSP) to Outpatient Transition Support. He stated the ICM/FSP comes from a design to provide services to individuals with acute and chronic mental health challenges that, if not addressed, could lead to severe and persistent functional impairment.

Tracy Helton

Tracey Helton, MPA, CATC, Program Manager, San Francisco County, stated she is a peer and a manager for the MHSA in San Francisco County. She provided a review of the proposed project from a peer perspective.

Jose Orbeta

Jose Orbeta, Peer Specialist, San Francisco County, stated the county has nothing in place to assure that these clients get to the outpatient program. He stated having a guide who has similar lived experience is imperative because it is needed in cities like San Francisco.

Commissioner Questions

Chair Boyd thanked the county representatives and the lived experience representative in this presentation. The Commission values that.

Commissioner Bunch stated what was described in the presentations seems like it should be something that should happen as someone is stepping down so that, whatever provider is meeting with someone in intensive case management services, they would hold their hand and take them to their first appointment, but it is not. She stated she appreciated what was brought to the table.

Commissioner Alvarez asked about the organizational readiness. She stated it is an important element of this project in getting the organization ready to look at sharing power with peer specialists. She stated that is what she heard coming out of the decision-making process – that power is shared with peer specialists in the creation of this program and in the implementation. She asked if she is making too much of it and how peer leadership and knowledge can be used to ensure this program is successful.

Ms. Helton stated that organizational readiness is a piece of it. When the county initially began discussing this project, many clinicians were moving from the 3-Fs model (peers doing floors, filing, and food) to peers being in a higher level of education and working within the clinics. She stated a big piece of organizational readiness was holding years' worth of meetings with the clinicians who have been interacting with a peer on each of the panels, with each of them having equal decision-making ability within that body.

Ms. Helton stated the county has spent a year preparing and looking at how clinicians interact with the peers in making clinical decisions, and rolling out this program. This would be an interesting and innovative piece that is transferrable to other counties.

Mr. Orbeta stated he was part of the meetings and planning. He stated the peer voice is needed and respected. He stated there are three separate groups that meet bimonthly to brainstorm to help streamline it so stakeholders know exactly what the peer role will be and the different things that are required for the transition between the ICM and the outpatient program.

Vice Chair Aslami-Tamplen asked what kind of training the clinical supervisor, the licensed therapist, will undergo to serve the peer role effectively. Ms. Helton stated individuals who interact with peers are trained in the Wellness Recovery Action Plan (WRAP) principles, de-escalation, motivational interviewing, and harm reduction. Peers are trained with peer professional training. She stated she has led up to 21 peers at one time and is a peer herself. San Francisco County, in particular, values peer leadership at the highest levels. That is what is envisioned for this team. Individuals with lived experience are applying for different county jobs as therapists and clinicians.

Vice Chair Aslami-Tamplen asked if the clinical supervisor may also be a peer.
Ms. Helton stated that would be ideal.

Commissioner Danovitch stated there is no question that there is a strong need. This is a population that slips through the cracks with incredible consequences with respect to morbidity and mortality. Most of the funds for the proposed project go to staffing and there are other mechanisms under the MHSA that fund these activities, such as community services and supports and workforce mechanisms.

Commissioner Danovitch stated the purpose of Innovation is to fund a pilot test of something to answer a question to determine if it works because it is not fundable

through other mechanisms because it is unknown if it will work, and then, if it works, to use those insights to sustain the program and disseminate it to other sites. He stated the county has asked good questions, all of which are important, but it is not clear from looking at the proposal how this initiative will answer those questions and how the answers to the questions will inform the ability to sustain this after the maximum years of funding run out. He stated those are the questions that need to be answered for the Commission to support this under the Innovation mechanism.

Mr. Momoh stated, during the research phase, the county did not see where the efficacy has been tested on how a Peer Linkage Team has been successful in helpful transition for clients from excessive case management outpatient services to appointment-based outpatient care, which is a lower level of care. He stated the proposed project is innovative because whether it works is unknown. Individuals making this transition become hard to reach and hard to engage. It is important to test the proposed project to see if it will work so the county can take the successful elements of the project and explore further mechanisms once the county has the confidence that this is something that is integral to the system that will build successful results.

Commissioner Danovitch agreed that the hypothesis that peers can help with this transition is a good one, but he suggested comparing a group that did not get the service with a group that did get the service. It would possibly take more than $1 million of evaluation costs to track down individuals in this sector and get the data back about what happened to them. These individuals slip through the cracks in current data sources, as well.

Commissioner Danovitch asked how to get the answer, since it is a question worth asking and answering. Mr. Momoh agreed that the county did not do justice to the evaluation section. He stated it is a good point to make a comparison between individuals who receive services and those who do not. He stated the county can develop the project to help test that and put more emphasis on evaluation to measure the impact. He introduced the lead evaluator, Diane Prentiss, to provide further detail.

Diane Prentiss, MHSA Epidemiologist/Evaluator, San Francisco Department of Public Health, agreed that in an ideal world there would be a control group and differences would be measured between the groups, but this is in an applied setting where this opportunity will be provided to individuals who are eligible for it.

Ms. Prentiss stated the evaluation baseline in this case is what has been happening over the last three years as compared to what happens after the project rolls out. The goal is to move the needle on increasing the number of referrals to outpatient and increasing the percentages of clients who engage at outpatient in a measurable way by accessing at least eight services within 90 days and comparing that to the baseline numbers that are currently being tracked.

Ms. Prentiss stated there are process issues to work out in the county's Avatar treatment tracking system because tracking referrals are not done in Avatar. She stated she expects that some clients will not avail themselves of this service. There may be

intrinsic problems with that in terms of a comparison, but at least there would be some basis for comparison of those who do not access this service.

Ms. Helton stated the impetus for this project is looking at years of data of individuals who did not have the different services and linkages. That is what facilitated creating this project. The county had so much information on individuals who had fallen out of services, where they had gone, and how they had to come back. Some of that data can be compared to the data from the new project.

Ms. Gundavajhala thanked the speakers for taking the time to share about their ongoing efforts and about this proposal. She stated she is in this role today to share from the youth perspective what sorts of questions or comments she has. Ms. Gundavajhala stated this program will service a wide population but, when looking at transition age youth, it sounds like the need identified is a linkage issue, a gap in services. She asked if there are other aspects of the transition age youth experience that might be met or addressed by this program – for instance, if this program will support young people in getting transitions through structural as well as clinical perspectives.

Ms. Helton stated the county has a TAY project that is an ICM. She stated one of the first places the county looked in creating this project was the transition between youth aging out of foster care. That was the first information gathering of how steep of a drop-off there was to inform decision-making. She stated the interest of including a TAY as one of the peers in the proposed project who will be involved in the transitions for the TAY in the system.

Public Comment

Sandra Marley stated concern about transparency in the budget and asked about peer navigator wages.

Robb Layne spoke in support of the proposed project.

Andrea Crook spoke in support of the proposed project.

Joy Torres spoke in support of the proposed project.

Commissioner Discussion

Commissioner Gordon asked why the proposed project is innovative. Mr. Momoh stated it is innovative because the county was unable to find where efficacy had been tested of a Peer Linkage Team, a peer transition team that supports clients in support of outpatient intensive case management programs and transitioning to appointment-based outpatient services. The county found low engagement in this area. The goal of the proposed project is to explore the impact and effectiveness of a highly skilled and trained Peer Linkage Team helping to successfully transition these individuals into the appointment-based outpatient setting.

Vice Chair Aslami-Tamplen stated there was a question about the budget during public comment. She stated the full copy of every county's Innovation plan is on the website. The meeting packet and online meeting materials include links to those plans. The plan

includes a detailed budget. She asked about the salary range for the three peer navigators because they are lumped together in the budget documents.

Ms. Helton stated the three peer navigators will make $22 per hour. Other peer navigators are classified as a supervisor, who will make $23 to $24 per hour depending on experience, and a bilingual navigator, who will potentially also make more. The salary ranges will be between $22 and $25 per hour depending on the role, responsibilities, and language capacity.

Chair Boyd asked about other like positions in San Francisco that fall into that salary range. Ms. Helton stated the starting salary for a Health Worker 1 is $21 per hour and is the lowest entry-level health worker position in the city and county. The peers who work in the contractor positions make anywhere from minimum wage to $20 per hour.

Commissioner Mitchell stated, even with those salaries, they will not be able to live in San Francisco. She stated a little bit of something is better than a whole lot of nothing. She stated she hears her colleagues' concerns but supports the proposed project. She stated the Commission seems to always face the difficult question of innovativeness of a project versus need. She stated in this case she defers to the need out of appreciation of what the county is attempting to do.

Vice Chair Aslami-Tamplen agreed. She stated she saw the innovation in this project. She stated she also saw a reoccurring issue throughout the state around the salary of peers. San Francisco is one of the most expensive areas in California. She encouraged the county representatives, as leaders in San Francisco, to advocate to raise the bar for peers. There is a lot of value in peers. Counties also need to consider how peers can live a meaningful life in the community they are serving.

Vice Chair Aslami-Tamplen moved to approve the proposed project.

Commissioner Bunch stated she also saw the need. She stated it is frustrating because it is a need that is based on the failure of another system because, when someone is in an intensive case management program, the handholding should be done by that program, such as wraparound where they are not done with a client until the client is successfully with another program. She stated she sees that does not happen and so she sees the need for something like this project.

Commissioner Danovitch stated he is supportive of the need and innovativeness. He stated what he would need to see to support the proposed project is a clearer evaluation plan, and what comes out of that evaluation is information that enables the county and/or others to decide to continue a program like this after the funding through this mechanism runs out. Without that, he stated he does not see how this addresses the question that it set out to answer. He stated it is addressable but he did not see it in the materials presented. He suggested that the county bring an improved plan back to the Commission at a future Commission meeting.

Commissioner Mitchell stated, if she were to make a motion, she would require that the program is not delayed, but that the county come back within a certain period of time with an evaluation tool to present to the Commission.

Commissioner Bunch seconded Vice Chair Aslami-Tamplen's motion.

Chair Boyd asked if Commissioners would like to make a friendly amendment that would include approval but that the Commission would like San Francisco County to present back including the information Commissioner Danovitch discussed.

Chief Counsel Yeroshek stated it is not necessary for that to be part of the motion. The Commission can approve it and then request that the county provide the full evaluation or more details. The approval is not contingent upon the county coming back because the Commission is still approving it.

Chair Boyd asked if there is a difference between requesting and giving a choice. Chief Counsel Yeroshek suggested that the Commission ask in public and receive a public commitment. Executive Director Ewing recommended including directing staff to work with the county to follow up on the Commission's behalf. Mr. Momoh gave a verbal commitment to come back to the Commission with an evaluation plan.

Action: Vice Chair Aslami-Tamplen made a motion, seconded by Commissioner Bunch, that:

The MHSOAC approves San Francisco County's Innovation plan as written with direction to staff to provide technical assistance to the county to fortify the evaluation methodology and report back to the Commission.

Name: Intensive Case Management/Full-Service Partnership to Outpatient Transition Support
Amount: $3,750,000
Program Length: Five (5) Years

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

The following Commissioners voted "Yes": Commissioners Alvarez, Bunch, Danovitch, Gordon, Madrigal-Weiss, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

Approval of Meeting Minutes

The Commission approved the meeting minutes for February 8, 2018, and February 22, 2018. (See Agenda Item 1, above, for details.)

ACTION

7: Award Triage Program Grants

Presenters: Tom Orrock, Chief, Commission Operations and Grants; Kristal Antonicelli, Project Lead

Vice Chair Aslami-Tamplen recused herself from the discussion and decision-making with regard to this agenda item and left the room pursuant to Commission policy.

Chair Boyd acknowledge Norma Pate, Deputy Director, who was unable to be in attendance. He stated Deputy Director Pate has put in a tremendous amount of work to help the Commission move forward with the triage grant program.

Tom Orrock, Chief, Commission Operations and Grants, provided an overview, with a slide presentation, of the background of SB 82, the Investment in Mental Health Wellness Act of 2013, and the purpose, goals, and direction of the triage programs. He deferred to Ms. Antonicelli to present the results of the triage Request for Applications (RFA) for the adults/TAY age group.

Kristal Antonicelli, Project Lead, continued the slide presentation and discussed the timeline; the RFA eligibility criteria, application requirements, collaboration, and implementation. Twenty applications were received and passed the administrative review process for this grant and all were scored as a result. The applications being recommended for funding today represent over 110 collaborations throughout the state of California. Over 200 positions are proposed in these programs and 35 percent of those are peer positions.

Ms. Antonicelli stated the recommendation to award the Adults/TAY Triage Personnel Grants to the following counties:

Alameda County, Berkeley City, Butte County, Calaveras County, Humboldt County, Los Angeles County, Merced County, Placer County, Sacramento County, San Francisco, Sonoma County, Stanislaus County, Tuolumne County, Ventura County, and Yolo County.

Ms. Antonicelli stated the deadline to appeal is April 5th. She stated any additional funds that may become available for the Adults/TAY triage grants will be allocated first to Alameda County and Berkeley City, the two applicants who are partially funded due to lack of funding, and then to the next highest scoring counties that were not funded until all funds are allocated.

Chief Counsel Yeroshek stated the awardees listed on the motion slide are listed in alphabetical order, not in order of score. The reason these counties were recommended to be granted these funds is because they were the highest scores within each of their categories.

Commissioner Bunch recused herself pursuant to Commission policy.

Commissioner Questions

Commissioner Alvarez asked about the challenges being addressed in the proposals and if there is an opportunity to share what one county is doing so there is a learning opportunity. She asked what the Commission's responsibility is to share the lessons learned in order to take some of these Innovations to scale.

Ms. Antonicelli stated there is a mandatory participation in statewide evaluation with submission of an application and subsequent award. That is still in progress but there will be a statewide evaluation that will look at program-to-program comparisons, best practices, cost savings, and things of that nature.

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

- *The MHSOAC awards the Adults/TAY Triage Personnel Grants to the following counties for the specified amounts listed and directs the Executive Director to issue a Notice of Intent to make the following awards:*

Alameda County	$5,326,702	Sacramento County	$4,019,929
Berkeley City	$871,139	San Francisco	$2,352,746
Butte County	$729,323	Sonoma County	$1,691,878
Calaveras County	$300,476	Stanislaus County	$1,265,717
Humboldt County	$978,964	Tuolumne County	$653,701
Los Angeles County	$24,877,879	Ventura County	$2,486,224
Merced County	$1,017,359	Yolo County	$294,579
Placer County	$1,133,384		

- *The MHSOAC establishes April 5, 2018 as the deadline for unsuccessful applicants to submit an Appeal consistent with the ten working days standard set forth in the Request for Applicants.*
- *The MHSOAC directs the Executive Director to notify the Commission Chair and Vice Chair of any appeals within two working days of the submission and to adjudicate the appeals consistent with the procedure provided in the Request for Applications.*
- *The MHSOAC directs the Executive Director to execute the contracts upon expiration of the appeal period or consideration of the appeals, whichever comes first.*
- *The MHSOAC directs any additional funds that may become available for the Adults/TAY triage grants to be allocated first to Alameda County and Berkeley City, the two applicants who are partially funded due to lack of funding, and then to the next highest scoring counties that were not funded until all funds are allocated.*
- *The MHSOAC authorizes the Executive Director to negotiate with Alameda County and Berkeley City including, but not limited to, terms such as delayed implementation while awaiting possible additional funds.*

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

The following Commissioners voted “Yes”: Commissioners Alvarez, Danovitch, Gordon, Madrigal-Weiss, and Mitchell, and Chair Boyd.

Vice Chair Aslami-Tamplen and Commissioner Bunch recused themselves.

8: Legislation

Presenters: Toby Ewing, Ph.D., Executive Director; Norma Pate, Deputy Director

Executive Director Ewing stated the Commission is in the middle of the policy process with the Legislature. One of the charges the Commission has asked is to inform and guide legislation. SB 1004, authored by Senators Wiener and Moorlach, was put on the agenda, which relates to the PEI program. Staff was hopeful to have amendments in print today, but because of delays in drafting staff was unable to do that.

Executive Director Ewing stated he asked Angela Hill from Senator Wiener's office, who is the lead author, and Adrienne Shilton from the Steinberg Institute, the sponsor of the bill, to discuss the proposal because it has implications for the Commission. He stated, although the bill is not yet in print, staff wanted the Commission to have an opportunity to engage and ask questions and also give the author and sponsor feedback.

Senator Wiener's Office

Angela Hill, Fellow, Senator Wiener's office, stated approximately one third of California's prisons and approximately one fourth of the homeless population are severely mentally ill. Suicide is the third leading cause of death for those aged 15 to 24. The approach needs to change to reach individuals who are suffering from mental illness before they are severely mentally ill and have been going untreated. The author of SB 1004 wants to focus more in this bill on bolstering and improving PEI programs throughout the state. Shifting the focus to PEI will break the devastating cycle.

Ms. Hill stated the need to look at PEI programs, give greater direction, and define best practices in order to see better outcomes and more stable lives lived. The Commission has an integral role in this process with the MHSA, can help achieve that goal, and can be the regulatory body to improve PEI programming.

Steinberg Institute

Adrienne Shilton, Government Affairs Director, Steinberg Institute, stated the state auditor noted that California lacks accountability for the $2 billion annual investment that the MHSA brings in, and no one agency has definitive authority for ensuring the strategic and effective use of those taxpayer dollars on services on measurable outcomes. The Steinberg Institute believes there is a failure not of funding and intent, but of leadership and strategic focus. The state auditor's report highlighted this shortcoming and echoed the need for effective services and treatment and found that counties were diligently trying to carry out their mission and that progress was hampered by ineffective leadership and oversight. She stated the state auditor also pointed out that there was over $200 million of unspent funds that should have reverted back to the state. These were funds that counties should have spent but could not spend. The bulk of these dollars were PEI and Innovation.

Ms. Shilton stated the Commission has been showing tremendous leadership, particularly when it comes to the Innovation component of the MHSA. The Steinberg Institute believes the Commission should have the same authority over the PEI component as it does over the Innovation component. Absent a statewide strategic

vision on these best practices, counties will continue to struggle to spend their full amount of PEI funds.

Ms. Shilton stated SB 1004 will strengthen the role of the Commission by requiring a clear vision on the priorities on the use of PEI funds. The priorities are early psychosis and mood disorder detection and intervention, outreach and engagement strategies that target TAY with the priority given to programs that partner with colleges, and childhood trauma prevention and early intervention.

Commissioner Questions

Chair Boyd thanked Senator Wiener for his care around mental health and for having the kind of robust work and dialogue to move the kinds of issues the Commission cares about and spends a lot of time talking about both as it relates to Innovation and PEI and associated regulations. He asked Ms. Hill to extend that back to Senator Wiener.

Chair Boyd thanked the Steinberg Institute for sponsoring the bill and for providing leadership and support on this issue.

Commissioner Gordon stated he had to leave but before he left wanted to let Commissioners know that he supported SB 1004.

Chair Boyd asked if Commissioner Gordon would support the Commission continuing to work with Senator Wiener's office and the Steinberg Institute as it relates to language and authorizing Chair Boyd to work alongside the Executive Director to move it forward.

Commissioner Gordon stated he would. He stated his priority to ensure the language was such that the Commission's role and responsibilities are clearly defined.

Ms. Gundavajhala stated the youth focus outlined by this piece of legislation is exciting. That young people are being considered and prioritized is important. She stated she does not feel informed enough to comment in-depth but asked about anticipated updates.

Ms. Shilton stated it is still early in the legislative process. The language presented today will be in print next week. She anticipated that the language will be added to throughout the summer as the bill moves forward.

Ms. Gundavajhala asked what kind of youth input will be incorporated into the process. Ms. Shilton stated outreach has primarily been to organizations that represent youth or serve youth in the bill process.

Vice Chair Aslami-Tamplen stated one of the areas in terms of the three PEI program categories under PEI funding that is missing is stigma reduction efforts. That is a big piece that is not there. She asked, besides those three categories, if the MHSOAC oversight and approving PEI programs are the main things being proposed in the bill.

Ms. Shilton stated they were. She stated the bill is really about the strategic vision and additional programmatic and fiscal oversight done by the MHSOAC. She stated the Steinberg Institute welcomes feedback on the priorities. She stated the categories are defined in a broad way. The Steinberg Institute did not want to be in a position to tell

counties specifically which PEI program to fund. The categories are framed out with core principles.

Ms. Shilton stated presumably a stigma discrimination reduction program could be run within one of the three categories. She stated stigma discrimination reduction is not specifically called out but is a principle governing all three categories.

Commissioner Alvarez suggested the recent Workforce Commission has a model that may be helpful and applicable. They have five priorities but two foundational principles. Diversity and technology in the workplace are foundational principles that go throughout all of the priorities.

Vice Chair Aslami-Tamplen stated the bill seems to refocus PEI. She asked how that impacts the PEI regulation. During the three to four years that the Commission was going through that PEI regulation process, many counties stated they needed a lot of technical assistance and the Commission was not necessarily able to step up due to staffing capacity. She asked about the proposed budget with this bill for additional staff for the Commission to fully support counties. She asked where counties are in this discussion.

Executive Director Ewing stated SB 1004 was put on the agenda because it explicitly identifies a role for the Commission and would bring about a significant change for the Commission to review and approve PEI spending. He stated staff has been working closely with the author's office and the Steinberg Institute to try to convey to them the principles the Commission has endorsed, such as creating technical assistance and support for counties. Staff has talked with the author's office about how to enhance the efficacy of the PEI dollars, which requires thinking about the other ways the Commission should engage in addition to plan review and approval.

Chair Boyd stated the Commission has been doing a lot of work around child and adolescent mental health along with the work on Innovation. He stated there is a strong need for mental health Innovation around children and adolescence. The Commission has been discussing a $5 million Innovation Incubator that would be focused on competency to stand trial and other issues. He asked if the Commission would support putting $5 million toward a child mental health Innovation Incubator.

Commissioner Alvarez stated one thing the Commission has been discussing is to modernize systems with the incredible technology out there. She suggested ensuring that, as technology moves forward, the Commission also considers technology for accessibility to communication, connecting individuals to resources, and other ways in which the mental health system can be strengthened. Technology can play a critical role in connecting rural communities through telehealth, connecting specialists, improving language access barriers, and other ways that technology can play a vital role. She challenged the Commission to think about technology within the context of mental health delivery to go further to ensuring that individuals get the care they need and deserve.

Executive Director Ewing stated, in terms of the Chair's direction, the way the Rules of Procedures work is that Commissioners would make a formal motion and vote on that

and go on the record. Staff does a lot of technical assistance. Technical assistance is when staff is called in to departments and legislative offices to explain the MHSA and the work of the Commission. The Commission does not take a position in the discussions, including on this bill. Staff draws from the positions the Commission has already taken to try to inform the debate without expressing that the Commission has taken a formal position, unless the Commission has taken a formal position. Just as staff was directed through a vote to try to secure funding for stakeholder advocacy on behalf of immigrants and refugees and to reduce criminal justice involvement, the appropriate procedure would be for the Commission to take a formal vote for additional funds for Innovation around children and youth.

Executive Director Ewing stated, in terms of Commissioner Alvarez's comments, part of what staff is trying to do in terms of the Innovation Incubator is to explore those options. He stated he spent the day in the Bay Area this week talking with experts about technology, applications, data analytics, all of the ways in which the world has evolved, and how to catch up in terms of some of these tools.

Executive Director Ewing stated part of the goal of the Innovation Incubator is to better connect and provide that technical assistance. Part of the tension heard with the two Innovation plans approved today was between the Commission's approval authority versus the Commission's ability to shape and support that innovation to happen.

Commissioner Mitchell asked if there is a possibility of weaving in a conversation regarding the Commission's ability to effect housing for the mentally challenged.

Executive Director Ewing stated there is a validating act through the courts to ensure that the structure of the No Place Like Home bond proposal is legal and is being held up because of the lawsuit. He stated, in the context of Senator Wiener's bill, lawmakers are frustrated that there is not a clear strategy, particularly in the PEI area. Increasingly, they recognize that there is also not a clear strategy in the Innovation space. There is frustration coming out of the auditor's report that there are unspent funds and that some counties have no unspent funds while others are sitting on large amounts.

Executive Director Ewing stated on April 17th the Joint Legislative Audit Committee in concert with Senator Beall's Committee on Mental Health is holding an oversight hearing to look at this issue. There are more policymakers this year that are aware of what is happening in mental health and investing in strategic opportunities around prevention, including housing.

Executive Director Ewing stated the way he reads the intent of Senator Wiener's bill is, in addition to the language, that they are asking the Commission to help set a strategic vision and operational strategy to ensure that these dollars are used more effectively. There is nothing in there that says not to include housing. He stated, if this bill moves forward, there is an opportunity for the Commission to begin to define that, particularly around housing, as a PEI strategy. There are examples around the country where housing is a foundational support such as the Housing First model. The presentations today affirmed that housing and stability are key drivers of trauma and adverse childhood experiences for children.

Ms. Gundavajhala stated there is funding for PEI and funding for TAY, but prevention is a lifelong task that may not necessarily be segmented by age. Presentations today brought up that many things can go undiagnosed for a long time, especially since there are often no supports, access, or language to describe experiences and needs.

Ms. Gundavajhala stated, in framing the whole idea of TAY as a population to serve, she hoped the goal is that there is no transition ultimately and that there is a smooth and seamless transition from a child into being an adult. The fact that TAY have been identified as a specific and vulnerable population rather than looking at this transition as a natural part of life means that there are specific vulnerabilities to the transition. Until the transition is completely eliminated, the work is not done.

Public Comment

Poshi Walker stated it is difficult to make public comment before learning what the Commission will vote on. The speaker asked how the Commission can support SB 1004 without language.

Chair Boyd clarified that the Commission will not be voting to support a bill that is not written. The Commission will be voting, if anything, to authorize the Executive Director with direction from the Chair to work with Senator Wiener's office to continue to evolve and develop the bill. He stated the frame of the question that may be most relevant for public comment is that this bill at its core would provide at the Commission level approval for PEI plans. The bill would shift PEI plan approval to the Commission, similar to county Innovation plans.

Poshi Walker echoed Vice Chair Aslami-Tamplen's comments. The speaker stated concern about the Commission's capacity to take this on, if additional staff would be part of the bill, and if the Commission would need to meet more often, since the agenda is full with Innovation plan approval. The speaker also stated concern about the language of "evidence" and "proven" and hoped that this bill would include recognition of community-defined practices and not just evidence-based practices.

Poshi Walker stated SB 1004 currently focuses on college youth. The speaker stated LGBTQ youth are overrepresented in the foster youth system, the juvenile justice system, and the homeless population. They are often bullied and harassed within the school environment and are under high risk of school dropout. Many LGBTQ youth do not make it to college yet are at high risk for mental health challenges. These disparities are increased for LGBTQ youth of color. The speaker strongly urged that youth outside of the college system be included in this bill.

Dorinda Wiseman, Deputy Executive Officer, California Behavioral Health Planning Council (CBHPC), stated the CBHPC is concerned about some of the language in the bill as it stands, disparities, whether or not counties will have flexibility and, while acknowledging the need for leadership, questions the Commission's capacity to expand its responsibilities. The speaker stated older adults are missing out on being assessed and provided interventions at their first break.

Stacie Hiramoto stated REMHDCO agrees that leadership and PEI programs need improving. The greatest hope for new programs that reduce disparities for underserved

racial, ethnic, and cultural communities lies within the PEI and Innovation components of the MHSA. The speaker was concerned that the bill may make it more difficult for such programs because they do not fit under one of the three priority categories. This is defined in the Fact Sheet for SB 1004 as not enough counties use evidence-based models of early psychosis care. PEI was not meant to favor evidence-based models or early intervention for psychosis over prevention leading to better mental health in general. The speaker requested an open forum for more public comment and to review the foundational document created by this Commission.

Joy Torres stated the MHSA is about homelessness, suicide rate, deaths, and treatment. There are many lawsuits in progress because legally individuals who are homeless can use PEI funds. Individuals who are homeless need someone with authority to tell Orange County to use it. The federal judge did and now the Orange County Board of Supervisors has issued $70 million for housing, but they want to do tents. The speaker suggested an Innovation fund to provide homeless PEI shelter care and permanent housing for older adults and individuals who have gone through trauma.

Andrea Crook stated, when discussing legislative priorities, it is hard for stakeholders to provide meaningful input without the necessary information. The speaker reached out to the Commission at the last meeting and requested an objective policy be made available at this meeting that would provide an opportunity to not only hear from stakeholders but to have input on the agenda for legislative priorities. The speaker stated there is not enough information and informed stakeholders are important prior to making policy.

Rory O'Brien also stated concern about the stakeholder process. The speaker addressed the conversation that occurred on the Innovation Incubator for children and youth. The speaker asked that the Commission be strategic regarding the children and youth Innovation Incubator idea and consider the amount of Innovation funds across the state that are not being spent.

Rory O’Brien stated Executive Director Ewing reported that some counties have spent all of their Innovation funds, but there are many counties that have not. It may be far more strategic for the Commission to request that counties propose projects specific to children and youth rather than putting a large amount of funds into a new incubator. The speaker is not sure whether the incubator is necessary or not and looks forward to more conversation on whether it is.

Tai’Rance "Chuckii" Kelly, Sr., NorCal MHA ACCESS Ambassador, spoke about gaps in services and communities and the housing issue. The speaker stated the need for more services for people of color.

Commissioner Discussion

Chair Boyd stated he did hear Andrea Crook’s request at the last Commission meeting about ensuring the Commission has transparency around legislative issues. He asked Andrea Crook’s organization and other organizations that have legislative issues to send feedback and suggestions to Commission staff, ideally within the next two weeks.

He stated he will review the feedback with the Executive Director prior to the next Commission meeting to help consider how to address those in meaningful ways moving forward.

Chair Boyd asked Chief Counsel Yeroshek for staff's proposed motion on SB 1004.

Chief Counsel Yeroshek stated the proposed motion would be to authorize the Chair to work with the Executive Director to continue the efforts in working with the author of SB 1004 to support the principles in the bill and to refine the language. She stated the motion is to continue to support the principles, not the specific language, because the amendment language is not published yet.

Vice Chair Aslami-Tamplen asked for a review of the principles of SB 1004.

Adrienne Shilton stated the two key principles are (1) to establish a strategic vision for PEI and (2) to change where the oversight and approval happens for county PEI plans providing the Commission approval of those plans.

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

The MHSOAC authorizes the Chair to work with the Executive Director to continue efforts in working with the author of Senate Bill 1004 to support the principles in the bill, (e.g. establish a strategic vision for PEI and have the Commission approve PEI plans) and refine the language.

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

The following Commissioners voted "Yes": Commissioners Alvarez, Danovitch, Madrigal-Weiss, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

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

The MHSOAC authorizes the Executive Director to work with the Legislature to seek $5 million to support a children's Innovation incubator.

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

The following Commissioners voted "Yes": Commissioners Alvarez, Danovitch, Madrigal-Weiss, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

INFORMATION

9: <u>Stakeholder Contract Update</u>

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

Chair Boyd tabled this item to the next Commission meeting.

GENERAL PUBLIC COMMENT

Sandra Marley asked if the stakeholder contract updates will be posted online for stakeholders who cannot physically be in attendance. Chair Boyd stated they will.

Andrea Crook stated NorCal MHA would like Commissioners' email addresses in a distribution list to forward information about the work that ACCESS California is doing. Currently, she emails Commission staff and staff can forward information. For example, NorCal MHA is hosting a leadership webinar on April 12th and doing leadership trainings in all of the five regions.

Chief Counsel Yeroshek suggested that Andrea Crook send staff an email with information on how to sign up to NorCal MHA Listserv and staff will forward it to Commissioners who can then sign up.

ADJOURN

There being no further business, the meeting was adjourned at 4:11 p.m.

AGENDA ITEM 2

Action

April 26, 2018 Commission Meeting

Los Angeles County Innovation Plans

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Los Angeles County's request to fund the following Innovative projects for a total amount of $12,373,988.

(A) **Mobile Transcranial Magnetic Stimulation - $2,499,102**
(B) **Peer Support Specialist Full Service Partnership: $9,874,886**

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.

- Los Angeles proposes to develop and implement a Mobile Transcranial Magnetic Stimulation (TMS) Program to reduce symptoms in clients with major depressive disorders. This project will be implemented in two or more phases: first phase will involve mobile TMS delivered to adult clients currently receiving FSP services. The second phase will involve the expansion of mobile TMS treatment to clients living in Board and Care facilities.
- Los Angeles County proposes to implement a Full Service Partnership (FSP) model comprised of peers with lived experiences as mental health consumers and/or justice-involved individuals to assist in serving the justice-involved population who meet the criteria to receive FSP services within the County.

Presenters for Mobile Transcranial Magnetic Stimulation Project:

- Jonathan E. Sherin, M.D., Ph.D., Director, Los Angeles County
- Marc Heiser, M.D., Ph.D., Psychiatrist, Los Angeles County
- Debbie Innes-Gomberg, Ph.D., Deputy Director, Los Angeles County

Presenters for Peer Support Specialist Full Service Partnership:

- Debbie Innes-Gomberg, Ph.D., Deputy Director, Los Angeles County

Enclosures (5): (1) Biographies for Los Angeles County Innovation Presenters; (2) Mobile Transcranial Magnetic Stimulation Project Brief (3) Mobile Transcranial Magnetic Stimulation Staff Analysis (4) Peer Support Specialist Full Service Partnership Project Brief; (5) Peer Support Specialist Full Service Partnership Staff Analysis.

Handout (2): PowerPoint will be presented at the meeting for each Project

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

http://mhsoac.ca.gov/document/2018-04/los-angeles-county-inn-plan-description-mobile-transcranial-magnetic-stimulation

http://mhsoac.ca.gov/document/2018-04/los-angeles-county-inn-plan-description-innovation-5-project-peer-support

Proposed Motion: The MHSOAC approves Los Angeles County's Innovation Projects, as follows:

Name:	Mobile Transcranial Magnetic Stimulation
Amount:	$2,499,102
Project Length:	Three (3) Years

Name:	Peer Support Specialist Full Service Partnership
Amount:	$9,874,886
Project Length:	Four (4) Years

Biographies for Los Angeles County Presenters

Debbie Innes-Gomberg, Ph.D.

Dr. Innes-Gomberg received her Ph.D. from CSPP-LA in 1992 and is the Deputy Director over Program Development and Outcomes for the Los Angeles County Department of Mental Health. Over her 25 year career she has assumed leadership roles in Jail Mental Health Services, Adult System of Care, served as a District Chief for the Long Beach/South Bay areas of Los Angeles County and oversees the administration of the Mental Health Services Act. Dr. Innes-Gomberg is the Co-Chair of the County Behavioral Health Directors' Association's (CBHDA) MHSA Committee, including a member of its Governing Board. She is a leader in LA County and across the State on the MHSA and on outcome and evaluation of mental health programs.

Jonathan Sherin, M.D., Ph.D.

Jonathan Sherin, M.D., Ph.D., is a longtime wellbeing advocate and – as of November 2016– the new Director of the Los Angeles County Department of Mental Health (LACDMH). In this role, he oversees the largest public mental health system in the United States with a budget approaching $2.5 billion and serving over 250,000 residents.

Prior to joining LACDMH, Dr. Sherin was Chief Medical Officer and Executive Vice President of Military Communities for Volunteers of America, one of our nation's largest direct service non-profits. Over the years, he has also served in a variety of clinical, academic, teaching, and administrative leadership positions. In his last such post, Dr. Sherin directed mental health for the Miami VA Healthcare System and functioned as Vice-Chairman of the Department of Psychiatry at the University of Miami.

As an expert on veteran issues, Dr. Sherin has testified to Congress on challenges faced by members of the military community, specifically as they relate to trauma, recovery, reintegration, and the risk of homelessness and suicide. As a researcher, Dr. Sherin has published in the fields of neurobiology and psychiatry – including a seminal article in "Science" magazine that features his work identifying a core sleep circuit in mammals (the "sleep switch"). He also received the prestigious Kempf Award from the American Psychiatric Association for his conceptual model of the psychotic process.

Dr. Sherin is currently a volunteer clinical professor of psychiatry and behavioral sciences at both UCLA and the University of Miami.

Marc Heiser, M.D.

Dr. Marc Heiser obtained his BA in English and Molecular and Cell Biology at UC Berkeley. He obtained his Medical Degree (MD) from UCSF where he also obtained

a Ph.D. in Neuroscience. He then went on to complete his residency training in psychiatry and a fellowship in child and adolescent psychiatry at UCLA.

Dr. Heiser has been involved with Transcranial Magnetic Stimulation (TMS) research since 2003 and was trained to use TMS to treat psychiatric disorders as a clinical fellow at UCLA in the Neuromodulation Division. Dr. Heiser has received awards from the American Academy of Child and Adolescent Psychiatry and the Brain & Behavior Research Foundation for his research with TMS and his work has been published in a number of prestigious journals. Currently, Dr. Heiser works for the Los Angeles County Department of Mental Health in the Juvenile Justice Mental Health Program and is developing a clinical TMS program. He is an attending physician in the Mood Disorder Clinic at the Veterans Affairs Greater Los Angeles Health System where he is also helping to start at clinical TMS program. Finally, Dr. Heiser is a clinical faculty at UCLA where is teaches fellows in psychiatry.

MHSA Innovation 4 Project
Mobile Transcranial Magnetic Stimulation (TMS)

Los Angeles County Department of Mental Health (LACDMH) proposes to implement an FDA-approved treatment that has become a standard treatment in private practice and in academic centers but has not been used in public mental health settings, mobile Transcranial Magnetic Stimulation (TMS). *It should be noted that TMS is not at all related or similar to Electro-convulsive Treatment (ECT).*

TMS is FDA approved for the treatment of depression and is a non-invasive treatment that can enhance or suppress the activity of neurons in targeted areas of the brain through the use of electromagnetic stimulation. According to the American Psychiatric Association best practice guidelines for the treatment of major depressive disorder, TMS is now a first-line treatment for depression that has not responded to one antidepressant medication (APA 2010) as well as being effective for treatment-resistant depression. In addition, recent clinical studies suggest that TMS can be an effective treatment for a number of other psychiatric disorders, including substance use disorders, schizophrenia, obsessive-compulsive disorder, and post-traumatic stress disorder.

TMS uses precisely targeted magnetic pulses similar to those used in Magnetic Resonance Imaging (MRI) to stimulate key areas of the brain that are underactive in clients with depression. The client reclines comfortably in the treatment chair and is awake and alert during treatment. An electromagnetic coil is then placed directly to the target area of the brain where the device generates magnetic fields that alter the electrical activity of neurons. The enhancing or suppressing of neuron activity depends upon a number of variables including the frequency of the TMS pulses. During treatment, the client hears a clicking sound and feels a tapping sensation on the head. The client can go back to their normal activities immediately after treatment. Treatment can last between 10-45 minutes and is administered once per day for 5 consecutive days per week for 4-8 weeks.

LACDMH proposes to implement a mobile TMS program in two or more phases. The first phase will involve TMS delivered to clients meeting the criteria specified under *Target Population* in a mobile van outfitted with the technology, delivered to fully consenting clients receiving services in adult outpatient programs, including FSP programs. The mobility of the van will result in the service being delivered wherever the client desires. During the first 6 months of the project, DMH will evaluate service, particularly from the perspective of the clients treated and will report back to the MHSOAC the preliminary findings. The second phase would involve expanding from clients in adult outpatient services to clients living in Board and Care facilities.

LACDMH estimates serving 384 clients a year across the county.

Target Population

The target population includes individuals receiving services in an FSP program or residing in board and care facilities that have a depression as a major part of their psychiatric symptoms and ***one or more of the following****:*

- Resistance to treatment with psychopharmacologic agents as evidenced by a lack of a clinically significant response to at least two psychopharmacologic agents in the current depressive episode; or

MHSA Innovation 4 Project
Mobile Transcranial Magnetic Stimulation (TMS)

- Inability to tolerate psychopharmacologic agents as evidenced by two trials of psychopharmacologic agents from two different agent classes; or
- History of response to TMS in a previous depressive episode; or
- A history of response to ECT in a previous or current episode or an inability to tolerate ECT, or is a candidate for, but has declined ECT and TMS is considered a less invasive treatment option.

However, because of the nature of the TMS treatment, we would exclude individuals with a history of seizure disorder and those with metal implants in the head or upper torso (e.g., cardiac pacemakers).

Innovation Primary Purpose

Overall, the primary purpose of this Innovation project is to improve the quality of mental health services and achieve greater outcomes by providing new and effective treatment to clients with chronic and severe mental illness.

Qualification as an Innovation Project
This project seeks to introduce a new approach or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.

The goals of this project include:

- Provide access to new and effective treatment to clients with chronic and severe mental illness
- Increase adherence to treatment by bringing the treatment to the client
- Reduce use of other resources (i.e., psychiatric hospitalization, Emergency Room visits, intensive supportive services, etc.)
- Improve social and occupational functioning that would lead to successful community reintegration
- Increase the quality of life of clients with histories of poorly treated depression.

The project would be a 3 year demonstration project.

Informed Consent Process
In order to ensure that each client is freely participating in this treatment, the treating psychiatrist will obtain informed consent from the client. This will require that the client understand the nature of the treatment, its potential for benefit, and its potential risks, the treating psychiatrist will obtain informed consent for each client. The procedure will be described in detail the procedures involved in the treatment including the use of a magnetic coil, the sensations associated with the treatment (tactile, auditory), the approximate duration of each session, the frequency of sessions, the approximate number of sessions and the potential need for maintenance treatments in order to prevent relapse.

Potential risks that will be discussed include the following:

MHSA Innovation 4 Project
Mobile Transcranial Magnetic Stimulation (TMS)

- The potential for a tapping sensation that can be annoying or painful at the site of stimulation (reported by approximately one third of clients and usually improves over course of treatment). The person administering the treatments may make adjustments in order to ensure that the treatment is tolerable for each client.
- The treatment can also produce contractions of superficial facial or jaw muscles occurring only during the treatment and that do not persist after treatments.
- Headaches may also occur as a result of the treatment (reported in approximately 50% of clients). These usually improve over the course of treatment and can be alleviated by over-the-counter pain medication
- TMS produces a loud clicking sound. Therefore we require clients to wear ear plugs during the treatments. There is no evidence that TMS permanently affects hearing if earplugs are worn.
- A seizure is the most serious risk associated with TMS. The risk of seizures, however, is exceedingly low (<1/30000 treatments).
- There is also a risk that the client may not improve or may experience worsening mood or anxiety. If these issues arise, they will be addressed by the treating TMS psychiatrist.
- Finally, as with all treatments, there are unforeseeable risks that we do not yet know about or that are not currently recognized. If possible, we will continue to follow the cohort of clients in this project longitudinally in order to further define such as yet unknown risks.

Potential Benefits of TMS that will be discussed:

- TMS has been shown to lead to a remission of depressive symptoms in between 30-68% of clients with treatment refractory depression.
- TMS may also improve symptoms of other psychiatric disorders including PTSD, psychosis, substance use disorders, autism, and eating disorders. However, more studies are needed in order to know how likely TMS is to be effective for these issues

The Unmet Need

Treatment refractory depression (TRD), defined as depression that has not responded to at least one antidepressant medication, affects approximately 4.2 million Americans. According to Los Angeles County Department of Mental Health (LACDMH) records, in the 2016-2017 fiscal year, approximately 42,000 individuals are being treated for major depressive disorder and an additional 23,000 individuals are receiving treatment for other disorders in which depression plays a key role (bipolar disorder and schizoaffective disorder). Based upon the literature, we estimate that at least 35% of these individuals have depressive symptoms that are treatment refractory.

MHSA Innovation 4 Project
Mobile Transcranial Magnetic Stimulation (TMS)

Mobile TMS Implementation Process

The components of this Innovation project are as follows:

1. Purchase TMS device and accessories including modified van that will transport the treatment to clinics, field-based locations and/or Board and Care facilities in Los Angeles County in phase 2.

2. A lead psychiatrist will oversee initial TMS treatment sessions and track progress by collecting symptoms and functional outcomes that can, in turn, be used to judge the efficacy of this program.

3. Hire and train staff (Nurse, Psychiatric Technician) to operate equipment.

4. Identify adult outpatient program, including FSP programs with higher numbers of clients who meet criteria listed in *Target Population* above and engage and educate clients, staff and family members about TMS. The DMH Peer Support Specialist will be part of a team responsible for engagement

5. Once clients have been identified and agree to treatment, they will be seen 1 times per day for 5 consecutive days per week for 4-8 weeks.

6. As clients begin treatment, client satisfaction, and reactions and weekly outcome data will guide use of TMS.

Evaluating the Efficacy of TMS

A depression outcome measure will be administered at the beginning of treatment and weekly throughout the course of treatment. Measures may include: Quick Inventory of Depressive Symptoms (QIDS-16, client rated), the Hamilton Depression Rating Scale (HDRS, clinician rated), and a measure for adaptive daily living and quality of life. Additional rating scales may be used to track comorbid symptoms as appropriate. Client satisfaction with TMS will also be assessed at the end of each session, utilizing a verbal check in and at the end of treatment. These assessment tools will enable clinicians to track improvements in depressive symptoms and functional outcomes that can, in turn, be used to judge the efficacy of this program.

Overarching Learning Questions

1. Will these individuals be adherent with a mobile TMS treatment program?
2. Is TMS an effective treatment for this population?
3. Does TMS for depression lead to improvement in comorbid symptoms (i.e., substance use, psychotic symptoms, etc.)?
4. If TMS is an effective treatment for this population, should the program be expanded to treat a larger part of the population?

Stakeholder involvement in proposed Innovation Project

LACDMH's stakeholder process meets Welfare and Institutions Code 5848 on composition of the System Leadership Team (SLT) and meaningful involvement of stakeholders related to mental

health planning, policy, implementation, monitoring, quality improvement, evaluation and budget allocations. The composition of the System Leadership Team meets California Code of Regulations Section 3300 on stakeholder diversity. Planning for this project began in the spring of 2017, but has been a focus of Dr. Sherin since becoming the Director of the Los Angeles County Department of Mental Health. A proposal was presented to the System Leadership Team on October 18, 2017 with a request for feedback. The feedback received was overwhelmingly positive. Stakeholders expressed an interest in expanding the target population to include other severely mentally ill individuals in other mental health settings than just B&C residents. In response to this feedback, it was explained that one of the goals of the project was to collect enough data to support an expansion of the target population. Feedback beyond that has been categorized in the following manner:

- Populations of interest:
  - Request to include FSP clients that have been identified as having more severe symptomatology.
  - Individuals who may reside in Institutions of Mental Disease (IMD) who may benefit from TMS treatment.
- Concern regarding painful side effects of the treatment.
- Clarification and differentiation between Electroconvulsive Therapy (ECT) and TMS treatment.
- Consider other funding sources to pay for TMS treatment.

Feedback has been considered and much of it incorporated into the proposal or will be incorporated into the implementation phase of this project.

In addition, we plan to solicit peer involvement by engaging individuals with lived experience in our peer resource center and those who have undergone TMS treatment to assist others that may be contemplating this type of treatment.

The Department's Mental Health Commission Executive Committee was briefed on January 11, 2018, with a formal presentation to the Commission on January, 25, 2018. Board Deputy briefings were completed during January, 2018.

After an initial presentation to the MHSOAC and the associated feedback, the Department chose to add a community worker/peer support specialist staff to the TMS team, reflecting a change to the overall budget of the proposed project. The Department also chose to broaden the client populations who may elect to participate in TMS to include clients in the adult outpatient mental health system including adult FSP programs (who meet criteria for TMS), again, based on stakeholder feedback. Taking a step further, based on key feedback from client advocates, DMH chose to phase the project such that services start in adult outpatient mental health settings and *not* in Board and Care facilities.

After, the February, 2018 presentation to the MHSOAC, four additional presentations have been made recently. A presentation was made to the Service Area 3 Advisory Committee on March 8, 2018. Positive feedback was received, with questions centering around the process of treatment including clarifying the frequency and length of treatment, sustainability of long term benefits and involvement of peers. On March 15, 2018, DMH held an additional peer focus group comprised of Wellness Outreach Workers, and paid peer advocates. DMH received positive feedback with

questions revolved around treatment side effects, ability to be on medication while receiving TMS treatment, funding, and length of treatment. Seven (7) post surveys were completed by peers as well as written comments were collected. Survey results: 71% of peers reported that they would recommend TMS treatment to a friend or family member, if they needed it; 86% felt that this was an important treatment that can be beneficial for many people; and 100% reported that they would support DMH in offering this treatment to those in need. On April 4th and 6th, 2018 presentations were made to a local clinic and to Service Area Advisory Committee 8, with positive feedback and questions asked for clarification regarding the process and length of TMS.

Sustainability

Analytics associated with mobile TMS, coupled with a comprehensive evaluation, will inform actions taken by the Department at the conclusion of the third year of the project. Factors to be taken into account will include user satisfaction and outcomes, advances in TMS at the conclusion of the project and the overall effectiveness of this treatment for specific populations. At the conclusion of the third year, DMH will explore continuing deemed services by maintaining operating staff through the MHSA Community and Service Supports (CSS) plan.

Timeframe of the Project and Project Milestones

Upon approval from the Mental Health Services Oversight and Accountability Commission, the Department will issue a solicitation to identify one or more companies with capacity to immediately initiate the deliverables in this project proposal including retrofitting a Transit Van with TMS medical device and accessories. The projected timeframe is as follows but, due to the innovative nature of this project, actual implementation steps may deviate in terms of sequence and/or timeframes:

- October 27, 2017: 30 Day Public Posting of Proposed Project
- February 22, 2018: Presentation to the MHSOAC
- March 14, 2018: Re-posting of proposal with the addition of a peer staff
- April 26, 2018: Re-presentation to the MHSOAC
- June, 2018: Van retrofitting with TMS medical device.
- July-August, 2018: Hire and train staff to administer treatment and collect outcome measures. In addition, identify eligible clients at board and care facilities that are willing to participate in TMS treatment.
- July-August, 2018: Launch project by beginning treatment and tracking progress weekly.
- FY 2018-2019: Development, testing and implementation of deliverables.
- FY 2019-2020 through FY 2020 – 2021: Continued use, evaluation and scaling and a final evaluation to the Department.

As with all components of the MHSA, implementation and preliminary outcomes will be reviewed with the LACDMH's SLT periodically and will be reported on in MHSA Annual Updates/MHSA Three Year Program and Expenditure Plans.

Budget

Fiscal Year 2018-19:

Modified Van:	$89,195	(One-time cost)

MHSA Innovation 4 Project
Mobile Transcranial Magnetic Stimulation (TMS)

Magventure TMS (1 device):	$69,433	(One-time cost)
Laptop	$2,000	(One-time cost)
Van Maintenance Plan:	$6,000	
Mental Health Psychiatrist:	$316,775	(Salary and Employee Benefits)
Mental Health Counselor, RN:	$151,234	(Salary and Employee Benefits)
Clinical Psychologist II	$133,863	(Salary and Employee Benefits)
Psychiatric Technician II:	$65,322	(Salary and Employee Benefits)
Community Worker	$53,950	(Salary and Employee Benefits)
Intermediate Typist Clerk:	$51,014	(Salary and Employee Benefits)
Operating Cost for 1 clinical position:	$4000	(One-time cost)

Total Cost: $942,786

Fiscal Year 2019-20:

Van Maintenance Plan:	$6,000	
Mental Health Psychiatrist:	$316,775	(Salary and Employee Benefits)
Mental Health Counselor, RN:	$151,234	(Salary and Employee Benefits)
Clinical Psychologist II	$133,863	(Salary and Employee Benefits)

The Psychologist will assume responsibility for the evaluation

Psychiatric Technician II:	$65,322	(Salary and Employee Benefits)
Intermediate Typist Clerk:	$51,014	(Salary and Employee Benefits)
Community Worker	$53,950	(Salary and Employee Benefits)

Total Cost: **$778,158**

Fiscal Year 2020-21:

Van Maintenance Plan:	$6,000	
Mental Health Psychiatrist:	$316,775	(Salary and Employee Benefits)
Mental Health Counselor, RN:	$151,234	(Salary and Employee Benefits)
Clinical Psychologist II	$133,863	(Salary and Employee Benefits)

The Psychologist will assume responsibility for the evaluation

Psychiatric Technician II:	$65,322	(Salary and Employee Benefits)
Intermediate Typist Clerk:	$51,014	(Salary and Employee Benefits)
Community Worker	$53,950	(Salary and Employee Benefits)

Total Cost: **$778,158**

Summary by Fiscal Year:

FY 18-19 Estimated Cost	$942,786
FY 19-20 Estimated Cost	$778,158
FY 20-21 Estimated Cost	$778,158

Total 3 year Project Cost: $2,499,102

Note- *the cost of the evaluation is the cost of the Psychologist conducting it: $401,590*

Budget Narrative:

MHSA Innovation 4 Project
Mobile Transcranial Magnetic Stimulation (TMS)

(1) Mental Health Psychiatrist: The psychiatrist will participate in outreach and education in B&C facilities with staff, providers and potential clients. The psychiatrist will also perform in-person evaluations to determine if a referred client meets criteria for and may benefit from TMS treatment. The psychiatrist will prescribe and manage the TMS treatments. Initially, the psychiatrist will be on site for treatments. However, the psychiatrist may be off site and manage daily TMS sessions via tele-psychiatry in conjunction with the mental health nurse and psychiatric technician who will always be on site.

(1) Mental Health Counselor, RN: The Mental Health Counselor RN will deliver the daily TMS treatment sessions and perform daily assessments of the client's symptoms and any side effects that will be communicated to the psychiatrist. They will also administer client rating scales. This team member will also be trained to provide first-aid and Basic Life Support (BLS) in case of emergency.

(1) Clinical Psychologist II: The Clinical Psychologist will assume responsibility for the evaluation of this project and will establish a database into which rating scales and other clinical data will be entered in order to track client progress/response to treatment, side effects, and treatment parameters. They will analyze this data which can then be de-identified and used for outcomes measurement reporting. The Clinical Psychologist will also provide outreach and education regarding outcomes of this project to other providers throughout L.A. County and the state of California.

(1) Psychiatric Technician II: The Psychiatric Technician will be driving the mobile TMS unit to treatment sites throughout L.A. County, will assist the Mental Health Counselor, RN with setup of the TMS device for each treatment session, will help administer clinical rating scales and will interface with B&C staff regarding client progress.

(1) Intermediate Typist Clerk: The Intermediate Typist Clerk will provide administrative support to the mobile TMS team. This includes, but is not limited to, securing TMS education presentation locations; preparing educational packets; registering attendees; sending registration confirmations; setting up the audio visual equipment for meetings; provide phone coverage for mobile TMS team; assist in the preparation of TMS related community meetings; responsible for maintaining records and the upkeep for the county TMS van; and serve as backup timekeeper and travel coordinator for the team.

(1) Community Worker: The Community Worker will be someone with lived experience that will outreach and engage potential clients, family members and/or caregivers to orient them to TMS treatment process. They will assist and support the TMS staff in checking in with clients receiving TMS services, in conducting community presentations and disseminating TMS informational materials. Additional duties include, but are not limited to, facilitating relations between the agency and client; serves as an advocate for client access to departmental and community resources;

acts as interpreter for client population; supports/assists in administering required outcome measures; and may accompany clients to TMS treatment sessions to provide additional support.

This project will be entirely funded by MHSA Innovation Plan.

STAFF ANALYSIS— LOS ANGELES COUNTY

Name of Innovative (INN) Project: **Mobile Transcranial Magnetic Stimulation**

Total INN Funding Requested: **$2,499,102**

Duration of Innovative Project: **Three (3) Years**

Review History:

Approved by the County Board of Supervisors:	Pending MHSOAC Approval
County submitted Innovation (INN Project):	April 13, 2018
MHSOAC consideration of INN Project:	April 26, 2018

Los Angeles previously presented this Innovation Project to the Commission on February 22, 2018. Rather than proceeding to vote on the project due to Commissioner comments and public feedback, Los Angeles County chose to withdraw the project. Substantial changes have since been incorporated and project was reposted for 30-day public comment. The County is now returning to present the revised project plan to the Commission, with substantial changes incorporated as a result of stakeholder feedback and client advocacy.

Project Introduction:

In order to reduce symptoms in clients with major depressive disorders, Los Angeles County proposes to develop and implement a Mobile Transcranial Magnetic Stimulation (TMS) Program in two phases. Initially, TMS treatment will be provided for clients who are receiving mental health outpatient services, including Full Service Partnership programs, and then treatment will expand to include interested clients living in Board and Care Facilities who have a history of being resistant to treatment.

Transcranial Magnetic Stimulation is a Food and Drug Administration (FDA) Approved treatment and is used to treat refractory depression. Although TMS treatment initially developed in 1985, the first TMS device was approved by the FDA on October 9, 2008 and has been primarily utilized in private practice and not available in public mental health settings.

The County states that the overarching goal of this project is to reduce the burden of symptoms of clients with treatment refractory depression with the hopes of increasing their social and occupational functioning. Treatment refractory depression, also known as treatment resistant depression, is a term used in clinical psychiatry to describe cases of major depressive disorder that do not respond adequately to appropriate courses of at least two antidepressants.

TMS treatment is still relatively new and there is still much to learn, and although it appears to be safe, the long-term side effects are unknown. There was conflicting evidence regarding the use and efficacy of TMS; however, the substantial clinical trials funded by the National Institute of Mental Health, found that 14% achieved remission with TMS treatment compared to 5% that received a sham (inactive-placebo) treatment. At the conclusion of the trial period, patients were permitted to enter a second phase of TMS treatment (including those who initially received the sham treatment). Remission rates during the second phase rose to nearly 30%.

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 (4) allowable primary purposes: increases access to mental health services to underserved groups; increases the quality of mental health services, including better outcomes; promotes interagency collaboration; and increases access to services, including, but not limited to, services provided through permanent supportive housing.

Los Angeles reports that this project meets the primary purpose of increasing the quality of mental health services, including measured outcomes, and meets the innovation criteria by seeking to introduce a new approach or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.

The Need

Los Angeles County states that approximately 4.2 million Americans are diagnosed with treatment refractory depression (as defined above). The County indicates they treated approximately 42,000 individuals for major depressive disorder within Fiscal Year 16/17; and an additional 23,000 individuals received treatment in which depression was part of their primary mental health diagnoses. The County estimates that approximately 35% (n=22,750) of the 65,000 individuals being treated for depression are in treatment refractory and do not respond to medication and/or therapy.

The County states individuals with severe chronic mental illness need high levels of mental health care and as a result, some of these individuals are unable to care for themselves and may require the assistance of B&C facilities to receive proper care and supervision. The County believes that individuals living in B&C facilities who are interested in receiving TMS treatment would benefit and may allow clients to lead a life of more independence. Furthermore, for those living in B&C facilities who choose to participate in this treatment, the mobility aspect of this project allows for adherence to

treatment since the County will be providing treatment at the B&C where the individual resides.

The Response

To address these issues, the County is proposing to offer and implement a Mobile Transcranial Magnetic Stimulation (TMS) program initially for individuals who currently receive outpatient mental health services and then for interested individuals residing in a B&C facility in order to provide treatment for those who meet the criteria of being in treatment refractory. Los Angeles proposes to purchase a TMS device, accessories for the device, and a modified van that will transport the TMS equipment to those receiving TMS treatment.

The initial phase of the TMS program will include adults who are in outpatient programs, including Full Service Partnership (FSP) programs, which have a large volume of clients. Clients will be engaged and educated on TMS treatment as well as family members and staff within the outpatient programs. This engagement process will be the responsibility of the Peer Support Specialist employed in this project.

During the initial six (6) months of the project, the County will evaluate the services provided from the client's perspective and will then return to the MHSOAC and report their preliminary findings for the first group that have received TMS treatment. The second phase of the project would include the expansion of the target population to include interested clients living in B&C facilities.

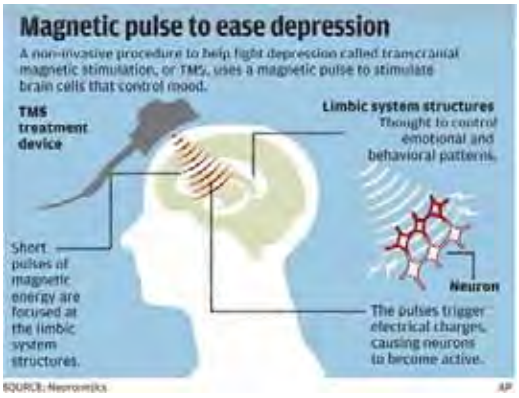
The County states that this project is innovative because TMS treatment has traditionally been utilized in private practice and in academic settings, and will now bring TMS treatment into the public mental health setting. If this project is successful, the evaluation of this plan may ultimately allow the state to consider expansion of its Medi-Cal policy to offer and provide TMS to the public.

A lead psychiatrist will provide oversight of initial TMS treatment sessions and track the client's progress which can assist in determining the efficacy of this project. The County will hire and train staff consisting of a Psychiatric Technician and a Nurse who will operate the equipment. The County indicates treatment sessions will typically last anywhere from 10-45 minutes and is administered once daily for five (5) consecutive days for a four (4) to eight (8) week period. Exact treatment protocols and durations will vary depending on the response to treatment.

Prior to treatment being delivered, the County will ensure that each client is choosing this treatment on their own volition. The psychiatrist will discuss with each client, in thorough detail, the nature of the treatment, the benefits and potential risks that are involved. Additionally, the client will also be advised of the duration and frequency of each session as well as the treatment regimen and potential need for maintenance treatments in order to avoid possible relapse. After the client indicates their understanding of the treatment, the psychiatrist will then obtain informed consent for each client. As an established practice with FDA approval and with supporting research from National Institute of Mental Health, Mobile TMS does not appear to meet the level of protection that an Institutional

Review Board (IRB) approval warrants. In our analysis and research, it appears is if the County's plan for establishing informed consent is sufficient in meeting client protections.

During treatment, sedation or general anesthesia is not required, so the patient is awake and alert and will be in a seated/reclined position. The electromagnetic coil rests directly on the temporal lobe, where the TMS device generates magnetic fields that ultimately adjust the electrical activity of neurons. Patients will be required to remove any magnetic-sensitive objects and wear ear plugs as the patient will hear an audible clicking sound, similar to a Magnetic Resonance Imaging (MRI) machine, and may feel a rhythmic tapping sensation underneath the coil. After treatment, the patient may resume their normal daily activities immediately as there is no recovery time.



Research shows that the most serious risk of TMS treatment is seizures, although the risk is extremely low. The County states individuals with a history of seizure disorder or those with metal implants in the head or upper torso (such as a pacemaker), will be excluded from receiving TMS treatment due to the risks involved. Some reports indicate that although TMS may produce discomfort, it is safe and has proven to be effective. Typical side effects may include headache, scalp discomfort at the stimulation site, and tingling or twitching of facial muscles. Half of all clients receiving TMS treatment report experiencing a headache after treatment but usually improve during the course of treatment and may be alleviated by over-the-counter pain medication.

During the initial Community Planning Process back in October 2017, clarification was asked of the County to distinguish the difference between TMS and Electroconvulsive Therapy. Research provides stark differences between these two (2) types of treatments:

Electroconvulsive Therapy (sometimes referred to as shock therapy):

- Cranial therapy used to treat mental illness or mood disorders
- Utilizes an electric current
- Usually administered in a hospital setting
- Various side effects, some as serious as memory loss
- Patients are given muscle relaxants to prevent damage to muscles and bones
- Patient is under general anesthesia

Transcranial Magnetic Stimulation:

- Cranial therapy used to treat mental illness or mood disorders
- Non-invasive
- Usually administered in doctor's office or outpatient setting
- Typically has no side effects
- No medication is needed to relax patients
- Patient is alert and awake during therapy

One of the benefits of the County offering Mobile TMS treatment is that it allows clients to receive treatment on a consistent basis without interruption because the treatment would be brought directly to where the client chooses to receive treatment. Once TMS is expanded to include B&C residents, treatment will be brought directly to their B&C facility.

The Community Planning Process

To facilitate culturally diverse stakeholder involvement, the County states they assembled a 58-member System Leadership Team (SLT) to provide input related to the various stages of planning surrounding innovation projects, meeting stakeholder composition in compliance with Welfare and Institutions Code 5848. The County indicated the planning of this project originally began in Spring 2017, and was presented to the SLT in October 2018, receiving positive feedback.

Los Angeles County has made several substantive changes as a result of the community stakeholder process. The County presented this Innovation Project before the Commission on February 22, 2018. There were numerous questions and concerns received from the Commissioners and the public regarding this project, including but not limited to: concerns received surrounded the validity of TMS treatment, the issue of informed consent for B&C residents receiving this treatment, the issue of conservatorship for B&C residents, and whether TMS was an FDA-approved treatment, as this treatment was not widely known as it has not been used in the public mental health setting. Rather than proceeding with the Commissioner's vote of the plan, the County decided to withdraw the Innovation Plan and incorporate some of the feedback that was received and return at a later date to re-present in front of the Commission.

Although the issue of conservatorship was a concern expressed during the MHSOAC Commission Meeting on February 22, 2018, the County stated during their presentation that only B&C residents with a conservator would be eligible to receive TMS treatment. This revised version of the Mobile TMS project also does not reference conservatorship. **The County may wish to provide information on whether the B&C residents who will receive TMS treatment will require a conservator before providing consent for treatment.**

Due to substantial comments and recommendations received both during and following the MHSOAC Commission Meeting on February 22, 2018, the County has incorporated substantial changes which resulted in the plan being reposted for 30-day public comment from March 13, 2018-April 12, 2018.

As a result of feedback from client advocates, the County has chosen to break up the project into two (2) phases as previously mentioned: the first phase will provide treatment for adult clients who currently receive county mental health services, including FSP programs; and the second phase will expand the target population by providing treatment to interested clients residing in B&C facilities.

Initially, the Mobile TMS project was specific to B&C residents who were treatment refractory. As a result of public feedback and client advocacy, the County has made the decision to focus the initial part of this project to provide TMS treatment on clients currently receiving treatment in adult outpatient programs, including FSP services, within the County. As part of the second phase of the project, the County will open up treatment to those interested clients residing in B&C facilities. Additionally, the County has included a Community Worker with lived experience to the Mobile TMS team to provide outreach and engage potential clients, family members and/or caregivers. The Community Worker will also serve as an advocate for clients receiving TMS treatment, provide linkages to community resources, and may accompany clients to TMS treatment to provide support, if needed.

In addition to the change in target population and implementation of this project resulting in a two (2) phase process, focus groups comprised of Wellness outreach Workers and paid peer advocates also met to discuss TMS side effects, funding, continuing to receive medications while receiving TMS treatment, and length of treatment. Surveys and comments were administered and collected and results were overwhelmingly positive. Survey results concluded that 71% of peers would recommend TMS treatment to a friend or family member; 86% felt this treatment would be beneficial for many people; and 100% stated they would support the County in offering this treatment to those in need.

The County states they will also solicit peer involvement by engaging individuals with lived experience who have undergone TMS treatment that may be able to provide real-life testimony on the efficacy of the treatment.

The County states that substantive feedback was considered and incorporated into the Innovation Project, and will be incorporated during the implementation of the project.

Learning Objectives and Evaluation

Los Angeles County has proposed implementing a Mobile Transcranial Magnetic Stimulation (TMS) program to treat psychiatric disorders within the county. The project outlined has been identified as a three-year demonstration project with a goal of improving the quality of mental health services for clients with chronic and severe mental illness.

The County will provide TMS treatment in a modified van. This will enable psychiatrists to meet and provide treatment to individuals receiving outpatient mental health services in an FSP program, or “interested clients” residing in B&C facilities with depression as a major part of their symptoms, as well as one or more of the following:

- Resistance to treatment with psychopharmacologic agents as evidenced by a lack of a clinically significant response to at least two psychopharmacologic agents in the current depressive episode; or

- An inability to tolerate psychopharmacologic agents as evidenced by two trials of psychopharmacologic agents from two different agent classes; or
- A history of response to TMS in a previous depressive episode; or
- A history of response to Electroconvulsive Therapy (ECT) in a previous or current episode or an inability to tolerate ECT, or is a candidate for, but has declined ECT and TMS is considered a less invasive treatment option.

The evaluation of the TMS program revolves around four main learning questions:

1. Will these individuals be adherent with a mobile TMS treatment program?
2. Is TMS an effective treatment for this population?
3. Does TMS for depression lead to improvement in comorbid symptoms (i.e., substance use, psychotic symptoms, etc.)?
4. If TMS is an effective treatment for this population, should the program be expanded to treat a larger part of the population?

In order to measure outcomes relative to the proposed learning questions, the County will utilize weekly symptom and functional based measures to track treatment progress. Specifically, the Mental Health Counselor, RN will administer the Quick Inventory of Depressive Symptoms (QIDS-16, patient rated), the Hamilton Depression Rating Scale (HDRS, clinician rated), and other measures for adaptive daily living, quality of life, and satisfaction with TMS. Tracking these data will allow the County to arrive at improvements in depressive symptom and functional outcomes.

The Budget

The proposed budget for this Innovation Project is $2,499,102 over three (3) years. Although this Innovation Project will be broken up in two or more phases with the first phase focusing on treatment for adult clients currently receiving FSP services and the second phase for B&C residents, the funds for the entire project are being requested upfront.

The majority of the budget is for direct administrative personnel costs which accounts for $2,316,474 (93%) of the total budget. Staff required for this project will include a Mental Health Psychiatrist, a Mental Health Counselor (RN), a Clinical Psychologist II, a Psychiatric Technician II, and an Intermediate Typist Clerk, and a Community Worker.

The County will make one-time purchases totaling $164,628 (6.6%) to purchase a modified van in the amount of $89,195 in order to transport the treatment equipment; TMS device for $69,433; and a laptop for $2,000. The one-time purchase will also include an operating cost of $4,000 which will cover the cost of space, computer and equipment for the Clinical Psychologist II. The budget costs for the maintenance of the van is $18,000 (0.72%), or $6,000 per fiscal year.

The County indicates the Clinical Psychologist II will be responsible for the collection, analysis, and dissemination of data that may contribute to statewide learning. Additionally, findings related to best practice guidelines and implementation efficacy will be shared with the mental health community with the desire to possibly expand the project within Los Angeles County, as well as other counties and states. A total of

$401,589 (16%) will be set aside for the evaluation component, which will be completed by the Clinical Psychologist II.

Regarding sustainability, the County states a final determination will be made at the end of the third year of the project and is contingent upon the overall success, effectiveness, analysis, and evaluation of the project. The County indicates they may elect to continue services and staff through the use of MHSA Community and Services Supports (CSS) funds. In reference to Assembly Bill 114 regarding reversion of funds, the County does not specify what fiscal year funds will be utilized to fund this project. **The County may wish to identify what fiscal year funds are being used for this project.**

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations; however, if Innovation Project is approved, the MHSOAC must receive and inform the MHSOAC of this certification of approval from the Los Angeles County Board of Supervisors before any Innovation Funds can be spent.

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COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

MHSA INNOVATION 5 PROJECT
PEER SUPPORT SPECIALIST (PSS) FULL SERVICE PARTNERSHIP

The Innovation

The Los Angeles County Department of Mental Health (LACDMH) proposes to implement and evaluate the effectiveness of serving justice-involved individuals utilizing a Full Service Partnership (FSP) model comprised of team members primarily who self-identify and utilize their lived experience as mental health consumers and/or justice-involved individuals. Traditional FSP programs have been staffed with a multi-disciplinary clinical team which have included peers. This PSS FSP program will modify the existing FSP team staffing to consist primarily of peers utilizing their lived experience to do *whatever it takes* to serve a justice-involved population who meet the criteria for adult FSP services in Los Angeles County. The service delivery will exemplify PSS strength and qualities, such as skills and competencies peers embody, to reduce symptoms, improve independent living skills and foster a sense of inclusion in the community.

Innovation Criteria

The Department is seeking to make a change to an existing practice in the field of mental health practice (FSP service delivery model and staffing) within Los Angeles County by expanding the role and prominence of peer support specialist staff on an FSP team. The primary purpose is to improve the quality of mental health services and achieve outcomes.

Project Length

This project will last 4 years.

Making the Case for Peer Support Specialist FSP Serving Justice-Involved Clients

Peer Support Specialist FSP

Since the inception of the Mental Health Services Act, LACDMH has sought out ways to create meaningful for roles for public mental health clients recovering from mental illness in the form of employment within public mental health programs, employment in the community and organized volunteer work with stipends. Peer support specialists are being employed in a growing number of settings and programs, from Wellness and Client-Run Centers to street outreach, housing and health navigation to Whole Person Care linkage and support. LACDMH's first Innovation project contained a model specifically designed to test out the role of peers supporting clients in crisis (Peer Respite Homes). The model demonstrated reductions in the number of days clients spent homeless within 6-12 months after a peer respite stay. Additionally, the number of emergency room visits by participants was reduced by more than 25% compared to baseline.

Most recently, LACDMH opened a Peer Resource Center on the bottom floor of our administration building and is recruiting for a Chief of Peer Services that will enhance the career ladder for peers, unify peer support training and eventual certification and develop a full array of opportunities for clients who wish to work as peer support specialists to do so.

This project will build on, and meaningfully enhance, those roles by modifying the direct service staffing to be 63% peers in recovery. Both teams will operate as an FSP team, with the expectation of providing the full range of FSP services, including outreach, engagement, housing and employment support, money management, case management and care coordination and support for clients with co-morbid mental health and substance use conditions. Each member of this FSP team will have a valuable knowledge of resources, in order to provide housing and employment services to this population. One technique PSS staff will use to engage clients is Motivational Interviewing, where peers will be better skilled at tapping into a client's intrinsic motivation for behavioral change, due to understanding their own recovery process. Tailoring the resources needed for this population and using appropriate linkages, to prepare the client for effective engagement and social connection, will lead to successful reintegration into the community. PSS will serve as a liaison between client and legal services to create a culture of trust, which will allow the client to feel less apprehension in obtaining legal advice to resolve issues which may have hindered their personal progress.

After-hours, 24/7 response during times of crisis will be addressed by a peer support specialist being paired with the clinical supervisor. In the event an FSP client needs to be placed on a Lanterman Petris Short (LPS) involuntary detention, the licensed supervisor will be LPS-Designated for that purpose. These FSP teams will also be responsible for collecting and reporting on FSP outcomes as mandated in regulation.

Each PSS FSP team will be composed of 10 members in total; one (1) Licensed Clinical Supervisor who is Lanterman Petris Short Act (LPS) designated, one (1) psychiatrist who is also LPS designated, one (1) Licensed Clinician who is LPS designated, 5 (5) peer staff, one (1) administrative support and one (1) clerical staff. Each peer staff will carry a caseload with a ratio of 1:10, PSS to client. The licensed clinician will serve as a team leader, will carry challenging cases as needed, will respond to crises situations with PSS, lend support and provide clinical direction, conduct initial assessments and care coordination plans in tandem with PSS staff and assist with 24/7 on-call responsibilities. A total of 50 clients will be served by each team, at any given time.

Focus on Justice-Involved Clients

The County of Los Angeles has recognized the need to address the issue of mentally ill individuals in the criminal justice system, and in particular, mentally ill individuals who cycle in and out of the Los Angeles County Jail. The County's commitment to this issue culminated in the creation of the Office of Diversion and Re-Entry. In order to accommodate the County's interest in developing enhanced outpatient mental health services for this population, FSP programs serving justice-involved clients expanded in three waves. First, LACDMH added 300 adult FSP slots for clients with recurring involvement in the criminal justice system.

Los Angeles County served 6,019 adult clients in FSP programs during FY 2016-17. Cumulatively, when comparing the number of clients incarcerated and the days spent in jail the year prior to enrollment in an FSP to after enrollment, adult FSP clients have experienced a 63% reduction in days in jail and a 17% reduction in FSP clients incarcerated

LACDMH is in the process of a second wave of FSP expansion by adding an additional 5,106 FSP slots for clients ages 18 and above. Of this additional capacity, 790 will be dedicated to clients involved in the criminal justice system.

The third wave of this effort would be the implementation of the Peer Support Specialist FSP project.

Breaking the Incarceration Cycle through Peer Support Specialist FSP

Employing the PSS within an FSP program for justice-involved individuals will improve the engagement process and prevent premature disenrollment from treatment. A PSS FSP program would be the transformational approach to address the needs of the justice-involved population who have mental health issues. LACDMH will learn from this innovation project, about how to enhance and maximize the role of peers throughout the mental health system where peers have often been underutilized. Through this partnership, a person's recovery will be addressed comprehensively. This Innovation project will include the PSS FSP team the opportunity to work closely with attorneys and paralegals to address the noted concerns, offered at no charge to the client.

Goals of This Project

1. Optimize meaningful roles for peer specialist staff in FSP programs, including roles related to initial outreach and engagement, ongoing engagement once clients are enrolled, case management and general support and assistance related to obtaining and maintaining housing, employment, benefits establishment.

2. Increase and improve engagement practices and access to care, with underserved and unserved target population, such as justice-involved individuals, through the use the PSS staff through the lense of lived experience.

3. Reduce stigma associated with "mental illness" through employing PSS throughout the mental health system.

4. Ensure PSS staff maintains their recovery while providing intensive services through continuous, specifically tailored training and support.

5. Enhance each PSS Supervisor's knowledge and skill set, regarding the provision of supervision and support to PSS staff.

6. Improve access and linkage connection to legal supportive services, in order to improve successful community integration.

7. Compare outcomes for PSS FSP with FSP programs with a multi-disciplinary staff that serve justice-involved populations.

Target Population

Services: The focal population includes Adults, 18 years of age or older, with a current Axis 1 diagnosis of a major psychiatric disorder who are currently incarcerated or who are at risk of being arrested and incarcerated, as operationalized by one or more of the following:

- Engagement in unlawful and risky behavior
- Unable to pay tickets or other justice-related fees

- Presence of warrants
- Two or more contacts with law enforcement in the past 90 days
- Inability to follow requirements of probation

Overarching Learning Questions and Evaluation

Both Peer Support Specialist FSP teams will be required to collect all FSP data elements and will enter that data into the LACDMH Outcome Measure Application (OMA), a web-based application used for the collection and reporting of FSP and other outcomes. An existing Psychologist employed by LACDMH will be responsible for the development of outcome reports and for the evaluation of this project, utilizing the same approach to outcome reporting as is done for all FSP programs.

1. Will justice involved individuals remain enrolled in FSP services with greater consistency throughout their treatment if support and care is provided by a PSS FSP rather than a traditional FSP team?
    a. Compare reasons for disenrollment (met goals, lost contact, disenrollment due to incarceration of 6 or more months)
    b. Compare average tenure in FSP for differences
    c. Compare FSP clients who remain in FSP for 1 and 2 years with traditional FSP teams serving justice-involved populations.
2. Are there differences in FSP data quality between PSS FSP and traditional FSP programs?
    a. Compare missing baseline reports, Key Event Tracking/Change completion rates and Three Month/Quarterly (3M) outcomes.
3. Are justice- involved FSP clients individuals less likely to recidivate if services are provided by a Peer FSP Team?
    a. Compare incarceration outcome reports (Baseline incarcerations from the year prior to entering FSP to incarcerations after enrollment; cohort incarceration analyses after 1 and 2 years in FSP).
4. Does the work of Peer Support Specialists result in FSP clients who are more successful in integrating back into their communities?
    a. Compare employment and volunteering patterns, distinguishing between in-house and community-based employment and volunteering.
    b. Compare living arrangement outcomes, particularly independent living, congregate living and homelessness.
5. What unique supports need to be put in place for Peer Support Specialists to be maximally effective in their roles in order to achieve effective client outcomes?
    a. Qualitative interviewing of Peer Support Specialists at intervals during the project. This information will not only be used for the evaluation of the project but also to inform ongoing training and technical assistance.
6. Will the addition of legal services to an FSP program help individuals reintegrate in a more timely and successful manner? Will combining the availability of legal services in conjunction with peer support help the justice-involved individual achieve desirable outcomes such as expungement, housing, employment and benefits establishment?
    a. Qualitative assessment of the impact of legal services.
7. Will PSS staff be able to provide the array of FSP services within their current scope of practice?
    a. Compare overall FSP outcomes for Peer Support Specialist FSP to outcomes for traditional FSP programs serving justice-involved populations.

b. Qualitative analysis of Peer Support Specialist competencies in providing each service array element.

8. When peer support specialists expand their roles to include case management and other services more commonly provided by multi-disciplinary staff does that result in peers reporting losing their unique roles associated with lived experience?

Training and Supervision for Peer Support Specialists

Peers will receive training in at least 3 distinct areas:

1. Training on the skills and techniques that are used in the role of a Peer Support Specialist, including:
    a. Intentional Peer Support training
    b. Facilitating the development and use of Wellness Recovery Action Planning (WRAP)
    c. Laws, ethnics and boundaries
    d. Interpersonal skills and engagement
    e. Cultural competence
    f. Self-awareness
    g. Documentation and claiming
    h. Safety and crisis planning
    i. Serving clients with co-occurring mental health and substance use conditions
    j. Role of peer support specialists
        i. Health navigation
        ii. Housing navigation
    k. Recovery services and supports
    l. Motivational Interviewing

2. Orientation to FSP
    a. FSP service array to be delivered by peer support specialists
    b. Delivering services in the field
    c. Use of Client Supportive Services funding
    d. Outreach and engagement strategies
    e. Family involvement
    f. FSP data collection and entry to the Outcome Measures Application (OMA)

3. Training on working with justice-involved clients
    a. Criminogenic factors and service considerations
    b. Justice facility protocols

In addition, as with all other staff, peer support specialists will have access to a wide array of trainings provided by and through LAC DMH. There will be weekly strengths-based didactic hour-long trainings scheduled, in order to integrate the foundational training and maximize PSS and supervisor knowledge base as it pertains to self-examination, wellbeing and client care. Technical assistance and training will also be a core component to the weekly trainings, in order to build and maintain best practices within the PSS FSP program. FSP services will not be interrupted during these team trainings. Monthly continuing educational workshops will continue with a deeper level of criteria for staff and skill development, in addition to ongoing FSP training. The two-fold purpose for this ongoing training is to assist this FSP team in building cohesion and resilience in order to achieve and sustain high quality of services. The supervisor in this Peer Operated program will need additional support based on the added

responsibility of supervising peers with minimal expertise. Additionally, supervisors will have their own training to enhance the skills needed to oversee this program.

The supervisor of each team will have exposure to the training material and experiences that each peer support specialist receives to establish continuity and consistency of approach. Each peer support specialist will receive weekly supervision, in addition to the daily team meetings which are a best practice in FSP.

Stakeholder Involvement in Proposed Innovation Project

Planning for this project began after discussions and concerns arose regarding how to address the needs of specialized populations, such as justice-involved. A peer focus group was conducted in addition to discussion with several peer providers, all of which expressed the need to find effective ways to outreach and engage marginalized populations. Peers who have been through the various social service systems and have learned to navigate these systems and effectively reintegrate into the community, were seen as an integral component of effective engagement to these populations. Subject matter experts shared from a personal stance, as well as knowledge of best practices and trends about the benefits and unique approach of peers in the workforce. Peer providers and stakeholders understand the needs of those whose lives are impacted by the legal system and encourage legal assistance as a preventive measure. FSP programs provide a direct and flexible pathway to these marginalized populations, allowing peers to engage without the barriers experienced by clients in traditional programs.

Feedback has been considered and incorporated into the proposal, and will be implemented.

Timeframe of the Project and Project Milestones

- June 21, 2017: LACDMH System Leadership Team presentation
- October 19, 2017: Held Peer Focus Group
- December 22, 2017- January 19, 2018: 30 Day Public Posting of Proposed Project

Upon approval of the Mental Health Services Oversight and Accountability Commission (MHSOAC), the Department will initiate immediate work on the solicitation and request for positions.

- Spring- September, 2018: Depending upon the Department's decision on whether services will be directly operated, contracted or a combination of both, position requests and/or a solicitation will be developed.
- September- late fall, 2018: Implementation initiated, starting with orientation and the training curriculum described above.

Disseminating Successful Learning

Throughout the four (4) year implementation of the PSS FSP, the Department will focus on learning including addressing barriers to implementation, identify and promote successful strategies, use outcomes to guide learning and implementation and development opportunities for shared learning. The LACDMH Peer Chief will play a lead role in incorporating learning and applying it to the array of peer

services available, as well as ensuring appropriate training and support are available for peer support specialist staff.

Based on the ongoing outcome evaluation, the Department will assess real-time the effectiveness of the these services, the support and training needed for PSS team members and will incorporate learning and successful approaches into the Department's service array and also into the expanding roles that peers play in our mental health service delivery system. The Department's Chief of Peer Services will be highly involved, if not leading the effort, to incorporate learning into practice.

Sustainability

At the conclusion of this project, if it is deemed successful, LACDMH would seek to use MHSA Community Services and Supports FSP funding to sustain the teams. Should Peer Certification legislation advance forward and be signed into law, Medi-Cal billing would be added to the mix of funding.

The Budget

Two teams will be comprised of the following staffing pattern:

- Mental Health Psychiatrist to prescribe medication and perform medication management
- Mental Health Clinical Supervisor to provide clinical and administrative supervision to all staff (with exception of psychiatrist)
- Psychiatric Social Worker II: Conduct Adult assessments, develop treatment plans and perform functions that must be completed by a Licensed Practitioner of the Healing Arts (LPHA).
- Medical Case Worker II (or provider equivalent position) to coordinate outcome data collection and other administrative tasks)
- 5 Community Workers/peer specialists- Provide all services and supports for FSP clients that are within the scope of practice for peer support specialists.
- Senior Typist Clerk/clerical staff – Answer phones, coordinate scheduling and oversee office functions.

The budget attachment includes one vehicle per team of 50 clients for purposes of providing field-based services or for the transportation of clients. Budgeting one vehicle for 50 clients is standard in LACDMH.

Because this will functionally be an FSP program, collecting FSP data, the evaluation will conducted in the same manner that LACDMH conducts the outcome evaluation for FSP. An existing psychologist in the Department will be responsible for the evaluation, therefore there is no budget for evaluation in this project.

The net MHSA Innovation budget across the 4 years of the project is $9,874,886, not inclusive of Medi-Cal revenue. See attachment for the full budget.

This project will be included as part of LACDMH's AB 114 posting for use of reverted MHSA Innovation funds for either FY 2008-09 or 2009-10, depending on expenditures associated with prior, yet current, Innovation projects.

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
PROGRAM DEVELOPMENT AND OUTCOMES BUREAU
MHSA INNOVATION 5 PROJECT - PEER SUPPORT SPECIALIST FULL SERVICE PARTNERSHIP (PEER FSP)

Attachment

DESCRIPTION

ITEM NO.	ITEM & DESCRIPTION			FTE's	1st FY TOTAL SALARY & EB	2nd FY TOTAL SALARY & EB	3rd FY TOTAL SALARY & EB	4th FY TOTAL SALARY & EB
SALARIES & EMPLOYEE BENEFITS (EB)								
4735A	MENTAL HEALTH PSYCHIATRIST			2.0	700,057	700,057	700,057	700,057
9038A	MENTAL HEALTH CLINICAL SUPERVISOR			2.0	256,315	256,315	256,315	256,315
9035A	PSYCHIATRIC SOCIAL WORKER II			2.0	229,461	229,461	229,461	229,461
9002A	MEDICAL CASE WORKER II			2.0	166,559	166,559	166,559	166,559
8103A	COMMUNITY WORKER			10.0	595,970	595,970	595,970	595,970
2216A	SENIOR TYPIST-CLERK			2.0	126,999	126,999	126,999	126,999
	TOTAL SALARIES AND EMPLOYEE BENEFITS	**TOTAL FTES**		**20.0**	**2,075,361**	**2,075,361**	**2,075,361**	**2,075,361**
TOTAL SALARIES & EMPLOYEE BENEFITS (EB)		**2,075,361**			**S&S Including ONE TIME**	**ONGOING S&S**	**ONGOING S&S**	**ONGOING S&S**
SERVICES & SUPPLIES (S & S): ONE TIME COST								
4612	*EDUCATION & TRAINING*		*8,000*		8,000			
CAPITAL ASSETS:								
6049	VEHICLES (2 @ $25,000)	50,000			50,000			
4612	INITIAL CERTIFICATION	22,000			22,000			
TOTAL SERVICES & SUPPLIES - ONE TIME		**72,000**			**80,000**			
MHSA FUNDED SERVICES								
	FLEX FUNDS (50 CLIENT SLOTS @ $3,000 EACH)		150,000		150,000	150,000	150,000	150,000
	LEGAL SERVICES (50 CLIENT SLOTS @ $10,000 EACH)		500,000		500,000	500,000	500,000	500,000
SERVICES & SUPPLIES: ONGOING COST								
2076	*COUNTY TELEPHONE*	*800*	*16,000*		*16,000*	*16,000*	*16,000*	*16,000*
2083	*CELLULAR PHONE CHARGES*	*700*	*12,600*		*12,600*	*12,600*	*12,600*	*12,600*
3240	*OFFICE SUPPLIES*	*600*	*12,000*		*12,000*	*12,000*	*12,000*	*12,000*
3971	*COMPUTERS, PRINTERS, SOFTWARE & PERIPHERALS*	*1,900*	*38,000*		*38,000*	*38,000*	*38,000*	*38,000*
4422	*BUILDING RENTALS*	*15,000*	*300,000*		*300,000*	*300,000*	*300,000*	*300,000*
3580	*CONSULTATION*	*2,500*	*50,000*		*25,000*	*25,000*	*25,000*	*25,000*
5092	*AUTO MILEAGE*	*200*	*4,000*		*4,000*	*4,000*	*4,000*	*4,000*
4612	*EDUCATION & TRAINING*	*-*	*12,000*		*12,000*	*12,000*	*12,000*	*12,000*
TOTAL SERVICES & SUPPLIES - ONGOING					**1,069,600**	**1,069,600**	**1,069,600**	**1,069,600**
GROSS PROGRAM COST					**3,224,961**	**3,144,961**	**3,144,961**	**3,144,961**
REVENUE (MEDICAL/FFP/NON EPSDT):					REVENUE			
9025	MCE (FFP)				237,960	230,120	230,120	230,120
9025	Non-EPSDT				475,920	460,240	460,240	460,240
TOTAL REVENUE					713,880	690,360	690,360	690,360
NET PROGRAM COST								
9911	**MHSA ONLY**				**$ 2,511,082**	**$ 2,454,601**	**$ 2,454,601**	**$ 2,454,601**
							TOTAL MHSA COST	**$ 9,874,886**

STAFF ANALYSIS - LOS ANGELES COUNTY

Innovation (INN) Project Name: **Peer Support Specialist Full Service Partnership**

Total INN Funding Requested: **$9,874,886**

Duration of Innovative Project: **Four (4) Years**

Review History:

Approved by the County Board of Supervisors:	Pending MHSOAC Approval
County submitted Innovation (INN Project):	March 19, 2018
MHSOAC consideration of INN Project:	April 26, 2018

Project Introduction:

Los Angeles County proposes to implement a Full-Service Partnership (FSP) model comprised of peers with lived experiences as mental health consumers and/or justice-involved individuals to assist in serving the justice-involved population who meet the criteria to receive FSP services within the County. To accomplish this, the County proposes to employ self-identified peers with lived experience to provide the full range of FSP services including case management, outreach, engagement and housing/employment support for clients with mental health and substance use.

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 (4) allowable primary purposes: increases access to mental health services to underserved groups; increases the quality of mental health services, including better outcomes; promotes interagency collaboration; and increases access to services, including, but not limited to, services provided through permanent supportive housing. Los Angeles claims this project meets the primary purpose of increasing the quality of mental health services, including measured outcomes, and meets the innovation criteria by making a change to an existing practice

in the field of mental health, including but not limited to, application to a different population.

The Need

Los Angeles County states they continue to actively seek ways to incorporate peers and utilize them in meaningful roles in an effort to assist mental health clients in their recovery process. The County has offered various programs where the role of peers attributed to the success of the program, and as a result, the County wishes to expand its use of peers to assess if peers can successfully implement an FSP model focused on serving mental health consumers.

Although the use and inclusion of peers is worthwhile, it is unclear how this became a need within the County. **County may wish to provide additional information as to how the need for this project was established, other than the need to utilize peers in an FSP model.**

The County indicates there is a need to serve mentally ill individuals who rotate in and out of the criminal justice system. The County states the target population includes adults with a current Axis 1 diagnosis who are currently incarcerated, or are at risk of being arrested and/or incarcerated, by meeting one of the following criteria:

- Engagement in unlawful and risky behavior
- Unable to pay tickets or other justice-related fees
- Presence of warrants
- Two (2) or more law enforcement contacts within the past 90 days
- Inability to follow probation requirements

According to the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV), clients having an Axis 1 diagnosis are for psychological diagnoses except for mental retardation and personality disorder. These psychological diagnoses include, but are not limited to: depression, anxiety disorders, bipolar disorder, ADHD, autism spectrum disorders, anorexia nervosa, bulimia nervosa, and schizophrenia.

In Fiscal Year 2016/17, a total of 6,019 clients were enrolled in FSP programs and as a result, those enrolled clients experienced a 63% reduction of days spent in jail and a 17% reduction in incarceration rates compared to those not enrolled in an FSP program.

As part of the County's commitment to facilitate the transition of justice-involved individuals back into the community, Los Angeles states that the use of peers who offer the full range of FSP services may assist clients to successfully reintegrate back into the community. Additionally, peers having lived experience may be able to provide meaningful insight and suitable linkages to assist in the client's recovery process.

The Response

The County is continuing its efforts to expand the use of peers in the community by opening a peer resource center located within their administration building. This center

will assist peers with employment opportunities, training and will eventually offer peer certification.

A previous Innovation Project brought forward by the County, Peer Respite Homes, also incorporated the use of peers supporting clients in crisis. These alternative peer-run crisis houses were used as alternatives to hospitalizations for persons who were not considered a danger to others. Baseline data reflected a 25% reduction for clients who visited an emergency room during a crisis. Additionally, clients experienced a reduction in the amount of days spent homeless after staying at a peer respite.

To assist clients who are justice-involved assimilate back into the community, Los Angeles will create two (2) teams of ten (10) members that will provide services, support, and linkages to clients meeting criteria to receive adult FSP services. Each member within these teams will be able to provide valuable resources regarding housing, employment services, legal services, case management, money management, and links to other services, as needed. Staff required for this project include: two (2) Mental Health Psychiatrists, two (2) Mental Health Clinical Supervisors, two (2) Psychiatric Social Workers, two (2) Medical Case Workers, ten (10) Community Workers (peer specialists), and two (2) Clerk Typists.

All Clinical Supervisors, Psychiatrists, and Psychiatric Social Workers employed in this project will be designated as Lanterman Petris Short Act (LPS) conservators. An LPS conservatorship is the legal term used in California which gives an adult conservator the responsibility to oversee the mental and medical treatment for an adult (conservatee) who has a serious mental challenge. For this project, the mental health professionals who are LPS designated will be able to appropriately assist those clients who may need to be placed on an involuntary detention.

Each Peer Specialist will carry a caseload of ten (10) clients and will respond to around-the-clock crisis situations, accompanied by their Licensed Clinical Supervisor. Licensed Clinical Supervisors will serve as team lead, handle challenging caseloads as needed, conduct initial assessments and create treatment plans in coordination with assigned Peer Support Staff. Each Peer Specialist will receive weekly supervision in addition to daily team meetings.

Peer Support Specialists will receive training in at least three (3) areas including, but not limited to, skills and techniques utilized in the role as a Peer Support Specialist, cultural competence, recovery services and supports, motivational interviewing, delivering services in the field, outreach and engagement strategies, and training regarding working with justice-involved individuals. Peer Support Specialists will continue to receive weekly hour-long trainings and all team members will receive monthly continuing educational workshops. MHSOAC staff expressed concern and recommended that all Peer Support Specialists receive clinical support, if needed, outside of their supervisory chain of command due to conflict of interest.

The County asserts the incorporation of Peer Support Specialists within an FSP program that provides services for justice-involved individuals will likely improve the engagement process and may prevent clients from dropping from their treatment program.

Part of this project also allows the FSP team to work with attorneys and paralegals, at no charge to the client, to assist clients in resolving any outstanding legal issues that may have prevented or delayed employment opportunities.

In discussing the details of this Innovation Project, MHSOAC staff inquired if Peer Support Specialists would be connected with their clients prior to their release from the County Jail as this would be beneficial during the discharge process from the criminal justice system. Although the County stated Peer Support Specialists would be connected prior to their client's release, the final version of this project does not contain information regarding Peer Support involvement during the discharge process. Additionally, MHSOAC staff recommended incorporating screening criteria for Peer Support Specialists to safeguard both the Peer and their client to avoid relapse from both parties; however, this information was also not captured in the final version of this project. **The County may wish to discuss if Peer Support Specialists will be paired with their clients prior to their release from the criminal justice system and if there will be screening criteria in place to avoid setbacks in the recovery process for both Peer and client.**

The Community Planning Process

To facilitate culturally diverse stakeholder involvement, the County states they assembled a 58-member System Leadership Team (SLT) to provide input related to the various stages of planning surrounding innovation projects, meeting stakeholder composition in compliance with Welfare and Institutions Code 5848.

The County indicates that planning for this project evolved as a result of concerns surrounding how to properly address the needs of those who are justice-involved. Focus groups including peers and peer providers convened and it was expressed that marginalized populations, such as those who are justice-involved, needed to be engaged and targeted with outreach efforts. The County asserts that the use of peers who have navigated through various social service programs may be instrumental in assisting justice-involved clients acclimate back into the community.

The MHSOAC shared this Innovation Project with stakeholders beginning February 21, 2018 and received two (2) comments from one (1) individual:

- Concern expressed that finding a licensed clinical supervisor with lived experience may be difficult. Additionally, it may be difficult to find a licensed clinical supervisor with lived experience who has completed a high level of training who would be able to adequately supervise peer specialists effectively
- Other comment suggested the didactic model of training for peers may not be effective and recommended an adult learning model structured around role playing and student involvement in curricula-based activities such as life skills, presentations, and recovery story development

Learning Objectives and Evaluation

Los Angeles County has proposed implementing a project modeling a traditional Full Service Partnership (FSP) program to address the needs of justice-involved individuals.

The project will be comprised of a team of ten (10) members, including five (5) Peer Support Specialists who can utilize their lived experience as mental health consumers and/or justice-involved individuals to better serve the target population. Specifically, the County will target adults 18 years of age or older with a current Axis 1 diagnosis of a major psychiatric disorder, who are currently incarcerated or at risk of being arrested and incarcerated. Those in risk of being arrested or incarcerated are operationalized as meeting one of the following:

- Engagement in unlawful and risky behavior
- Unable to pay tickets or other justice-related fees
- Presence of warrants
- Two or more contacts with law enforcement in the past 90 days
- Inability to follow requirements of probation.

The County indicates a total of 50 clients will be served by each team at any given time but it is unclear as to the total number of clients that will be served. **The County may wish to clarify the total number of clients they intend on serving annually.**

A number of goals have been identified by Los Angeles County. Goals of the project (**see pg. 3 of County plan**) seek to gain a better understanding of the role of peers in FSP programs, understand engagement practices and access to care with justice-involved individuals using a Peer Support Specialist team, reducing stigma associated with mental illness, improve access and linkage to legal support services, among others.

To meet these learning goals, the County has laid out a number of learning questions, including:

1. Will justice involved individuals remain enrolled in FSP services with greater consistency throughout their treatment if support and care is provided by a Peer Support Specialist FSP team rather than a traditional FSP team?
2. Are there differences in FSP data quality between Peer Support Specialist FSPs and traditional FSP programs?
3. Are justice-involved FSP clients less likely to recidivate if services are provided by a peer FSP team?
4. Does the work of Peer Support Specialists result in FSP clients who are more successful in integrating back into their communities?
5. What unique supports need to be put in place for Peer Support Specialists to be maximally effective in their roles in order to achieve effective client outcomes?
6. Will the addition of legal services to an FSP program help individuals reintegrate in a more timely and successful manner?
7. Will combining the availability of legal services in conjunction with peer support help the justice-involved individual achieve desirable outcomes, such as expungement, housing, employment, and benefits establishment?
8. Will Peer Support Specialist staff be able to provide the array of FSP services within their current scope of practice?
9. When Peer Support Specialists expand their roles to include case management and other services more commonly provided by multi-disciplinary staff does that result in peers reporting losing unique roles associated with lived experience?

Los Angeles County has identified measures and baseline data for each learning question. Examples include: tracking and comparing client enrollment in the Peer Support Specialist FSP program compared to traditional FSP clients; incarcerations prior to entering the Peer Support Specialist FSP in comparison to incarcerations after enrollment; missing baseline reports, event tracking/changes, completion rates compared to three month/quarterly outcomes; employment and volunteering patterns, living arrangement outcomes, etc. between traditional FSP program and Peer Support Specialist FSP; qualitative interviewing of Peer Support Specialists at intervals during the project, among others. (**see pg. 4 of County plan**). All data will be collected by Peer Support Specialist FSP teams, which will be maintained in a web-based application that is currently being used for other FSP programs. Data analysis and the final evaluation report will be completed by a county psychologist currently employed by Los Angeles County Department of Mental Health.

The Budget

The total cost of this project totals $12,659,846; however, the County anticipates Medi-Cal reimbursement in the amount of $2,784,960. The actual proposed MHSA Innovation Project budget is $9,874,886 over four (4) years.

The majority of the budget is going towards personnel costs which accounts for $8,301,444 (84%) of the total budget. There are a total of twenty (20) staff required for this project which includes: two (2) Mental Health Psychiatrists, two (2) Mental Health Clinical Supervisors, two (2) Psychiatric Social Workers, two (2) Medical Case Workers, ten (10) Community Workers, and two (2) Clerk Typists.

The County will make one-time purchases in the amount of $80,000 (8%). These costs will include the purchase of two (2) vehicles each in the amount of $25,000 and education and training provided at the onset of the project in the amount of $8,000. Additionally, one-time costs include the training and certification of all peers in the amount of $22,000. Each team will have one (1) vehicle to provide field-based services or to transport clients to appointments, if needed.

The County's indirect and direct costs are $4,278,400 which includes funds for legal services in the amount of $500,000 (50 clients @ $10,000 each), flex funds for clients in the amount of $150,000 (50 clients @ $3,000 each), and the rest of the funds for purchases of cell phones, office supplies, computer equipment, vehicle maintenance, and education and training costs.

The County indicates the Mental Health Psychiatrists will be responsible for the prescription of medication and overall medication management and the Mental Health Clinical Supervisors will provide clinical and administrative supervision for all staff, with the exception of the Psychiatrist. The Peer Specialists, employed as community workers, will provide necessary services and supports for clients. All initial assessments and development of treatment plans will be the responsibility of the Psychiatric Social Workers while Medical Case Workers will assist in the coordination of data collection. Lastly, senior clerks will assist with office functions such as answering phones and the coordination of schedules.

Peers play a pivotal role in this innovation project and will undergo continuous training, while monitoring and ensuring that their own recovery is not put at risk. Los Angeles indicates that the data collection and evaluation of all FSP plans are currently conducted by an existing psychologist employed by their county. The County claims that since this project will essentially be ran as an FSP program, the psychologist will also be responsible for the collection of data and overall evaluation of this project. As a result, there is no budget allocation specific to the evaluation of this project as there is existing staff who will assume responsibility for the evaluation component. **The County may wish to clarify if CSS funds will be utilized to pay the existing psychologist for their evaluative services.**

Regarding sustainability and dependent upon the overall success of the project, the County states they would like to utilize MHSA Community Services and Supports funding to sustain the teams employed by this project. If legislation is passed regarding the certification of peers, the County indicates Medi-Cal billing would also leverage funding to sustain this project.

In reference to Assembly Bill 114 regarding reversion of funds, the County indicates the funds for this project will be utilized from either Fiscal Year 2008/09 or Fiscal Year 2009/10, although the specific amount is unknown. **The County may wish to clarify the total amount being utilized from Fiscal Year 2008/09 funds.**

Additional Regulatory Requirements

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

References

http://namilacc.org/wp-content/uploads/2015/02/LPS-Conservatorship-Phamplet-2014.pdf

https://en.wikipedia.org/wiki/Diagnostic_and_Statistical_Manual_of_Mental_Disorders

AGENDA ITEM 3

Action

April 26, 2018 Commission Meeting

Orange County and Modoc County Innovation Plans

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Orange and Modoc Counties request to fund a new Innovative project: MHSA Innovative Collaboration Project- Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions. Orange County is requesting a total of $24,000,000 over four (4) years. Modoc County is requesting a total of $270,000 over three (3) years. Orange and Modoc Counties propose to increase access to mental health services to underserved groups by working with the Joint Powers Authority, CalMHSA, to join Los Angeles County, Kern County and Mono County in a multi-county demonstration project to implement a group of technology-based mental health solutions that utilize chat rooms and passive data collection to identify the early signal biomarkers for mental health symptoms and offer prompt intervention.

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

Presenters:

- Jeffrey A. Nagel, Ph.D., Orange County Director;
- Sharon Ishikawa, Ph.D., Orange County MHSA Coordinator;
- Flor Yousefian Tehrani, Psy.D., LMFT, Orange County Program Manager;
- Karen Stockton, Ph.D., Modoc County Director;
- Rhonda Bandy, Ph.D., Modoc County MHSA Program Manager;
- Guillermo Diaz, M.B.A., Modoc County Peer Specialist;
- Adelaida B. More, A.A., Executive Director, Sunray's of Hope, Inc.;
- Ronald Gilbert, Operations Manager, Sunray's of Hope, Inc.;
- Karin Kalk, MA, Director, California Institute for Behavioral Health Solutions.

Enclosures (6): (1) Biographies for Orange County Innovation Presenters; (2) Biographies for Modoc County Innovation Presenters; (3) Staff Innovation Summary, Orange; (4) Staff Innovation Summary, Modoc; and (5) County Project Brief, Orange (6) County Project Brief, Modoc.

Handout (1): PowerPoint Presentation

Additional Materials (2): Links to the Counties complete Innovation Plan are available on the MHSOAC website at the following URL:

Orange County plan
http://mhsoac.ca.gov/document/2018-04/orange-county-inn-plan-description-mental-health-technology-solutions

Modoc County Plan
http://mhsoac.ca.gov/document/2018-04/modoc-county-inn-plan-description-increasing-access-mental-health-services

Proposed Motion: The MHSOAC approves Orange County's Innovation plan as follows:

> **Name:** Mental Health Technology Solutions
> **Amount:** $24,000,000
> **Project Length:** Four (4) Years

Proposed Motion: The MHSOAC approves Modoc County's Innovation plan as follows:

> **Name:** Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions
> **Amount:** $270,000
> **Project Length:** Three (3) Years

Biographies for Orange County Presenters
Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions

Jeffrey A. Nagel, Ph.D.

Jeff Nagel is the Director of Operations for Behavioral Health Services, having previously served as the MHSA Coordinator for Orange County. He is a licensed clinical psychologist, and earned a Doctorate in Clinical Child/ School Psychology from the University of North Texas in 1989. He has held several positions in his nearly 28 years with the county, including running Administrative Services and serving as the agency's Chief Compliance Officer for over ten years

Sharon Ishikawa, Ph.D.

Sharon Ishikawa is the MHSA Coordinator for Orange County. She was previously a researcher for Orange County's Community Services and Supports (CSS) programs, and earned a Doctorate in Clinical Psychology from the University of California, Los Angeles. Prior to coming to the County, she was a Project Scientist at UC Irvine and oversaw the daily operations of a clinical research project evaluating the effectiveness of Cognitive Behavior Therapy delivered over smartphones.

Flor Yousefian Tehrani, Psy.D., LMFT

Flor Yousefian Tehrani is the Innovation Program Manager and has been involved in the development, implementation and evaluation of Orange County Innovation projects since 2011. She is a licensed marriage and family therapist, and earned a Doctorate in Couple and Family Therapy from Alliant International University, Irvine.

Karin Kalk, M.A.

Karin is Director for Health Care Reform with the California Institute for Behavioral Health Solutions. She is currently the Project Manager for the Tech Suite Collaborative. Since 2001, Karin has been providing consulting services throughout California in both private and public managed care and service delivery organizations; these services have included project management, quality/process improvement, and service system design. Prior to this work in the mental health field, Karin was Vice President and General Manager for ForHealth, Inc., a venture-capital funded company offering a specialized medical program for long term care residents through full and partial risk arrangements with senior health plans. Before joining ForHealth, she served as Vice President of Operations for AHI Healthcare Systems, a publicly traded managed care company serving over 200,000 members throughout the country. Karin received her Master's degree in Health Administration from Duke University, her Bachelor of Arts degree in Animal Physiology from University of California, San Diego and has additional formal training in project management, improvement science and IHI's Breakthrough Series improvement methodology.

Biographies for Modoc County Presenters
Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions

Karen Stockton, Ph.D., M.S.W., B.S.N.

Karen Stockton has served as the Health Services (HS) Director for the County of Modoc since June 1, 2006. As HS Director, she also serves as Director of Behavioral Health Services and is responsible for oversight of the MHSA service planning and service delivery. As a part of the County Behavioral Health Association of California (CBHDA) she serves as the Chair of the Superior Region Committee. She has also served on the CalMHSA SEE Team and the MHSOAC Evaluation Advisory Committee. Prior to coming to Modoc County, she was Chair of the Department of Social Work at Andrews University, Berrien Springs, MI. She received her Ph.D. in Leadership in 2003. She has worked for almost 50 years in the fields of nursing, health education, community services, social work, mental health, social justice advocacy and policy development.

Rhonda Bandy, Ph.D., M.Mus., B.Mus.

Rhonda Bandy has served as the MHSA Program Manager for the County of Modoc since February 28, 2017. She is also the Privacy Officer and has additional duties in Quality Improvement. She received her Ph.D. in Leadership in 2010 and has worked in the fields of education, community services, indigent health services, hospital leadership, health education, voluntary organizational disaster response, and non-profit community involvement.

Guillermo (Billy) Diaz, M.B.A., A.B.J. (Bachelor's Degree, Communications/Journalism)

Guillermo (Billy) Diaz is a bi-lingual, self-disclosed person with lived experience. He has an open chart for treatment as a person suffering from manic-bipolar disorder. Since 2010 he has been working as a Behavioral Health Peer Specialist for Modoc County Behavioral Health. He is a certified facilitator for WRAP (wellness and recovery action planning) and currently serves as the Chairman of the Board at Sunray's of Hope, the local wellness and recovery center. He is a member of the Modoc County Behavioral Health Cultural Competency and Quality Assurance Committees and in 2016 became a certified mental health advocate as an ACCESS California Ambassador for the twelve counties in the Superior Region in Northern California.

Ronald (Ronnie) Gilbert

Ronald (Ronnie) Gilbert is scheduled to complete his A.A. in Bio-Psychological Science in 2019 at Chico State University. Ronald became Operations Manager of Sunray's of Hope, Inc., in 2017 after originally starting there as Program Coordinator in 2015. He is a peer support specialist and a self-disclosed person with lived experience and family members with lived experience. He is trained in Crisis Intervention and is a member of the Modoc County Behavioral Health Advisory Board and the Modoc County Behavioral Health Cultural Competency committee. Ronnie is engaged in a three-year term as an ACCESS Ambassador for the 12-county Superior Region of Northern California beginning in December, 2017.

Adelaida (Ida) B. More, A.A. (Human Resource Management)

Adelaida (Ida) B. More is a bi-lingual, self-disclosed person with lived experience and family members with lived experience in mental health and substance use. She is a peer specialist and a peer specialist supervisor, as well as a certified WRAP (wellness and recovery action planning) facilitator. Since 2012, Ida has been the Executive Director of Sunray's of Hope, a peer-to-peer run organization and in 2016 became certified as a mental health advocate and ambassador of ACCESS CA for the twelve counties in the Superior Region of Northern California. In addition to these activities, Ida serves on the Modoc County Behavioral Health Quality Improvement committee and works as a part-time Office Specialist for Modoc County Behavioral Health.

Karin Kalk, M.A.

Karin is Director for Health Care Reform with the California Institute for Behavioral Health Solutions. She is currently the Project Manager for the Tech Suite Collaborative. Since 2001, Karin has been providing consulting services throughout California in both private and public managed care and service delivery organizations; these services have included project management, quality/process improvement, and service system design. Prior to this work in the mental health field, Karin was Vice President and General Manager for ForHealth, Inc., a venture-capital funded company offering a specialized medical program for long term care residents through full and partial risk arrangements with senior health plans. Before joining ForHealth, she served as Vice President of Operations for AHI Healthcare Systems, a publicly traded managed care company serving over 200,000 members throughout the country. Karin received her Master's degree in Health Administration from Duke University, her Bachelor of Arts degree in Animal Physiology from University of California, San Diego and has additional formal training in project management, improvement science and IHI's Breakthrough Series improvement methodology.

STAFF ANALYSIS— ORANGE COUNTY

Name of Innovative (INN) Project:	**Mental Health Technology Solutions**
Total INN Funding Requested:	**$24,000,000**
Duration of INN Project:	**Four (4) Fiscal Years**

Review History:

Approved by the County Board of Supervisors: April 10, 2018
County submitted INN Project: March 27, 2018
MHSOAC consideration of INN Project: April 26, 2018

Project Introduction:

Orange County is proposing to join Los Angeles County, Kern County and Mono County in a multi-county collaboration project to implement a group of technology-based mental health solutions that utilize a web-based network of trained, on-call, peers to chat 24/7 with individuals experiencing symptoms of mental illness; digital detection of emotional, thought and behavioral disturbances through passively collected data; and virtual, evidence-based on-line treatment protocols that use avatars to deliver clinical care.

The multi-county collaborative will utilize the Joint Powers Authority, California Mental Health Services Authority, and (CalMHSA), to act as the fiscal agent for all participating counties. CalMHSA will contract out with one or more technology vendors to implement the suite. The collaborative envisions five core components available in the suite for participating counties to choose from based on the specific needs of their community. In addition, a project manager was hired to lead the collaborative and assist participating counties.

Los Angeles County and Kern County initiated the project and both plans were approved by the MHSOAC on October 26, 2017. Mono County was approved to join the collaborative on February 23, 2018. Both Orange County and Modoc County are proposing to join the collaborative and it is anticipated that several other counties will also propose to join the project in the coming months.

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 (4) allowable primary purposes: increases access to mental health services to underserved groups; increases the quality of mental health services, including better outcomes; promotes interagency collaboration; and increases access to services, including, but not limited to, services provided through permanent supportive housing.

The Need

Orange County reports that stakeholder feedback, a comprehensive needs assessment, and a consumer survey helped them identify the following needs of individuals in their county: stigma reduction, comprehensive case management, family support services, system navigation, linguistic competence, challenges with system navigation, lack of understanding of available services, discomfort with discussing personal problems, concerns about others finding out that they had a mental health problem, and a desire to have providers who understand their culture and speak their language. In addition, the County received feedback that individuals had challenges accessing services after hours and have a need for more one-on-one support.

Separately, Orange County examined results from a school readiness questionnaire designed to assess the developmental health of children between the ages of 3.5 to 6.5 years. The County learned that 30 percent of Orange County children were not on track in the emotional maturity domain and that another 30 percent were at risk.

After evaluating their community needs, Orange County determined that a large-scale approach to outreach, engagement, system navigation and service delivery is necessary to address the needs identified by the community. Orange County also determined that specifically targeting family members of children and adults at risk of developing or living with mental illness will help them evaluate the impact of this project.

The multi-county collaborative, Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions, provides

Orange County an opportunity to address the identified needs and contribute to statewide learning.

The Response

To address these issues identified above, Orange County proposes to join Los Angeles County, Kern County and Mono County in a multi-county collaboration project to address a shared need of increasing access to mental health services for unserved and underserved groups; to reduce stigma and increase early intervention. In order to address these shared needs, the collaboration proposes to partner with one or more technology-based mental health services with the goal to: (1) detect mental illness earlier; (2) intervene earlier to prevent mental illness and relapse and improve client outcomes; (3) provide alternate modes of engagement, support and intervention; and (4) test out the collection of passive data as a method to identify early signs of mental health symptoms.

In order to meet these goals by digitally expanding access to mental health care, the Counties propose to contract with vendors who will provide applications that individuals can voluntarily download and access through smartphones, home computers and computer stations at various locations (schools, libraries, NAMI offices, client run organizations, senior centers, etc.)

The collaborative envisions five core components available in the suite: Peer Support and Digital Therapeutics; Virtual Evidence-Based Therapy Using an Avatar; Digital Phenotyping; Community Engagement and Outreach and Outcome Evaluation.

Orange County provides the following descriptions of the components they will choose to implement:

> The peer chat component will offer support delivered by a trained peer mentor, who will be assisted by AI (Artificial Intelligence) during the chat session. The chat option will also include group chat rooms facilitated by the peer mentors, specifically for family members and/or parents of children living with mental illness. The peer chat component will be accessible on the County website, as well as mobile phones or tablets. This component of the Technology Solutions suite of apps will offer large scale access to support at any time during the day or night, increasing the options available for an individual seeking help.
>
> The Therapy Avatar component (i.e., virtual evidence-based therapy using an avatar) will offer scripted mindfulness exercises and Cognitive Behavioral Therapy interventions delivered through an Avatar. Exercises will be customized through AI and based on a person's responses, allowing for an interactive process between the person and the Avatar. The interaction with an Avatar can offer a sense of

safety and security for individuals who experience stigma or shame associated with mental illness. This process will encourage engagement in mental health support and provide an access point for individuals who prefer anonymity.

The Customized Wellness Coach (i.e., digital phenotyping) is a unique component to the Technology Solutions suite of applications in that it will not require any input or information from the individual. This component will rely on the information that is already gathered by a person's mobile device, using it to automatically tailor wellness strategies to the person's needs. Through this process, this component has the potential to detect early warning signs or prevent the development of mental illness.

Orange County will work with the contracted vendors to implement the Peer Chat and Avatar components in order to customize these apps and provide information, referral and linkage to Orange County services and supports. The County is also planning to provide face-to-face peer support services as an additional source of support for individuals linked to County programs.

As a whole, the collaborative hopes that the use of the digital platform, including digital phenotyping, will support the user to increase understanding of how they are feeling and lead to earlier detection of mental health needs/problems and treatment options. Dr. Insel cautions that better data does not result in better care without an effective bridge. He states that smartphones can provide the tools for assessments and interventions in order to create a "learning mental health system" but that a set of standards and a consumer's guide for digital mental health in the public sector needs to be created.

Additional researchers have encouraged the development of procedures that, "… offer individuals better control of their diverse digital footprints with opportunities to control the information they wish to share" (Bidargaddi et al). This approach may build trust with individuals and avoid ethical challenges. There is an opportunity for the Counties participating in this demonstration project to develop a set of standards and a consumer's guide to digital mental health as a dynamic contribution to statewide learning.

This opportunity to increase access to mental health services using technology is not without concern. Misuse of personal data has gained worldwide attention with Facebook acknowledging that data from 87 million Facebook users may have been shared by a third party without explicit consent. Commenting on the incident, Facebook Chief Operating Officer Sheryl Sandberg stated, "we know that we did not do enough to protect people's data" (Inskeep 2018). Sandberg states that Facebook is committed to changing their practices to protect the data of users and that they are working hard to provide information so that users understand how their information is shared.

In addition, recent reports point out that app users do not necessarily own their data and that third parties often sell user data for profit. This raises the concern of personally identifiable data. Michal Kosinski, et al. reports that "algorithms can now cross-reference wearable-generated biometric data with other "digital traces" of users' behavior" to reveal a person's identity and even predict personality and risk-taking behaviors.

MHSOAC staff recommend that the project lead for the collaborative and CalMHSA address how privacy and data will be securely protected by the contracted vendors and how the use of data will be monitored by the collaborative. Staff also recommend that the project lead and participating counties discuss how users will provide informed consent and be educated about the use of their data.

The Community Planning Process (CPP)

Orange County reports that they reviewed stakeholder input gathered in Fall 2017 for the MHSA Three-Year Plan and identified that stated needs could be met by joining the tech suite collaborative. Between November 2017 and March 2018, County Innovation staff conducted 14 stakeholder meetings and gathered input on joining the collaborative.

During the CPP process, County Innovation staff received enough inquiries to create a list of frequently asked questions to share on their website.

One concern expressed during the CPP process concerned individuals who may not benefit from the technology-based mental health services. Orange County acknowledges that use of the suite will be voluntary and open to all potential users but that they can provide outreach and education to review the purpose and potential of the suite. Orange County is considering having peer staff provide presentations to health care providers of how to refer clients who would most benefit from the technology. Orange County will collaborate with participating counties to identify additional strategies to address this concern.

In addition, during the 30-day public comment period, the County was urged to include specific options in the suite of apps for children, adolescents and Transitional Age Youth (TAY). The County committed to presenting the feedback to the Tech Solutions Steering Committee.

This Innovation Project was shared with MHSOAC stakeholders beginning on January 29, 2018. No letters of opposition or support were received.

Learning Objectives and Evaluation

Orange County has proposed collaborating with Los Angeles County in their implementation of their Innovation project titled, "Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions."

The technology suite will be implemented to educate users on the signs and symptoms of mental illness, improve early identification of emotional and/or behavioral destabilization, and to increase access to mental health services among consumers.

Orange County proposes participating in all five components of the Tech Solutions project, including: peer chat and digital therapeutics, virtual evidence-based therapy, digital phenotyping for early detection and intervention, community engagement and outreach, as well as the outcome evaluation. Consistent with Los Angeles County's original plan, Orange County will target a number of individuals, including individuals with sub-acute mental health symptom presentations, family members of children or adults suffering from mental illness, socially isolated individuals, etc. (**for complete list, see pg. 12 of County plan**). In total, Orange County anticipates serving approximately 320,000 individuals throughout the duration of the project.

The overall learning goals/objectives identified by Orange County include:

1. Detect and acknowledge mental health symptoms sooner
2. Reduce stigma associated with mental illness
3. Increase access to support and care
4. Increase purpose, belonging and social connectedness
5. Analyze and collect data from a variety of sources to improve mental health needs assessment and service delivery.

To meet these learning goals/objectives, the County has laid out a number of learning questions. In addition to addressing all learning questions laid out in the original Los Angeles County plan (**see pg. 7 of County plan**), county-specific learning questions have been developed. These learning questions address individual/family impact, Behavioral Health Services (BHS) System Impact, as well as Community Impact, and include:

- *Individual/Family Impact*
    - Who do the suite of apps work best for?
    - Does the proportion of crisis evaluations and/or crisis evaluations that result in hospitalization within a city decrease following intensive promotion of the Tech Solutions apps in that community?
    - Is the proportion of crisis evaluations and/or crisis evaluations that result in hospitalization lower in cities that received intensive promotion of the Tech Solutions apps relative to cities that did not?

- *BHS System Impact*
    - How does use of the Tech Solutions apps impact enrollment into existing BHS programs?
    - Are some BHS programs affected more than others?

- *Community Impact*
    - Is there an increase in the number of app users within Orange County compared to the number of users prior to the Tech Solutions project?
    - Is the marketing and promotional campaign effective? Are some campaign strategies more effective than others at increasing enrollment into Tech Solutions?
    - Are some apps utilized more than others?
    - Do the utilization rates of apps differ according to population characteristics (i.e., age, gender, preferred language)?
    - Are there differences among individuals who choose to enroll in a technology-based mental health project compared to individuals who do not?

Consistent with all other counties collaborating in the Tech Solutions project, Orange County hopes to arrive at a number of outcomes, including:

1. An increase in purpose, belonging, and social connectedness;
2. A reduction in the duration of untreated or undertreated mental illness;
3. An increase in timely access to mental health care for unserved and underserved populations;
4. An increase in ability to identify cognitive, emotional, and behavioral changes and actively address them;
5. An increase in quality of life, including activity level, employment, school involvement, etc. as identified by the user.

Measures that will be utilized to arrive at each outcome and address each learning question have been identified by the County (**see pg. 9 of County plan**). Data used to measure each outcome that will include passive data, users reached, level of user engagement, access and timeliness of care, as well as clinical outcomes. The County will participate in the multi-county evaluation by gathering data internally and contributing data gathered during the project.

The MHSOAC recognizes that the Innovation regulations do not directly address evaluations of multi-county collaborations. There may be an opportunity to revise regulations to address statewide evaluation methods, including but not limited to, sampling methods.

The Budget

The proposed budget for this Innovation Project is $24,000,000 over the course of four (4) fiscal years.

Innovation funds will solely by used for this project and include: fiscal year 2015-16 funds and a portion of the $13,429,412 in funds subject to reversion through fiscal year 2014-15.

Orange County organized their budget by grouping costs associated with each component of the tech suite together: 24/7 Peer Chat, Therapy Avatar, Customized Wellness coach, Marketing, Evaluation and Administrative (**see Budget Grid on pg. 21 and budget narrative on pgs. 16-20 of County plan for more detail**).

The 24/7 Peer Chat component is budgeted to cost $5,366,829 and funds 12 to 16 FTE Peer Specialists at the rate County Mental Health Worker rate of $21 per hour; 3 to4 FTE Marriage and Family Therapists or Social Workers; Software Engineers, Data Scientists; Information Security and training.

The Therapy Avatar component is budgeted to cost $1,901,281 and funds a Clinical Consultant at 0.5 FTE in year one and 0.25 FTE in years 2-4; Software Engineers; Data Scientist; and Information Security.

The customized wellness Coach component is budgeted to cost $1,901,281 and funds a Clinical Consultant at 0.5 FTE in year one and 0.25 FTE in years 2-4; Software Engineers; Data Scientist; and Information Security.

Administrative costs total $5,521,909 (23 percent) and include the County contribution of $1,142,854 to CalMHSA (5 percent) to oversee the multi-county administrative and financial components; translation services, indirect and direct costs; and travel.

Evaluation costs total $4,488,992 (19 percent) and fund a 0.2 FTE Principal Investigator, who will serve as the lead researcher and be responsible for oversight of the evaluation component, including the development of an evaluation design and methodology; a 0.2 FTE Co-Principal Investigator to assist the Principal Investigator; three 0.10 FTE Co-Investigators from specific fields to provide subject matter expertise; 1 FTE Research Staff, responsible for collection and tracking of data; 1 FTE Statistician; 0.75 FTE County Research Liaison; and costs associated with Process Evaluation and Administrative costs.

If the project is deemed successful, Orange County states that they will continue the program using MHSA Prevention and Early Intervention funds.

If this project is discontinued, the County states that the final year of the project will focus on Peer Specialists transitioning users to appropriate County and/or community behavioral health services and supports.

Additional Regulatory Requirements

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

References

Allen, Jessica & Balfour, Reuben & Bell, Ruth & Marmot, Michael. (2014). Social Determinants of Mental Health. International Review of Psychiatry. 26. 10.3109/09540261.2014.928270.

Bidargaddi, N., Musiat, P., Makinen, V.-P., Ermes, M., Schrader, G., & Licinio, J. (2017). Digital footprints: facilitating large-scale environmental psychiatric research in naturalistic settings through data from everyday technologies. Molecular Psychiatry, 22(2), 164–169. http://doi.org/10.1038/mp.2016.224

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Insel TR. Digital PhenotypingTechnology for a New Science of Behavior. JAMA. 2017;318(13):1215–1216. doi:10.1001/jama.2017.11295

Full project proposal can be accessed here:

http://mhsoac.ca.gov/document/2018-04/orange-county-inn-plan-description-mental-health-technology-solutions

STAFF ANALYSIS— MODOC COUNTY

Name of Innovative (INN) Project:	**Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions**
Total INN Funding Requested:	**$270,000**
Duration of INN Project:	**Three (3) Fiscal Years**

Review History:

Approved by the County Board of Supervisors:	March 13, 2018
County submitted INN Project:	March 12, 2018
MHSOAC consideration of INN Project:	April 26, 2018

Project Introduction:

Modoc County is proposing to join Los Angeles County, Kern County and Mono County in a multi-county collaboration project to implement a group of technology-based mental health solutions that utilize a web-based network of trained, on-call, peers to chat 24/7 with individuals experiencing symptoms of mental illness; digital detection of emotional, thought and behavioral disturbances through passively collected data; and virtual, evidence-based on-line treatment protocols that use avatars to deliver clinical care.

The multi-county collaborative will utilize the Joint Powers Authority, California Mental Health Services Authority, and (CalMHSA), to act as the fiscal agent for all participating counties. CalMHSA will contract out with one or more technology vendors to implement the suite. In addition, a project manager was hired to lead the collaborative and assist participating counties. Los Angeles County and Kern County initiated the project and both plans were approved by the MHSOAC on October 26, 2017. Mono County was approved to join the collaborative on February 23, 2018. Both Modoc County and Orange County are proposing to join the collaborative and it is anticipated that several other counties will also propose to join the project in the coming months.

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 (4) allowable primary purposes: increases access to mental health services to underserved groups; increases the quality of mental health services, including better outcomes; promotes interagency collaboration; and increases access to services, including, but not limited to, services provided through permanent supportive housing.

The Need

Modoc County is a remote, rural county with a population of 8,795 spreading over almost 4,000 square miles (an average of 2.5 people per mile). The largest age group is persons over the age of 65, representing almost 24 percent of the population and double the statewide average.

Modoc County has a statistically higher rate of poverty (18.4 percent) than national (12.7 percent) and statewide averages (14.3 percent). Research suggests that both generational poverty and situational poverty increases the risk of individuals experiencing disruption from mental health needs (Elliott 2016; Allen, et al 2014).

The County reports that access to services continues to be a challenge in the most rural areas of their county. In addition, the County lists several needs identified by stakeholders: (1) stigma reduction, (2) anonymity and privacy when seeking mental health services, (3) discomfort with traditional clinical services, (4) a desire for a more accurate way to report personal wellness data, (5) earlier detection of symptoms combined with earlier access to services, and (6) concern that older adults are particularly vulnerable to issues preventing access to quality mental health care.

Modoc County hopes that prioritizing the use of their Innovation funds to “step-up” to join the technology suite collaboration, will result in better outcomes locally and contribute to a stronger, data-driven, learning collective statewide.

The Response

To address these issues, the County envisions joining Los Angeles County, Kern County and Mono County in a multi-county collaboration project to address a shared need of increasing access to mental health services for unserved and underserved groups; to reduce stigma and increase early intervention. In order to address these shared needs, the collaboration proposes to partner with one or more technology-based mental health

services with the goal to: (1) detect mental illness earlier; (2) intervene earlier to prevent mental illness and relapse and improve client outcomes; (3) provide alternate modes of engagement, support and intervention; and (4) test out the collection of passive data as a method to identify early signs of mental health symptoms.

In order to meet these goals by digitally expanding access to mental health care, the Counties propose to contract with vendors who will provide applications that individuals can voluntarily download and access through smartphones, home computers and computer stations at various locations (schools, libraries, NAMI offices, client run organizations, senior centers, etc.)

Modoc County reports that their ability to address the complexity of needs identified by stakeholders on their own is limited and feels that joining this collaborative is an opportunity to significantly address the needs and make a larger impact than what they could achieve alone.

Modoc County intends to participate in the selection of suite options as they become available in order to choose options that will best serve their community. Specifically, Modoc County will select suite options that increase access to care and maximize passive data collection while addressing their unique rural challenges preventing access to technology. Modoc County has budgeted to purchase devices and web access to ensure accessibility for the targeted populations.

In addition, Modoc County remains committed to advancing their system-wide strategy to make data available and useful in day-to-day service delivery. They plan to utilize the selected suites and link their current Innovation I Project: Electronic Behavioral Health Solutions (eBHS) and Innovations and Improvement Through Data (IITD) with this project.

Modoc County staff will make it a priority to represent their need to keep eBHS in sync with the data elements collected and transferred to the collaborative so that they have full use of their county data in real-time for personal wellness and treatment planning as well as for local quality improvement and evaluation activities.

Modoc County plans to contribute to the evaluation design planning to ensure that they are able to track data elements for evaluation, build out eBHS as necessary to merge new data elements into the system and transmit them to the overall evaluation data collection system. Through ongoing involvement, they want to assess the ongoing viability of eBHS as a management and data analytics tool that can possibly be utilized in other counties.

The collaborative hopes that the use of the digital platform, including digital phenotyping, will support the user to increase understanding of how they are feeling and lead to earlier detection of mental health needs/problems and treatment options. Dr. Insel cautions that better data does not result in better care without an effective bridge. He states that smartphones can provide the tools for assessments and interventions in order to create a “learning mental health system” but that a set of standards and a consumer’s guide for digital mental health in the public sector needs to be created.

Additional researchers have encouraged the development of procedures that, "… offer individuals better control of their diverse digital footprints with opportunities to control the information they wish to share" (Bidargaddi et al). This approach may build trust with individuals and avoid ethical challenges. There is an opportunity for the Counties participating in this demonstration project to develop a set of standards and a consumer's guide to digital mental health as a dynamic contribution to statewide learning.

Misuse of personal data has gained worldwide attention with Facebook acknowledging that data from 87 million Facebook users may have been shared by a third party without explicit consent. Commenting on the incident, Facebook Chief Operating Officer Sheryl Sandberg stated, "we know that we did not do enough to protect people's data" (Inskeep 2018). Sandberg states that Facebook is committed to changing their practices to protect the data of users and that they are working hard to provide information so that users understand how their information is shared.

In addition, recent reports point out that app users do not necessarily own their data and that third parties often sell user data for profit. This raises the concern of personally identifiable data. Michal Kosinski, et al. reports that "algorithms can now cross-reference wearable-generated biometric data with other "digital traces" of users' behavior" to reveal a person's identity and even predict personality and risk-taking behaviors.

MHSOAC staff recommend that the project lead for the collaborative and CalMHSA address how privacy and data will be securely protected by the contracted vendors and how the use of data will be monitored by the collaborative. Staff also recommend that the project lead and participating counties discuss how users will provide informed consent and be educated about the use of their data.

The Community Planning Process

The County reports that they received feedback in 2016 and 2017 that additional services and access to care remained issues in outlying regions. The County also reports that they received ongoing support for the exploration of use of technology as potential way to increase access and linkage.

Stakeholder meetings were held in January of 2018 and that a total of 117 stakeholders were present. The County states that concerns were raised regarding how individuals would be able to afford any necessary devices to participate. As a result, the County has budgeted $30,100 to support individuals to gain access to devices and the web in order to participate in this project.

In addition, the County reports that discussion with peers resulted in plans to boost peer support and modeling related to the collection and use of wellness data and changing use of the term "passive data" to personal wellness data collection. The County plans to engage in ongoing conversations of where and when it will be best to use local peer support staff as the selection of tech suite components are finalized. The County has budgeted $13,000 for the peer support contract and plans to consult with a Peer Specialist in the design, selection and implementation of the tech suite as well as during the evaluation process. The County also reports that consumer and family member involvement in the implementation and evaluation process is a funded priority.

If this plan is approved, Modoc County will formally join the project and begin creating a technology suite steering committee comprised of stakeholders.

This Innovation Project was shared with MHSOAC stakeholders beginning on February 1, 2018. No letters of opposition or support were received.

Learning Objectives and Evaluation

Modoc County has proposed collaborating with Los Angeles County in their implementation of their Innovation project titled, "Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions." The technology suite will be implemented to educate users on the signs and symptoms of mental illness, improve early identification of emotional and/or behavioral destabilization, and to increase access to mental health services among consumers. Specifically, Modoc County seeks to access components of the technology suite that meets the need of their target population—namely, 1) individuals in remote, isolated areas of the county who have less access to social support and mental health services, 2) transition-aged youth with first-break psychosis, and 3) transition-aged youth and adults, engaged in whole-health wellness plans, who desire to track passive data for personal wellness and treatment planning. The County estimates that 300 individuals will be served during the duration of the project.

Modoc County intends on connecting this project with a previous Innovation project titled "Electronic Behavioral Health Solutions and Improvement through Data" in order to expand data use and improve clinical decision making of all clients represented in the county. **The County may wish to elaborate on progress and any outcomes of their current Innovation project and provide an example of how it will be utilized with the proposed project.**

The County has identified three main goals that will guide their innovation project:

1. Expand and diversify capacity to overcome isolation, stigma, privacy, and other social barriers
2. Detect mental illness earlier, including depression, psychosis, and bipolar disorder
3. Intervene earlier to prevent mental illness and improve client outcomes.

A multiplicity of other goals will be developed for this project as the selection of tech products is made. Learning questions the County has identified match those laid out in Los Angeles County's original innovation plan, and have been revised to meet the needs of the county (**see pg. 6 of full plan**). Outcomes the County hopes to arrive at include:

1. An increase in purpose, belonging, and social connectedness
2. A reduction in the duration of untreated or undertreated mental illness
3. An increase in timely access to mental health care for unserved and underserved populations
4. An increase in ability to identify cognitive, emotional, and behavioral changes and actively address them
5. An increase in quality of life, including activity level, employment, school involvement, etc. as identified by the user.

In order to measure outcomes that address each learning question, the County will use passive data, as well as current electronic data. **The County may wish to identify the baseline data that will be utilized to arrive at the outcomes identified.** The County will participate in the multi-county evaluation by gathering data internally and contributing data gathered during the project.

Innovation regulations do not directly address evaluations of multi-county collaborations. There may be an opportunity to revise regulations to address statewide evaluation methods, including but not limited to, sampling methods.

The Budget

The proposed budget for this Innovation Project is $270,000 over the course of three fiscal years (approximately 36 months).

Innovation funds will solely be used for this project and include: $74,612 in funds subject to reversion through fiscal year 13-14 and the remaining $195,388 will come from projected funds from fiscal year 14-15 through fiscal year 19-20.

Personnel costs total $84,909 and fund the Behavioral Health Director at 0.1 FTE, MHSA Project Manager at 0.1 FTE, Information Systems Coordinator at 0.2 FTE and Modoc County Administrative Assistant/Analyst at 0.25 FTE to plan and implement the Innovation project.

In addition, Modoc County proposes to allocate $13,000 to fund Behavioral Health Peer Specialist Services through a contract with the Sunrays of Hope, Inc.

Operating costs total $7,991 and cover the cost of travel for planning and implementation meetings.

Non-recurring costs total $30,100 and will be utilized for technology devices, equipment and web access. Due to limited access to devices, web access and bandwidth available, Modoc County has budgeted to purchase devices and web access to ensure accessibility for the targeted populations.

Modoc County lists $80,000 as their contribution towards the technology suite. The County will purchase products from the technology suite that will best provide alternative modes to accessing social support and mental health services in order to address the previously identified barriers.

Administrative costs total $27,000 (10 percent). The County will contribute $13,500 to CalMHSA (5 percent) to oversee the multi-county administrative and financial components and $13,500 for local administrative costs.

The County states that $27,000 will be used for promotion of the project and evaluation (10 percent).

It is anticipated that Modoc County will participate in the collaborative coordination, promotion, and evaluation and contribute a portion based on an established formula related to the total cost of the project.

If the project is deemed successful, Modoc County states that they will continue the program using a combination of Prevention and Early Intervention, Community Services and Supports and other funds. If this project is discontinued due to poor outcomes or loss of stakeholder support, the county states that they will provide education to staff and clients to ensure a smooth transition into the current system of care.

Additional Regulatory Requirements

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

References

Allen, Jessica & Balfour, Reuben & Bell, Ruth & Marmot, Michael. (2014). Social Determinants of Mental Health. International Review of Psychiatry. 26. 10.3109/09540261.2014.928270.

Bidargaddi, N., Musiat, P., Makinen, V.-P., Ermes, M., Schrader, G., & Licinio, J. (2017). Digital footprints: facilitating large-scale environmental psychiatric research in naturalistic settings through data from everyday technologies. Molecular Psychiatry, 22(2), 164–169. http://doi.org/10.1038/mp.2016.224

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Insel TR. Digital PhenotypingTechnology for a New Science of Behavior. JAMA. 2017;318(13):1215–1216. doi:10.1001/jama.2017.11295

Full project proposal can be accessed here:

http://mhsoac.ca.gov/document/2018-04/modoc-county-inn-plan-description-increasing-access-mental-health-services

Mental Health Technology Solutions

"The Tech suite has the potential to provide a new approach for community members to access resources and support."

~ Orange County Stakeholder

Community Program Planning Process

Between November 2017 and March 2018, a series of stakeholder meetings were held to gather input on joining Tech Solutions.

ATTENDEES

- Consumers
- Family members
- Healthcare providers
- MHSA Steering Committee members
- Mental Health Board members

MEETING STRUCTURE

Meetings were held weekly, and each lasted an average of 2 hours. Innovation (INN) staff provided summaries of each meeting to enable new and continuing members to engage in the process.

Each meeting began with an open discussion to address questions and concerns. INN staff compiled a list of frequently asked questions (FAQs) raised throughout the planning process. INN staff were also available to address questions prior to and after each meeting.

Orange County Behavioral Health Needs and Gaps

During a public forum in Fall 2017, Orange County stakeholders identified stigma reduction, comprehensive case management, family support, system navigation and linguistic competence as behavioral health needs and gaps in Orange County. Similarly, a Member Health Needs Assessment survey completed by 5,812 Orange County CalOptima members identified system navigation and fear of stigma associated with mental illness as key factors that impact access to and use of mental health services.

Members expressed a lack of understanding about available services, discomfort with discussing personal problems and concerns about others finding out that they had a mental health problem. In addition, members reported that they prefer providers who speak their language and understand their culture. Members also reported challenges in accessing services outside of business hours, ineffective outreach and engagement strategies and the need for one-on-one support.

Furthermore, results from the Early Developmental Index (EDI), a school readiness questionnaire designed to assess the developmental health of children between the ages of 3.5 to 6.5 years identified that 30% of Orange County children were at risk and another 30% were not developmentally on track in the emotional maturity domain, which assesses areas such as hyperactivity, inattention, aggression, anxiety, fear and prosocial/helping behaviors. These results highlight the need for increased prevention services to families in the community.

The community feedback, along with the comprehensive needs assessment and EDI results, indicate that a large-scale approach to outreach, engagement, system navigation and service delivery is necessary to address the County's priorities. The Mental Health Technology Solutions (i.e., Tech Solutions) project offers Orange County the opportunity to address the primary problems and priorities identified by the community.

CULTURAL INCLUSIVITY

INN staff has continued to gather community feedback to identify strategies to engage hard to reach, unserved and underserved populations.

In April 2018, INN staff facilitated 1-hour discussion groups with specific populations, including:

- Peer Specialists
- LGBTQ
- Asian/Pacific Islander
- Iranian
- College students
- Korean
- Veterans

To ensure continued meaningful stakeholder involvment, Orange County plans to continue facilitating regular meetings to discuss the outreach and impact of this project.

TARGET POPULATION

One of the key values that the Tech Solutions project could provide is expanding the scope and reach of prevention efforts within Orange County. Targeted prevention programs are needed for families of children at risk of developing mental illness.

Orange County proposes to specifically target family members of children and adults at risk of developing or living with mental illness.

Orange County's Participation

Component	Description	Need in Orange County
Peer Chat 	• Peer chat support • Available 24/7 • Available in user's preferred language	• Family/peer support • Increases access to services • System navigation • Linguistic competence
Therapy Avatar 	• Delivers evidence-based interventions • Customizes interventions using AI	• Anonymity/ stigma reduction • Reduces barriers to access • System navigation
Customized Wellness Coach 	• Utilizes smartphone data to engage, educate and suggest wellness strategies	• Early detection of symptoms
Marketing 	• Promotion of project/suite of apps	• Essential to engaging users in hard to reach, unserved and/or underserved communities
Evaluation 	• Evaluation of project impact/outcomes	• Critical to an INN project • Identifies successful components • Can inform current programs

Project staff will include peer specialists, located within Orange County, who will assist with the implementation of the project.

Orange County proposes a large scale outreach and marketing campaign to promote the Tech Solutions suite of mental health apps. The suite of apps will be accessible to all Orange County residents who own a smartphone, tablet, computer or have access to computer devices. Participation in this project is voluntary, with the option for individuals to download and/or delete the suite of applications at any time.

As participants utilize the suite of apps, they may be linked to County Behavioral Health Services as appropriate through the Peer Chat or Therapy Avatar components. It is anticipated that Orange County will collaborate with the vendors to customize these apps and provide information, referral and linkage to Orange County services and supports. Face-to-face peer support services will also be offered as additional support for individuals linked to County programs.

The County plans to adopt all of the overarching learning questions outlined in previous proposals and collaborate with the approved counties throughout its participation in this project. In the event that the collaborative county partners exit this project during Orange County's four-year timeframe, Orange County plans to continue its evaluation of the overarching learning questions and finish the evaluation accordingly.

In addition to the overarching questions that will be evaluated across all participating counties, and as a result of the local planning, Orange County proposes county-specific questions to examine the impact of this project on the individual/family, County behavioral health programs, and community.

Upon MHSOAC approval, Orange County will finalize a Participant Agreement with CalMHSA; work with CalMHSA to draft contracts with qualified vendors; and collaborate with CalMHSA and the selected technology companies to customize the suite of apps to Orange County's target population and learning objectives.

Budget

Orange County anticipates that its estimated portion of project expenditures for four fiscal years shall not exceed $24 million, with final budget determination prior to solicitation of the project. The proposed budget was developed in partnership with stakeholders during the planning process, as well as through consultations with subject matter experts in technology-based applications and discussions with qualified vendors identified by CalMHSA. Detailed expenditures are outlined in the full proposal.

Budget elements are an approximation and funds allocated to each element may change as finalization of contracts for services are determined.

Budget Grid

Component	Year 1	Year 2	Year 3	Year 4	Total	% Budget
24/7 Peer Chat	$1,156,996	$1,403,278	$1,403,278	$1,403,278	$5,366,829	22%
Therapy Avatar	$487,215	$487,215	$463,426	$463,426	$1,901,281	8%
Customized Wellness Coach	$487,215	$487,215	$463,426	$463,426	$1,901,281	8%
Marketing	$2,613,490	$1,046,040	$580,060	$580,060	$4,819,650	20%
Evaluation	$1,122,248	$1,122,248	$1,122,248	$1,122,248	$4,488,992	19%
Administrative	$1,709,642	$1,369,102	$1,221,582	$1,221,582	$5,521,909	23%
Total Proposed Budget	$7,576,804	$5,915,097	$5,254,020	$5,254,020	$23,999,943	100%

Budget by Proportion: A different view with similar outcomes

Although Orange County developed a detailed budget for its participation based on current rates and research, it is equally imperative to consider proposing a budget based on county size/proportion. Orange County has taken this into consideration and would like to offer the following, proportional perspective. Ultimately, this perspective also arrives at the $24 million estimate proposed and requested by Orange County:

- Los Angeles (LA) County has 10.1 million residents
  - Orange County has 3.2 million residents, 1/3 the population of LA
- As such, LA County proposed $33 million for 3 years
  - Orange County's equivalent proportion for 3 years would be $11 million
  - Orange County proposes 4 years, so an additional year must be factored in
    - $11 million + $3.7 million = $14.7 (~$15 million)
- The MHSOAC and community emphasized the need for hiring local, paid peers
  - Orange County budgeted for 10-16 full-time peer specialists, using the County's Mental Health Worker II rate
    - ~$15 million + $4.8 million = $19.8 million (~$20 million)
- Consultations with the qualified evaluators revealed that a process evaluation is missing in this project and is necessary for successful evaluation
  - Orange County added this element to the proposal and budgeted $1 million
    - ~$20 million + $1 million = ~$21 million
- Administrative costs
  - 18% of *operating* costs must be allocated to OC Indirect costs
  - 5% of the *total* budget must be allocated to CalMHSA
    - $21 million + ~$2 million = ~$23 million

REVERTED FUNDS

At present, the State Department of Health Care Services has identified that Orange County has $13,429,412 in reverted Innovation funds through FY 2014-15 (subject to change pending conclusion of the appeal process).

Upon MHSOAC approval to join the Tech Solutions project, Orange County plans to use FY 2015-16 Innovation funds, as well as a portion of reverted Innovation dollars.

SUSTAINABILITY

The analytics associated with the suite of technology services, coupled with comprehensive evaluation, will inform sustainability at the conclusion of this project.

Factors that will be taken into consideration include user satisfaction, outcomes, and overall effectiveness of the suite of apps.

If deemed successful, Orange County proposes to continue the Tech Solutions project or its components through the MHSA Prevention and Early Intervention component.

Due to the Innovative nature of this project, actual implementation steps may deviate in sequence and/or timeframes.

Proposed Timeline

November 2017– March 2018

- Orange County Community Planning Process
- Development of Tech Solutions Steering Committee
- Participation in cross-county Tech Solutions Steering Committee meetings

December 2017 – February 2018

- Selection and award of contracts

January 2018

- Received MHSA Steering Committee vote to join Tech Solutions
- Posted for 30-day public comment

February 2018

- Launch of virtual services on the Department's website
- Mental Health Board Public Hearing – received vote to join Tech Solutions

March – April 2018

- Identify analytics to be collected and reported on, including developing reporting framework
- Obtained Board of Supervisors approval to join project
- Seek MHSOAC approval to join the Tech Solutions
- Finalize Participation Agreement

April – June 2018

- Selection and award of contracts with qualified vendors
- Customize app components to Orange County
- Begin staffing project: Peer Specialists, Outreach Coordinator and staff
- Engage in ongoing cross-county Tech Solutions Steering Committee meetings
- Develop marketing content
- Begin promotional activities
- Launch of virtual services through identified strategic access points, including schools, libraries, NAMI, client run organizations, social media, senior centers, etc.

April – August 2018

- Development, testing and implementation of digital phenotyping (i.e., deliverable #2)
- Introduction of technology-based mental health solutions to users via schools, social media, and other key community organziations

June – July 2019

- Development, testing and implementation of deliverable #2, including identifying key access points

COMMUNITY PROGRAM PLANNING – STAKEHOLDER FEEDBACK

"It was an intense process, but as a team I think we worked very well and came out with some great ideas. A model of how we can move forward on other projects!"

"Lots of open meeting opportunities for the community to understand and give input to the plan."

"I do not think that there has been another project that has had as much input from consumers, community-based organizations, and the MHSA Steering Committee members.Meetings were held frequently, at different times and locations, and "phone in" options were provided to allow for a variety of participation."

"I commend staff for their thoughtful engagement of the community around Tech Solutions and their many efforts to outreach to our broader community."

"The process was very detailed and inclusive. Staff did a great job to present background information, process and need at various stakeholder engagement meetings."

MHSA Innovative Collaboration Project - Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions

Modoc County Summary

Project Introduction

Modoc County Behavioral Health and its collaborative county partners intends to utilize a suite of technology-based mental health services and solutions which collect passive data that identifies early signs and signals of mental health symptoms and will then provide access and linkage to intervention. Technology-based services would be accessible to clients and public users through devices like computers, tablets, smartphones and other mobile devices. The project will identify those in need of mental health care services through active online engagement, automated screening, and assessment. Services are focused on prevention, early intervention, and family and social support intended to decrease the need for psychiatric hospital and emergency care service.

As a part of their MHSA Innovations pursuits, Los Angeles and Kern Counties joined forces to develop a collaborative approach to purchasing, deploying and advancing technology-based mental health supports and services. In light of the opportunity for greater purchasing power, shared learning and evaluation, and input into the evaluation of this technology, Modoc County Behavioral Health (MCBH) engaged with our stakeholders to determine if the collaborative could be leveraged to serve our local needs.

Based on feedback from stakeholders and in the spirit of collaboration for a state-wide perspective, Modoc County hopes to achieve the following goals by joining the MHSA Innovative Collaboration Project of utilizing a suite of technology-based mental health solutions:

Collaborative Goals:

1. Offer technology-based social support/engagement as an adjunct to traditional services and as an alternative to them.
2. Provide alternate modes of engagement, support and intervention.

Modoc County Specific Goals:

1. Detect mental illness, particularly first break psychosis and depression.
2. Expand and diversify capacity to overcome isolation (social, geographical, climatic, self-stigma, privacy).
3. Intervene earlier, especially with young adults to prevent mental illness and improve client outcomes.

The Need

Modoc County is a geographically large county of 4,200 square miles with a small population of 8,795 people. This sparse population qualifies the county to be designated as a “Frontier County” by the State of California. With a density of only 2.5 people per square mile, mental health service delivery is difficult due to the lack of enough population to support an adequate delivery system.

Our aim is to partner with, and financially contribute to, a collaborative of counties with varying capacities sharing resources aimed to support service delivery systems in all types of population densities. We share the aims of the collaboration while having our own unique aim which speaks to the stakeholder reoccurring prioritization of **the need to build access capacity to reduce isolation and lack of social support** in a way that is sensitive to the unique phenomena of individuals living in small well-acquainted communities who suffer from a lack of anonymity and privacy. Additionally, stakeholders continue to highlight the need to detect mental illness earlier and intervene more effectively, especially with youth.

Community Planning Process

The project was presented to over 117 stakeholders (a little more than 1% of the county population) in communities throughout Modoc County during thirteen presentations in January of 2018. Stakeholders were 15% Hispanic, 81% White and 4% Native American (as compared to the overall county demographics of 15% Hispanic, 80% White and 5% Native American, with other races represented being too few to show up statistically). The program proposal was posted on February 1, 2018 to allow for the 30-day public review period before the scheduled public hearing presentation held by the Behavioral Health Advisory Board on March 5, 2018. No additional substantive stakeholder feedback was received during the Public Review and Comment period or the Public Hearing.

This project was supported and deemed beneficial to Modoc County by the vast majority of stakeholders. During the Community Planning Process, stakeholders remarked on the possible benefits of the project: Older adults in Alturas indicated this type of program could help them with support because they are homebound and have little access to transportation. Resource providers and agencies working with local families indicated the project would work well in reaching youth who are technology savvy, but may not be ready to seek help with mental health issues.

Peers enthusiastically engaged in discussions regarding how they could support the project through modeling and case management. Their ongoing feedback regarding where and when it is best to use local peer support staff, depending on the product(s) selected, will be incorporated into the implementation process. We have included a budget line to increase peer support/case management services for this project. This feedback will continue to be a consideration during the implementation phase of this project. Budget consideration was given to a concern related to how individuals would be able to afford any necessary devices and/or internet access to participate.

The Response

In discussing the stakeholder feedback with the Modoc County Behavioral Health Advisory Board (MCBHAB), Director Karen Stockton proposed joining the other California counties in a technology-based Innovation project. The MCBHAB unanimously expressed their support to pursue the project to help reduce isolation, increase access to services, and identify onset of mental illness sooner. Peer members expressed their ongoing interest in supporting the project locally. Further, they eagerly offered to actively partner with MCBH staff to present the project to the Commissioners of the Mental Health Services Oversight and Accountability Commission (MHSOAC).

Because of positive stakeholder and peer feedback, Modoc County is seeking to partner with the innovative collaborative effort to bring the technology suite of products to our residents. We will work together with the other counties to contract with vendors for product development, provide peer and expert support, and contribute to evaluation strategies. This project will be funded through joining the collaborative financial pool for services contracted through CalMHSA, our local innovation budget, and other in-kind mental health funding streams as necessary.

On the Modoc County level, services will be targeted to three subsets of our population, as identified by our stakeholders:

1) Young adults (TAY): as members most amenable to technology and less likely to participate in traditional mental health services, “products” will be selected and offered to collect passive wellness data to identify illness earlier, especially for individuals with first break psychosis, in addition to products developed to connect them to peers and as alternatives to traditional services.

2) Isolated individuals: for those who live in remote areas geographically and climatically, the "suite of products" will be selected to connect them to peers and others in a "chat" situation, online treatment products and/or passive data collection devices as indicated.
3) Older adults: expected to be most challenged by technology, some have self-identified themselves as using technology to stay socially connected with family and friends, in addition to proudly sporting their personal "fitbits" to give them feedback on exercise, sleep habits, etc. As a group most likely to be challenged by lack of transportation and isolation, the products will be selected, as above, for isolated individuals and priority given to alternatives to traditional services for identification and treatment of depression.

Security and privacy will be provided subject to the online statement provided by CalMHSA (http://calmhsa.org/privacy-statement/) and local Modoc County security and privacy regulations.

Modoc County welcomes program ambiguity, especially in the initial stages of this innovation as significantly positive. Ambiguity allows for flexibility, maneuverability and the ability to connect generic pieces of the "suite of products" to the unique, localized perspective of Modoc County.

Learning Objectives and Evaluation

It is anticipated that as many as 75-100 individuals could utilize the technology-based suite in Modoc County. This estimation is based on the numbers of individuals we currently serve and county-wide penetration reports.

We hope to accomplish the following objectives through this innovation project:

Collaborative outcome learning objectives, learning questions and evaluation:

1. Expand and diversify capacity to overcome isolation, stigma, privacy and other social barriers to expand capacity to provide alternate modes of engagement, support and intervention.
2. Detect mental illness earlier, including depression, psychosis, and bipolar disorder.
3. Intervene earlier to prevent mental illness and improve client outcomes.
4. Utilization of technology-based behavioral health solutions which engage, educate and provide intervention to individuals experiencing symptoms of mental illness.
5. Use passive sensory data to engage, educate and suggest behavioral health activation strategies to users.
6. Create a strategic approach to access points to expose individuals to technology-based mental health solutions.
7. Develop method and conduct outcome evaluation of all elements of the project.

Modoc County specific learning objectives, learning questions and evaluation:

1) Detect mental illness earlier and utilize tools to intervene more effectively, particularly with first break psychosis and in depression (with a focus on older adults).
2) Intervene earlier in mental illness to prevent mental illness in young adults with first break psychosis and improve client outcomes.
3) Identify demographic information of those who use peer support through this technological platform.
4) Determine whether virtual chatting and peer-based interventions will result in greater social connectedness, reduction of symptoms related to mental illness and increase wellbeing.
5) Identify which virtual-based strategies are most helpful in compelling individuals to feel willing and capable of seeking necessary behavioral health care or services.

6) Determine whether passive data collected from smart phones or other mobile devices can accurately detect changes in mental health status and prompt behavioral change effectively.
7) Identify which, if any, digital data informs the need for mental health interventions and coordination of care.
8) Determine effective strategies to reduce the duration of untreated mental illness.
9) Additional goals will be addressed in Modoc's project as relevant to MCBH's selection of products based on our local needs.

Modoc County will be involved at every stage of the evaluation process by contributing funds toward a shared evaluation, participation in development of the evaluation plan, advocacy for inclusion of Modoc priority measures, data collection, data analysis and dissemination of outcomes.

Measures may include, but not be limited to, user demographic data, passive data, measures specific to first break psychosis and depression, participation and completion rates, satisfaction ratings, wellbeing measures, qualitative peer support data and feedback on implementation process, challenges, and barriers.

Budget

Modoc Behavioral Health anticipates their portion of the estimated cost of **project expenditures for three fiscal years shall not exceed $270,000**, with final budget detail determination prior to solicitation of the project. All funds utilized directly for this project will be MHSA Innovations Component funding.

Funds subject to reversion through FY 13-14	$ 74,612
Funds remaining unobligated & projected FY14/15 - FY19/20	$195,388
Total	$270,000

Budget elements are an approximation, and proportion of funds allocated to each element may change as finalization of contracts for services and evaluation are determined. It is anticipated the CalMHSA will be utilized as the fiscal agent for a portion of the program and the percentage funds they manage will be assessed.

As described in the total proposed budget table below, the funds will be divided between personnel costs, contract travel, contract costs for peer support, technology and equipment, evaluation, and administrative costs.

Total Proposed Budget Table:

Expenditures	FY17/18 Partial Year	FY 18/19	FY 19/20	FY 20/21 Partial Year	Total
Personnel Costs: Salaries	8,000	28,303	28,303	20,303	**84,909**
BH Peer Support Contract	2,000	5,000	5,000	1,000	**13,000**
Operating Costs: Travel	2,000	2,000	2,000	1,991	**7,991**
Non-reoccurring Costs: Technology-County Devices/Equipment & Web access		15,100	15,000		**30,100**
"Suite" or "Cafeteria" Products	10,000	35,000	35,000		**80,000**
Administrative costs:					
Local		5,000	5,000	3,500	**13,500**
CalMHSA		5,000	5,000	3,500	**13,500**
Promotion & Evaluation		10,000	10,000	7,000	**27,000**
Total:	**22,000**	**105,403**	**105,303**	**37,294**	**270,000**

AGENDA ITEM 4

Information

April 26, 2018 Commission Meeting

Executive Director Report Out

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

Presenter: Toby Ewing, Executive Director

Enclosures (6): (1) The Motions Summary from the March 22, 2018 Commission Meeting; (2) Evaluation Dashboard; (3) Calendar of Commission activities; (4) Innovation Review Outline; (5) Innovation Dashboard; and (6) Department of Health Care Services Revenue and Expenditure Reports status update

Handout: None

Recommended Action: Information item only

Motions Summary

Commission Meeting
March 22, 2018

Motion #: 1

Date: March 22, 2018

Time: 2:18pm

Proposed Motion: The MHSOAC approves Trinity County's Innovation plan as follows:

Name: Cedar Home Peer Respite
Amount: $267,000
Project Length: Twenty Seven (27) Months

Commissioner making motion: Vice-Chair Aslami-Tamplen
Commissioner seconding motion: Commissioner Gordon

Motion carried 7 yes, 1 no, and 0 abstain, per roll call vote as follows:

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

Motion #: 2

Date: March 22, 2018

Time: 2:57pm

Proposed Motion: The MHSOAC approves San Francisco County's Innovation plan as written with direction to staff to provide technical assistance to the county to fortify the evaluation methodology and report back to the Commission.

Name: Intensive Case Management/Full-Service Partnership to Outpatient Transition Support
Amount: $3,750,000
Project Length: Five (5) Years

Commissioner making motion: Vice-Chair Aslami-Tamplen
Commissioner seconding motion: Commissioner Bunch

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

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

Motion #: 3

Date: March 22, 2018

Time: 3:00pm

Proposed Motion:

The Commission approves the February 8, 2018 and February 22, 2018 Meeting Minutes.

Commissioner making motion: Vice-Chair Aslami-Tamplen
Commissioner seconding motion: Chair Boyd

Motion carried 5 yes, 0 no, and 3 abstain, per roll call vote as follows:

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

Motion #: 4

Date: March 22, 2018

Time: 3:11pm

Proposed Motion:

■ The MHSOAC awards the Adults/TAY Triage Personnel Grants to the following counties for the specified amounts listed and directs the Executive Director to issue a Notice of Intent to make the following awards:

Alameda County	$5,326,702	Sacramento County	$4,019,929
Berkeley City	$871,139	San Francisco	$2,352,746
Butte County	$729,323	Sonoma County	$1,691,878
Calaveras County	$300,476	Stanislaus County	$1,265,717
Humboldt County	$978,964	Tuolumne County	$653,701
Los Angeles County	$24,877,879	Ventura County	$2,486,224
Merced County	$1,017,359	Yolo County	$294,579
Placer County	$1,133,384		

■ The MHSOAC establishes April 5, 2018 as the deadline for unsuccessful applicants to submit an Appeal consistent with the ten working days standard set forth in the Request for Applicants.

■ The MHSOAC directs the Executive Director to notify the Commission Chair and Vice Chair of any appeals within two working days of the submission and to adjudicate the appeals consistent with the procedure provided in the Request for Applications.

■ The MHSOAC directs the Executive Director to execute the contracts upon expiration of the appeal period or consideration of the appeals, whichever comes first.

■ The MHSOAC directs any additional funds that may become available for the Adults/TAY triage grants to be allocated first to Alameda County and Berkeley City, the two applicants who are partially funded due to lack of funding and then to the next highest scoring counties that were not funded until all funds are allocated.

■ The MHSOAC authorizes the Executive Director to negotiate with Alameda County and Berkeley City including, but not limited to, terms such as delayed implementation while awaiting possible additional funds.

Commissioner making motion: Commissioner Danovitch
Commissioner seconding motion: Commissioner Madrigal-Weiss

Commissioners Aslami-Tamplen and Bunch recused themselves.
Motion carried 6 yes, 0 no, and 0 abstain, per roll call vote as follows:

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

Motion #: 5

Date: March 22, 2018

Time: 4:05pm

Proposed Motion:

The MHSOAC authorizes the Chair to work with the Executive Director to continue efforts in working with the author of Senate Bill 1004 to support the principles in the bill, (e.g. establish a strategic vision for PEI and have the Commission approve PEI plans) and refine the language.

Commissioner making motion: Commissioner Danovitch
Commissioner seconding motion: Commissioner Mitchell

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

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

Motion #: 6

Date: March 22, 2018

Time: 4:06pm

Proposed Motion:

The MHSOAC authorizes the Executive Director to work with the Legislature to seek $5 million to support a children's innovation incubator.

Commissioner making motion: Commissioner Mitchell
Commissioner seconding motion: Commissioner Alvarez

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

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

MHSOAC Evaluation Dashboard

Summary: The Mental Health Services Oversight and Accountability 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

- **DOJ Criminal Data Linkage & Analysis** *Mental Health Data Alliance*
  Update: Deliverables 4 first monthly assignment and payment complete other two (2) are still in progress. Contract's Total Spent increased.

- **Visualization Configuration & Publication Support Services** *The iFish Group*
  Update: Deliverable 4 status changed to complete. Contract's Total Spent increased. Deliverable 2 and Deliverable 3 have updated due dates.

Enclosures: MHSOAC Evaluation Dashboard

Recommended Action: None

Presenter: None

Motion: None

MHSOAC Evaluation Dashboard April 2018

(updated 4/10/18)

Current MHSOAC Evaluation Contracts & Deliverables

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 - 06/30/18

Total Contract Amount: $98,450

Total Spent: $37,976

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

Deliverables		October 2017 – June 2018					
1	Statewide Criminal Justice Data Linkage Report	11/14/17					
2.1	County Participation Confirmation Report		11/30/17				
3.1	Evaluation Report of Longitudinal Criminal Justice Involvement among FSP Clients			06/01/18			
3.2	FSP Client Self-report Arrest Data Validation Report				06/01/18		
3.3	CSI Duplicative Client Record Study Report					06/01/18	
4	Monthly Review and Approval of Agile Deliverables						03/18-05/18

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 April 2018

(updated 4/10/18)

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: $500,000

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

Deliverables		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

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

MHSOAC Evaluation Dashboard April 2018

(updated 4/10/18)

Mental Health Services
Oversight & Accountability Commission

The iFish Group

Hosting and Managed Services (17MHSOAC024)

MHSOAC Staff: Pu Peng

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

Total Contract Amount: $423,923

Total Spent: $273,943

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

	Deliverables	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

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

Mental Health Services
Oversight & Accountability Commission
1325 J ST STE 1700
SACRAMENTO CA 95814
(916) 445-8696
www.mhsoac.ca.gov

2018 Commission Meeting Dates

January 25th **Sacramento Office of Education, Mather, CA**
February 22nd **MHSOAC, Sacramento, CA**
March 22nd **MHSOAC, Sacramento, CA**
April 26th **Anaheim, CA**
May 24th **MHSOAC, Sacramento, CA**
July 26th **Location TBD**
August 23rd **Sacramento, CA (tentative)**
September 27th **Los Angeles, CA (tentative)**
October 25th **Mono County (tentative)**
November 15th **Sacramento, CA (tentative)**

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD
April 2018

INN Proposals CALENDARED:

TOYAL # of CALENDARED INN PROPOSALS	COUNTY	TOTAL INN AMOUNT
2 (MAY)	Butte, Sacramento	$19,426,874

INN Proposals to be CALENDARED:

TOTAL # of DRAFT INN PROPOSALS RECEIVED	# of COUNTIES THAT SUBMITTED	TOTAL INN AMOUNT REQUESTED
15	11	$42,308,013

INN Concepts being DEVELOPED:

TOTAL # of INNOVATIVE CONCEPTS RECEIVED	# of COUNTIES THAT SUBMITTED	TOTAL INN AMOUNT REQUESTED
7	6	$13,562,916

APPROVED INNOVATION PLANS-FIVE (5) FISCAL YEARS

2017-2018
- Total INN Dollars : **$97,922,071**
- Total INN Extensions: $5,172,606
- Total # of Projects: 23
- **# of Counties Submitted: 12**

2016-2017
- Total INN Dollars : **$66,347,688**
- Total INN Extensions: $2,008,608
- Total # of Projects: 27
- **# of Counties Submitted: 18**

2015-2016
- Total INN Dollars : **$46,920,919**
- Total INN Extensions: $5,587,378
- Total # of Projects: 17
- **# of Counties Submitted: 15**

2014-2015
- Total INN Dollars : **$127,742,348**
- Total INN Extensions: $1,111,054
- Total # of Projects: 26
- **# of Counties Submitted: 16**

2013-2014
- Total INN Dollars : **$7,867,712**
- Total INN Extensions: $0.00
- Total # of Projects: 14
- **# of Counties Submitted: 8**

Fifty-two (52) Counties have presented an INN Plan to the Commission since 2013= 88%

***Seven (7) Counties have NOT presented an INN Plan to the Commission since 2013= 12%**

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 April 12th, 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.

DHCS Validated RER Status Table

	FY 12-13		FY 13-14		FY 14-15		FY 15-16		FY 16-17	
County	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
Alameda	1/4/2015	1/6/2015	1/10/2017	1/5/2017	9/14/2017	9/29/2017	9/29/2017	9/29/2017	1/2/2018	1/3/2018
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	1/25/2018	2/1/2018
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	1/24/2018
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	2/23/2018	2/26/2018
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	1/24/2018
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	2/22/2018	2/22/2018
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	2/7/2018	1/30/2018	2/7/2018
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	1/29/2018	1/29/2018
Lake	1/31/2018	1/31/2018	2/12/2018	2/12/2018						
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	1/31/2018	2/1/2018		
Madera	4/1/2015	11/8/2016	11/13/2016	12/7/2016	12/6/2016	12/7/2016	5/12/2017		3/27/2018	
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	1/31/2018	2/1/2018
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	3/14/2018	3/14/2018
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	2/1/2018	2/1/2018
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	4/12/2018	
Monterey	4/27/2015	5/6/2015	10/20/2017	10/23/2017	3/29/2018					
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	1/25/2018
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	1/23/2018
Plumas	11/3/2015	11/3/2015	4/10/2017	4/10/2017	6/8/2017	6/23/2017	3/27/2018	3/28/2018		
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	1/25/2018
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	1/25/2018
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	3/21/2018	3/27/2018
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	1/25/2018
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	2/15/2018	2/16/2018
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	1/25/2018
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	3/29/2018	3/30/2018
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	1/25/2018
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	4/3/2018	4/3/2018	4/3/2018	4/3/2018	4/3/2018	4/3/2018	4/3/2018	4/3/2018
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	2/15/2018
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		
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	1/25/2018
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	2/16/2018	3/1/2018
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	3/9/2018	3/12/2018	3/23/2018	3/26/2018
Total	59	59	59	59	56	55	55	53	31	27

Current From: 4/12/18

AGENDA ITEM 5

Information

April 26, 2018 Commission Meeting

California State Auditor's February 2018 Report on the Mental Health Services Act

Summary: The Commission will be presented with an overview regarding the State Auditor's February 2018 report on oversight of the Mental Health Services Act.

The overview provides background on the impetus for the State Auditor's report, a summary of key findings, and recommendations.

The Auditor's report including the responses to the audit report from DHCS, the Commission, and Alameda County Behavioral Health Care Services is on the State Auditor's website:

- https://www.bsa.ca.gov/reports/2017-117/index.html

Background

In June 2017 the Joint Legislative Audit Committee directed the State Auditor to conduct an audit on the oversight of the Mental Health Services Act (MHSA). This audit request was initiated by Senator Beall, a member of the Joint Legislative Audit Committee and of the Mental Health Services Oversight and Accountability Commission.

The audit request was, in part, a result of the Commission work on the MHSA fiscal reversion policy. A full copy of the April 2017 Reversion Report is on the Commission's website:

- http://www.mhsoac.ca.gov/fiscal-reversion-0

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

Enclosures: (1) Overview of the California State Auditor February 2018 Report: *Mental Health Services Act, The State Could Better Ensure the Effective Use Of Mental Health Services Act Funding;* (2) Audit*: Mental Health Services Act, The State Could Better Ensure the Effective Use of Mental Health Services Act Funding*

Overview of the California State Auditor February 2018 Report:
Mental Health Services Act, The State Could Better Ensure the Effective Use Of Mental Health Services Act Funding

INTRODUCTION

On February 27, 2018 the California State Auditor released a report on the Mental Health Services Act, "The State Could Better Ensure the Effective Use of Mental Health Services Act funding". The report focuses on the responsibilities of the Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission.

This overview provides a brief background on the impetus for the State Auditor's report, a summary of key findings and recommendations related to the California Department of Health Care Services (DHCS) and the Commission, and discusses next steps for the Commission's consideration.

A full copy of the Auditor's report, including the responses to the audit report from the DHCS, the Commission, and Alameda County Behavioral Health Care Services, is on the State Auditor's website (https://www.bsa.ca.gov/reports/2017-117/index.html).

BACKGROUND

In June 2017 the Joint Legislative Audit Committee directed the State Auditor to audit the oversight of the Mental Health Services Act. This effort was led by Senator Beall, a member of the Joint Legislative Audit Committee and of the Mental Health Services Oversight and Accountability Commission.

The audit request was, in part, a result of the Commission work on the MHSA fiscal reversion policy. A full copy of the April 2017 Reversion Report is on the Commission's website http://www.mhsoac.ca.gov/fiscal-reversion-0).

In its April 2017 fiscal reversion report, the Commission found that counties held in excess of $100 million that, by law should have been returned to the State Mental Health Services Fund by the end of fiscal year 2015-16 The Commission's policy report noted that, according to DHCS, no funds had reverted since 2008.

The Commission has to date not been able to fully document the amount of unspent MHSA funds held by the counties because the State has not received all of the required, annual Revenue and Expenditure Reports. The Commission's report found that despite these annual reporting requirements, many counties had not submitted their reports by the annual deadline, and in some cases had not submitted required reports within a year or more of the deadline.

In response to the Commission's work on fiscal reversion, in July 2017 the Legislature enacted Assembly Bill 114 (Chapter 38, Statutes of 2017), which allowed counties to retain funds that should have reverted in prior years. AB 114 also required DHCS to report on the funds that otherwise would have been subject to reversion and the counties are required to develop a spending plan by July 1, 2018 and spend those funds prior to July 1, 2020.

SUMMARY OF KEY FINDINGS

The Auditor lists the following three key findings:

- ✓ DHCS' ineffective oversight of local mental health agencies and the MHS Fund allowed hundreds of millions of dollars to remain unspent.
- ✓ DHCS has provided only minimal oversight of the MHSA funds that local mental health agencies received.
- ✓ The Oversight Commission is implementing processes to evaluate the effectiveness of MHSA-Funded programs.

Department of Health Care Services (DHCS)

❖ Due to DHCS' ineffective oversight of local mental health agencies, as of the end of fiscal year 2015-16 there was between $469 million to $586 million in unspent MHSA being held by the local mental health agencies. The Auditor bases this finding on the following:

- ✓ $231 million of unspent funds at the county level as of the end of fiscal year 2015-16 that should have been reverted to the State for reallocation to the other counties. These unspent funds held by the counties were the result of DHCS' failure to develop a process to implement the return of unspent MHSA funds.
  - ✓ The Audit report points out that the Legislature provided a one-time fix through Assembly Bill (AB) 114 that allowed counties to keep the funds subject to reversion as of July 1, 2017. AB 114 also directs DHCS to resolve the issue of funds subject to reversion after July 1, 2017.

- ✓ $81 million in unspent MHSA interest through fiscal year 2015-16 is held at the county level. The report finds that due to lack of guidance from DHCS, counties have been inconsistent on how they treat interest earned on MHSA funds held locally. This lack of guidance has allowed counties to accumulate millions in unspent MHSA interest without reference to a reversion period in which the funds must be spent or returned to the State fund.
  - The report cites that the three counties visited, Alameda, Riverside, and San Diego have not established policies governing how to spend interest on MHSA funds. Alameda reported $3.9 million in unspent MHSA interest as of FY 2015-16 and treated it as fiscal reserve because it believed the interest was not subject to reversion. Riverside indicated it had $6.6 million in interest and it too believed it was not subject to reversion. San Diego had $11 million in interest.

- ✓ Between $157 million and $274 million in excessive local prudent reserves as of end of fiscal year 2015-16. These funds are in addition to cash reserves—MHSA revenues that have not yet

been expended or transferred to a local prudent reserve. Counties are required by law to maintain a local prudent reserve in their local MHS funds, not subject to fiscal reversion, to insure that essential mental health services can be maintained when new MHSA revenues fall below recent averages, adjusted for population growth and inflation. According to the audit report, the excessive reserves are a consequence of DHCS not establishing a process for overseeing the sufficiency of local mental health MHSA fund reserves. The audit report states that these reserves totaled approximately $535 million at the end of fiscal year 2015-16.

Current law permits counties to transfer a portion of annual Community Services and Supports (CSS) revenue into its local MHS prudent reserve or to two other MHSA component accounts (Workforce Education and Training programs or for Capital Facilities and Technological Needs projects).

- The report states that because prudent reserve accounts are not subject to reversion, the lack of DHCS guidance has permitted counties to shelter unspent CSS funds from reversion.
- The report recommended DHCS use historical declines in the MHSA funding for CSS to establish a reasonable level of reserves. The audit reports, that the average revenue decrease in years in which revenues declined from the prior year was 23 percent of the prior year's revenue, with a maximum decline of 33 percent from the prior year. The audit states that had DHCS required counties to maintain a maximum prudent reserve level of 23 percent, an additional $274 million would have been available for mental health services in fiscal year 2015-16.
- According to the audit, DHCS intends to include a standard reserve level in the regulations that it anticipates submitting in January 2019.

❖ DHCS has spent from $7.9 million to $8.6 million annually over the past four fiscal years to administer the fund and has not developed the regulations necessary to implement fiscal reversion, regulate prudent reserve levels, or manage interest earned on unspent local MHS funds. According to the audit report, DHCS initially anticipated submitting the regulations for regulatory review in June 2018 but in its response to the audit report the department has pushed the date back to January 2019. However, AB 114 specifically authorizes DHCS to implement, interpret or make specific the MHSA-related fiscal provisions of the bill via all-county letters or similar instructions until such regulations are in place.

❖ DHCS has not exercised appropriate oversight of the MHS Fund balance under its authority. Per the State Controller's accounting records, there was a MHS Fund balance in DHCS' appropriations of $225 million that has existed since 2012. According to the audit report, as of February 2018 the State Controller made an adjustment and removed the $225 million fund balance. The audit report notes that DHCS will work with the State Controller to ascertain the reason for the adjustment.

❖ DHCS provided only minimal oversight of the MHSA Funds that local mental health agencies received.

✓ DHCS has developed reporting instructions but it has made little effort to ensure counties submit their annual revenue and expenditure reports on time. This has hampered DHCS' ability to calculate MHSA reversion and properly oversee MHSA spending. State regulations requires counties to submit their annual report by December 31 following the end of the fiscal year. Most

counties failed to submit their reports on time. Only 1 of the 59 counties had submitted its fiscal year 2015-16 report by the regulatory deadline.

- ✓ DHCS has had the legal authority and the funding to establish regulations that would allow it to implement sanctions against counties that do not comply with the annual reporting requirements since 2012. DHCS anticipates developing regulations in January 2019.

❖ Although DHCS has taken some steps towards implementing fiscal audits, it had not completed an audit for any county as of December 2017. Specifically, in 2014 DHCS developed a process for MHSA fiscal audits and hired three permanent audit staff, and had done the fieldwork at three counties but none of these audits have been finalized.

- ✓ The report noted that DHCS indicated that audit results will not be released until it establishes a regulatory appeals process that enable a county to challenge any of the audit findings of unallowed costs. DHCS anticipates submitting the audit appeals regulations in the spring of 2019.

- ✓ According to the audit report DHCS' has decided to conduct MHSA fiscal audits in conjunction with its Medi-Cal cost reports, which has resulted in DHCS focusing on data and processes that are outdated because of the backlog of overdue Medi-Cal cost reports. Given the age of the information, the audit's findings and recommendations would have limited value. According to the report, DHCS acknowledged that performing fiscal audits on more recent fiscal years may be needed to ensure more relevant reviews and findings of controls over MHSA funds.

- ✓ DHCS has not developed regulations nor has it implemented program review process to ensure MHSA projects operated by local mental health agencies comply with program requirements contained in state laws and regulations.

The Oversight Commission

❖ The Commission is implementing processes to provide technical assistance to and improve dialogue with the counties regarding Innovation projects.

- ✓ Counties have struggled to spend Innovation funds within the required time frame. Even though Innovation funds are only 5 percent of the total MHSA that counties receive, they account for approximately 63 percent of the $231 million in MHSA funds the audit report identified as subject to reversion as of the end of fiscal year 2015-16.

- ✓ The audit report references the Commission's Innovation subcommittee's list of the challenges that counties face when developing viable Innovation projects as factors that might have contributed to counties' inability to spend Innovation funds in a timely manner:
  - Pressure from local stakeholders to focus on direct services that are less risky and result in easily attainable outcomes.
  - Lack of clarity as to the types of projects the commissioners consider "innovative."
  - Not enough dissemination of lessons learned from project ideas that did not succeed and limited sharing of new project ideas among local mental health agencies.

- ✓ The report states that the actions the Commission has taken, such as establishing the subcommittee on Innovation, updating the template for use by counties in submitting their proposed Innovation projects, and the one-day Innovation event, are reasonable steps to encourage more engagement and dialogue between the counties and the Commission. The audit report notes that it is too soon to know the impact of these actions on improving the counties' understanding of Innovation and reducing the level of unspent Innovation funds.

- ✓ The report notes that the length of the Commission's approval process does not appear to have been a factor affecting the ability of counties to spend Innovation funds.

❖ The Commission is adopting a process for analyzing the local mental health agencies' status reports for Prevention and Innovation projects.

- ✓ The report states that the Commission is taking steps to implement its responsibility to evaluate the effectiveness of the Prevention and Innovation projects. It notes the regulations issued by the Commission in 2015 in response to a 2013 change in state law require local mental health agencies to submit detailed demographic date on the populations that are being served by the counties. The first status report was due December 2017 and the audit report suggests that the Commission has not developed internal processes to review and analyze the reports.

- ✓ The report mentions that in August 2017, the Commission launched an online MHSA fiscal transparency tool that uses an interactive map to display the counties' annual MHSA revenues, expenditure, and year-end balances of unspent funds.

❖ The Commission is developing statewide metrics to evaluate the effectiveness of MHSA-funded triage grants.

- ✓ The first round of triage grants that the Commission awarded required the counties that receive the grants to submit progress reports on the number of triage personnel they have hired, the individuals they have served, and the encounters with individuals that have led to referrals to mental health services. The report notes that the Commission reviews these reports and conducts site visits to ensure that the grantees have attained the goals they identified in their grant applications.

- ✓ The audit report notes that the initial round of grants did not have a unified evaluation approach and the evaluations the Commission received from the grantees represented different approaches and proved too diverse for the Commission to aggregate and translate into a statewide picture. The report acknowledges that the Commission is funding a statewide evaluation for the second round of triage grants.

- ✓ The report states that the steps the Commission had taken were reasonable but questions why the Commission had not established a statewide process for evaluating triage effectiveness sooner.

Alameda, Riverside, and San Diego Counties

The audit report briefly mentions the results of its review of three local mental health agencies: Alameda, Riverside, and San Diego. The report notes that these three counties allocated MHSA funds appropriately, and generally monitored their MHSA-funded projects effectively.

AUDITOR'S RECOMMENDATIONS AND AGENCIES' RESPONSES

The audit report contains specific recommendations to address the findings. There are eight recommendations directed to DHCS, three directed to the Commission, and one directed to Alameda County.

As part of the audit process, each agency was provided a confidential draft of the findings and recommendations related to the specific agency and an opportunity to respond. As provided by the Bagley-Keene Open Meeting Act, the Commission held a closed session on February 8, 2018 to review the confidential draft and write a response.

The audit report contains a copy of the responses submitted by DHCS, the Commission and Alameda County. It also contains the Auditor's comments to DHCS' response.

Each of the recommendations and a summary of the responses are listed below. A reference to the page number where the full responses may be found is provided.

Recommendations Directed to DHCS and DHCS' Response

- ❖ To effectively monitor MHSA spending and provide guidance to the local mental health agencies, DHCS should publish its proposed regulations in the California Regulatory Notice Register by June 2018 and subsequently take the following actions:

  - ✓ Develop an MHSA reversion process to ensure the State can reallocate any MHSA funds that local mental health agencies do not spend within the statutory reversion time frames.
    - DHCS agrees with the recommendation. The DHCS' full response is on page 51 of the audit report.

  - ✓ Clarify that the interest the local mental health agencies earn on unspent MHSA funds is subject to the same reversion requirements as the MHSA funds they received.
    - DHCS agrees with the recommendation. The DHCS' full response is on page 52 of the audit report.

  - ✓ Establish and enforce an MHSA reserve level that will allow local mental health agencies to maintain sufficient funds to continue providing crucial mental health services in times of economic hardship, but that will not result in them holding reserves that are excessive. DHCS should also establish controls over local mental health agencies' deposits to and withdrawals from their reserves.
    - DHCS agrees with the recommendation. The DHCS' full response is on page 53 of the audit report.

- ❖ DHCS should complete its analysis of the $225 million fund balance in the MHS Fund by May 1, 2018 to determine why this balance existed, whether there is any impact on funding to the local mental health agencies and, if so, distribute those funds accordingly. It should also establish a process to regularly scrutinize the MHS Fund to identify any excess fund balances and the reasons for such balances.
    - DHCS partially agrees with the recommendation. The DHCS' full response is on page 54 of the audit report.

- ❖ To ensure that it provides effective oversight of local mental health agencies' reporting of MHSA funds, DHCS should publish its proposed [fiscal] regulations in the California Regulatory Notice Register by June 2018. DHCS should then subsequently implement a process that will enable it to withhold MHSA funds from local mental health agencies that fail to submit their annual reports on time.
    - DHCS partially agrees with the recommendation. The DHCS' full response is on page 54 of the audit report.

- ❖ To ensure that local mental health agencies appropriately spend MHSA funds, DHCS should publish its proposed [audit appeal] regulations in the California Regulatory Notice Register by September 2018. It should then develop and implement an MHSA fiscal audit process, independent of the Medi-Cal reviews, to review revenues and expenditures for the most recent fiscal year.
    - DHCS disagrees with the recommendation. The DHCS' full response is on page 55 of the audit report.

- ❖ To ensure that local mental health agencies comply with their performance contracts and MHSA requirements, DHCS should establish a process for conducting comprehensive program reviews and begin conducting those reviews by July 2018.
    - DHCS agrees with the recommendation. The DHCS' full response is on page 56 of the audit report.

Recommendations Directed to the Commission and the Commission's Response

- ❖ To ensure that local mental health agencies are able to spend Innovation program funds in a timely manner, the Commission should continue its efforts to help local mental health agencies understand the types of Innovation projects that the commissioners believe are appropriate. These efforts should include engagement and dialogue with local mental health agencies through Innovation events and forums about the types of innovative approaches that would meet the requirements of the MHSA. The Commission should use meetings of the Innovation subcommittee or a similar mechanism to evaluate the progress of its efforts to reduce unspent Innovation funds and the need for continued engagement and dialogue with local mental health agencies.

- ❖ To ensure proper oversight and evaluation of outcomes for the Prevention and Innovation projects, the Commission should finalize its internal processes for reviewing and analyzing the program statues reports no later than July 2018. Further, in order to fulfill its statutory responsibility to provide oversight and accountability of MHSA programs, the Commission should ensure that it

launches all three data tools to track local mental health agencies' funding, services and outcomes as it intends.

- ❖ To ensure the MHSA-funded triage grants are effective, the Commission should require that local mental health agencies uniformly report data on their uses of triage grants. It should also establish statewide metrics to evaluate the impact of triage grants by July 2018.

Recommendations Directed to Alameda County and the County's Response

- ❖ To strengthen its monitoring of MHSA projects and ensure that it spends MHSA funds appropriately, Alameda should develop and implement MHSA program monitoring guidelines to ensure that staff appropriately perform and document their monitoring activities.
  - Alameda County agrees with the recommendation. The County's full response is on page 72 of the audit report.

NEXT STEPS

- ❖ Follow up on the $225 million noted in the audit report that was removed from the DHCS' fund balance by the State Controller in February 2018.
  - In response to Commission staff's request, Department Finance (DOF) stated that there was no $225 million fund balance in the MHSF and that the amount identified in the audit report was an old holdover appropriation of county funds which DOF believes is attributed to the transition from Department of Mental Health to DHCS. DOF informed staff that the appropriation did not have an impact to county MHS Fund allocation when DOF completed its monthly fund reconciliation.
  - Commission staff has reached out to the State Controller Office to get further clarification on the adjustment and will work with DHCS on this issue.
- ❖ As to the recommendations directed to the Commission:
  - Staff is continuing its efforts to support local mental health agencies in their Innovation projects. As directed by the Commission at the February 2018, staff is proceeding with developing the Innovation Incubator business plan.
  - Staff is analyzing the Prevention and Early Intervention (PEI) and the Innovation annual reports that were submitted by the counties. To date, there are twenty- two counties that have not yet submit the PEI report and thirteen counties that have not submitted their Innovation report. Staff is working with these counties to better understand the delay and provide assistance to ensure the reports are submitted.
  - Staff is proceeding with implementing the Commission's authorization to enter into a $10 million contract for evaluating the second round of Triage grants.

AGENDA ITEM 6

Action

April 26, 2018 Commission Meeting

Award Senate Bill 82 Children's Triage Program Grants

Summary: The Mental health Services Oversight and Accountability Commission has issued three separate Requests for Applications (RFA) for Senate Bill 82 Triage Program Grants. On March 22, 2018, the Commission awarded the first set of grants for a total of $48 million to 15 counties to operate mental health crisis triage intervention programs for adults and transitional age youth. At the April 26, 2018 meeting the Commission will consider awarding the second set of grants which is for children's Triage Program.

On February 12, 2018, the Commission released the second of the three RFAs. Up to $29.6 million dollars was made available to fund programs that provide services for those who are in need of a mental health crisis intervention in the 0-21 age range. The third RFA has been released and is intended to fund programs aimed at crisis services for children and/or their parents/caregivers. This final triage RFA is still in open procurement.

Applications for the 0-21 RFA were due on April 6, 2018. Applications were scored by Mental Health Services Oversight and Accountability Commission staff. An overview of the winning Applications will be provided to the Commission with a staff recommendation to approve those Applications.

Background

Senate Bill (SB) 82, (Committee on Budget and Fiscal Review, Chapter 34, statutes of 2013), enacted the Investment in Mental Health Wellness Act (Act). Through a competitive grant process, the Act afforded California the opportunity to use Mental Health Services Act (MHSA) funds to expand crisis services for individuals who were experiencing a mental health crisis by increasing the number of crisis triage personnel throughout the state. Often through collaborative relationships with community partners and entities such as hospitals and law enforcement, crisis triage personnel provide linkages for services and direct services.

The main objectives of the Act are to decrease unnecessary expenditures of law enforcement personnel, decrease the overutilization of hospital emergency departments by individuals in a mental health crisis, and to divert individuals in crisis to more appropriate levels of care.

Round One

In February 2014, the Commission funded and administered contracts to implement triage grant services for 24 counties. These counties received a total of $32 million per year over the course of the grants, which were to run from fiscal years (FY) 2013-14 through 2016-17. Due to implementation delays, the Commission extended the time available to expend awarded triage grant dollars by one fiscal year. This extension will end on June 30, 2018.

The first round of grants resulted in more than 70,000 instances of individuals utilizing the services provided through the triage grants. Outcomes associated with

these grants include an increase in access and linkages to services and resources and in the utilization of peers in crisis intervention, a reduction in psychiatric hospitalizations and in stigma associated with mental illness, and improved consumer well-being and coordination of services.

Despite these successes, children's advocates expressed concern that the perception among providers and counties was that Triage funds were specifically authorized to serve adults, even though the authorizing legislation is silent on that issue. As a result of those concerns and the underrepresentation of children and youth in the first round of Triage grant programs, the Legislature modified the authorizing statute to clarify that Triage funds can be used to provide services that are specific to serving children and youth in schools and other settings. SB 833 (Committee on Budget and Fiscal Review, Chapter 414, statutes of 2016) amended the Investment in Mental Health Wellness Act to specifically authorize the triage grants to provide a complete continuum of crisis intervention services and supports for children aged 21 and under and their families and caregivers.

Round Two

In mid-2016, Commission staff began the process of writing an RFA in preparation for a second round of grant funding, slated to begin in FY 2018-19. Interested parties, stakeholders, the California Hospital Association, California Sheriffs, law enforcement personnel, other collaborative partners, and Subject Matter Experts were engaged in forums, meetings, and/or presentations to garner information about the successes and challenges of the Triage Grant programs. These efforts included quarterly meetings with county Triage Grant Coordinators, on-site visits to active triage grant programs, an informational meeting with law enforcement, a forum on Triage, an informational meeting in Berkeley, and meetings with the Commission's Client and Family Leadership Committee and the Cultural and Linguistic Competence Committee.

During this time, Commission staff utilized the lessons learned from the information gathered and made a series of recommendations to the Commission related to the next round of grants that resulted in the following actions:

July 2017	The Commission adopted the staff-recommended principals derived from the June 29, 2017, SB 82 Triage Grant Information Gathering Meeting. These principles included the following: o Statewide evaluation strategy o Set aside for children's triage funding o Population based apportionment
August 2017	The Commission voted to make 50 percent of Triage funds available for children and youth ages birth to 21 years. The remaining 50 percent would be made available to transition aged youth and adults.
November 2017	The Commission authorized the Executive Director to release the SB 82 funds in a competitive manner and within that amount, no less than $30 million be made available for county-school mental health partnerships.

Proposed Motion:

- The MHSOAC awards the 0-21 Triage Personnel Grants to the recommended counties for the specified amounts listed and directs the Executive Director to issue a Notice of Intent to make the recommended awards.

- The MHSOAC establishes May 10, 2018 as the deadline for unsuccessful applicants to submit an Appeal consistent with the ten working days standard set forth in the Request for Applicants.

- The MHSOAC directs the Executive Director to notify the Commission Chair and Vice Chair of any appeals within two working days of the submission and to adjudicate the appeals consistent with the procedure provided in the Request for Applications.

- The MHSOAC directs the Executive Director to execute the contracts upon expiration of the appeal period or consideration of the appeals, whichever comes first.

- The MHSOAC directs any additional funds that may become available for the 0-21 triage grants to be allocated first to applicants who are partially funded due to lack of funding and then to the next highest scoring counties that were not funded until all funds are allocated.

- The MHSOAC authorizes the Executive Director to negotiate with partially funded counties including, but not limited to, terms such as delayed implementation while awaiting possible additional funds.

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

Enclosure: None

Handout: A PowerPoint will be provided at the meeting

AGENDA ITEM 7

Action

April 26, 2018 Commission Meeting

Evaluation Contracts Authorization

Summary: In 2015, the Commission began an effort to document and make publicly available information on mental health revenues and expenditures, services, and outcomes. The first phase of that work focused on fiscal transparency and included the Commission's report on Fiscal Reversion and the release of the fiscal transparency tool, covering revenues received, expenditures, and funding available for allocation.

Phase two, covering mental health programs and services, is currently in development. This tool will provide information on mental health programs and services, including information on people served. This information is drawn from the reporting counties provide to the Commission through their Three-Year Program and Expenditure Plans, and other reports.

Phase three would identify, track and display key information on mental health outcomes. The Commission's initial efforts to track outcomes focus on the seven core outcomes identified in the Prevention and Early Intervention component of the MHSA, namely, reductions in criminal justice involvement, school failure, removal of children from their homes, homelessness, suicide, unemployment, and prolonged suffering.

As part of this work, the Commission recently linked data on arrests and convictions with mental health client data. That work is intended to improve understanding of whether and how mental health services, such as Full-Service Partnership wrap-around services, are reducing criminal justice involvement. Similar work is underway to link mental health data with other data sets, including employment, education, and child welfare.

The Commission also has been exploring options to track disparities, and other goals established in the Act.

Commissioners have discussed the need to create a broader discussion of mental health outcomes beyond these goals, such as timely access to care.

In support of this need, the Commission will consider authorizing the Executive Director to enter into one or more contracts, not to exceed $1,400,000, to support the development and implementation of a strategy to identify and track existing and additional mental health outcomes.

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

Enclosures: None.

Handouts: A PowerPoint will be presented at the meeting.

Proposed Motion: The Commission authorizes the Executive Director to enter into one or more contracts, not to exceed $1,400,000, to support the development and implementation of a statewide strategy for MHSA evaluation, including establishing statewide outcomes goals, outcomes tracking, component evaluation, and ongoing evaluation.

AGENDA ITEM 8

Action

April 26, 2018 Commission Meeting

Approval of Innovation Funds for Community Planning of Innovation Projects

Summary: San Diego County has requested authorization to use $100,000 of Innovation funds for a community planning process to guide an Innovation project. The County is proposing using a Human-Centered Design strategy in this process.

Appropriate Use of Innovation Funds? In considering this request, the Commission should explore whether use of Innovation funding is appropriate for this purpose. The Mental Health Services Act requires the counties to dedicate up to five percent of their MHSA funds for community planning purposes, including Innovation planning. County officials suggest they primarily use funding from their Community Services and Supports (CSS), or other county funds, to pay for the Innovation planning.

Precedence. During its November 2017 meeting, the Commission authorized Santa Clara County to use approximately $572,000 in Innovation funding to support a planning phase for its Head Space Innovation Project. Following the planning process, the County indicated it would return to the Commission to seek support for implementation funding. Supporting this request is consistent with the Commission's vote to authorize Santa Clara County's use of Innovation funding for planning project development purposes.

Reasonable Limits on Planning Funds. The Commission has the option of considering this request for San Diego County or for all counties. The Commission should consider directing staff to work with counties to develop a reasonable and appropriate limit on the use of Innovation funds for Innovation planning and a strategy to monitor the use of those funds.

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

Enclosures: March 28, 2018 letter from San Diego County.

Proposed Motion: The Commission approves San Diego County's request to spend $100,000 of Innovation funds to support a Human-Centered Design strategy to develop its next Innovation Project. Commission directs staff to develop and present to the Commission a strategy for approving use of Innovation funds to support counties' planning for Innovation projects.

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

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ALFREDO AGUIRRE
DIRECTOR, BEHAVIORAL HEALTH SERVICES

March 28, 2018

Toby Ewing, PhD
Executive Director
Mental Health Services Oversight and Accountability Commission (MHSOAC)
1300 17th Street
Sacramento, CA 95811

Dear Dr. Ewing,

This letter is in regard to the Community Planning Process (CPP) conducted by the County of San Diego Health & Human Services Agency, Behavioral Health Services (BHS). As part of our CPP, we are intending to pilot a human-centered design process to guide an Innovation project proposal. The proposal, as informed by our stakeholders, will feature technology-based enhancements for mental health practice.

To engage a consultant for the design process, we request your consent as Executive Director, for an expenditure of $100,000 of BHS Innovation funds. The expenditure will provide for a contract to develop and facilitate an objective process with our community stakeholders. Our contract proposal will seek an organization that is skilled in human-centered design, a highly regarded practice in technology industries and academia that includes the end-user in all stages of design. The contractor will be selected through a stringent competitive procurement.

Being aware of statewide efforts to improve behavioral health practice through technology, we expect to interconnect with other Counties and the MHSOAC at every step. We hope to be able to benefit from learnings generated by all partners. At the intersection of wellness and technology there is much to learn, and we can progress more steadily as a team.

Sincerely,

ALFREDO AGUIRRE, LCSW, Director
Behavioral Health Services

AA:lc

cc: Adrienne Collins Yancey, MPH, MHSA Coordinator/Prevention Services Manager. BHS

AGENDA ITEM 9

Information

April 26, 2018 Commission Meeting

Draft Business Plan for Innovation Incubator

Summary: The Governor has included in his January 2018 budget proposal $5 million in funding for the Commission to establish an Innovation Incubator as a strategy to support county mental health innovations. The Governor's proposal would require these funds to focus on strategies to reduce the number of mental health consumers who become involved with the criminal justice system.

Consistent with a vote of the Commission at its March 22, 2018 meeting, staff has asked the Assembly and Senate Budget Committees to consider augmenting that investment by an additional $5 million to support innovations around the needs of children.

In support of this funding proposal, the Commission retained California Forward and X-SECTOR LAB to support the development of a business plan for the Innovation Incubator for the Commission's consideration.

Executive Director Ewing will provide a brief overview of the project including information from the February 2018 Innovation Summit convened by the Commission. David Smith, with X-SECTOR LAB, will provide an overview of the proposed process for the development of the business plan.

Presenters:

- Toby Ewing, Ph.D., Executive Director; and
- David Smith, X-SECTOR LAB

Enclosures: Project Brief

Proposed Motion: Information only item

Mental Health Services
Oversight & Accountability Commission

BUILDING AN INCUBATOR FOR MENTAL HEALTH INNOVATION IN CALIFORNIA

Summary

The innovation provisions of the Mental Health Services Act (MHSA) provide California the opportunity to develop, test and scale new approaches to service delivery with the potential to significantly improve mental health services and outcomes. The primary purpose of MHSA's innovation projects is to achieve the following:

- Increase access to mental health services to underserved groups, including but not limited to, services provided through permanent supportive housing
- Promote interagency and community collaboration related to mental health services
- Increase the quality of mental health services and measurable outcomes, including the reduction of:
  - homelessness
  - incarceration
  - suicide
  - unemployment
  - other mental health related challenges

From April to July 2018, the Mental Health Services Oversight and Accountability Commission (MHSOAC), in partnership with California Forward and X Sector Labs, will undergo a series of public meetings and design labs to explore the administrative functions, build a business plan, and develop criteria for the management of an organization that can incubate mental health innovation in California. This process will inform the MHSOAC on best practices and analogous models, and it will provide an opportunity for stakeholder engagement. A proposal will be completed for presentation and discussion at the MHSOAC Commission meeting in July 2018.

This innovation incubator would help counties:

- **Work collectively** to develop partnerships within their communities and among counties
- Secure **technical assistance** and connect the incubation process with the formal community planning process
- Design and implement better **community engagement** strategies, including innovation with consumers and community partners at the center
- **Evaluate** projects and emerging practices to encourage replication and continuous improvement
- Disseminate information on challenges and progress through a **community of practice**

Key Questions to Investigate

1. What are the desired functions of the innovation incubator (challenges, solutions, services delivered, outputs and outcomes)?
2. What is the business model (or set of models) for a sustainable innovation incubator?
   - Which agencies and organizations should be involved and how can they be involved from the beginning to support, own and make it successful and viable?
3. What is the best model for management, governance and operation?
4. Who will run the incubator over time (operator selection process)?

Challenge and Opportunity

Counties develop plans for spending innovation funds and the Commission reviews and approves those plans. The Commission has found that the innovation component of the MHSA could be enhanced through the support and technical assistance of external innovators and subject matter experts, as well as strategies to encourage cross-county collaboration.

The Commission recently explored the circumstances, procedures and services associated with individuals with mental health needs who become involved in the criminal justice system. State policymakers are concerned about the significant increase in court referrals to State Hospitals for those deemed incompetent to stand trial. The growing costs and unsatisfactory outcomes associated with this intersection of the mental health and criminal justice systems are unacceptable, and these circumstances present the need and opportunity for innovation in services and practices that could reduce the number of and better manage these cases.

The Commission believes there are opportunities throughout the mental health system to transform practices and services in ways that improve care and results. The Commission aspires to work with counties to develop the right support structure to produce these innovations. The incubator will be a consulting service that brings together experts from health care, technology, communications, translation science and management sectors to improve California's use of innovation funds. The Commission will establish a selection process to identify a partner to design, create and launch this incubation service.

The incubator will be a physical venue for innovation where groups of counties can come for human-centered design experiences, collaboration opportunities, and prototyping interventions that can be funded for implementation. The initial focus of the incubator will be on reducing the number of mental health consumers who become involved in the criminal justice system as a strategy to reduce the number of people declared incompetent to stand trial in California, while also exploring other high priority mental health needs.

Timeline and Key Dates

APRIL 26
MHSOAC COMMISSIONER MEETING
LOS ANGELES

TBD
STAKEHOLDER MEETING
SACRAMENTO

MAY-JUNE: DESIGN LABS
SAN FRANCISCO BAY AREA & L.A. COUNTY

- **Focus: Desired functions/services/outcomes/ business model/partners**
- **Participants: County/State Agencies, Community Partners, Mental Health Services Providers, and Innovation/Design Experts**

MAY 24: COMMISSION MEETING ***PRESENTATION OF EARLY LEARNINGS***
SACRAMENTO

JULY 26: COMMISSION MEETING ***PRESENTATION OF BUSINESS PLAN***
LOS ANGELES

Background

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA) to expand mental health service throughout the state. The Act specifies allocations for county expenditures but permits each county to develop plans to address their specific needs. Of the total funding provided to each county, five percent (5%) is required to support innovation projects. The Act created the Mental Health Services Oversight and Accountability Commission (MHSOAC) to provide broad oversight and leadership in the community mental health system statewide. MHSOAC is charged with numerous roles, including the exploration of innovative strategies to transform community mental health services and oversight and approval of over $100 million per year in county innovation projects.

AGENDA ITEM 10

Action

April 26, 2018 Commission Meeting

Legislation

Summary: The Commission will consider whether to support legislations related to mental health services under the Mental Health Services Act.

Enclosed for the Commission's review is a list of bills staff is aware of that relates to mental health under the Mental Health Services Act that the Commission may wish to support:

Presenters:

- Toby Ewing Ph.D., Executive Director
- Norma Pate, Deputy Director

Enclosures: (1) Legislative Tracking Chart; (2) Copy of bills and committee analyses

Handout: None

Proposed Motion: The MHSOAC authorizes the Executive Director to pursue discussions with the Legislature consistent with the direction given by the Commission.

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

2018 Legislative Report to the Commission

April 13, 2018

Sponsored Legislation

Senate Bill 1019 (Beall)

Title: Youth mental health and substance use disorder services.

Summary: Current law provides that funds appropriated by the Legislature to the California Health Facilities Financing Authority and the Mental Health Services Oversight and Accountability Commission for the purposes of the Investment in Mental Health Wellness Act of 2013 be made available to selected counties or counties acting jointly, except as otherwise provided, and used to provide, among other things, a complete continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state. The act requires the commission to allocate funds to triage personnel, as specified. This bill would require the commission, when making these funds available, to allocate at least one-half of those funds for services or programs targeted at children and youth 18 years of age and under.

Status/Location: Scheduled to be heard by the Senate Education Committee on April 18, 2018 at 1:30 p.m.

Senate Bill 1113 (Monning)

Title: Mental health in the workplace: voluntary standards.

Summary: Would authorize the Mental Health Services Oversight and Accountability Commission to establish a framework and voluntary standard for mental health in the workplace that serves to reduce mental health stigma, increase public, employee, and employer awareness of the recovery goals of the Mental Health Services Act, and provide guidance to California's employer community to put in place strategies and programs, determined by the commission, to support the mental health and wellness of employees.

Status/Location: Senate Appropriations

Supported Legislation

Assembly Bill 2325 (Irwin)

Title: County mental health services: veterans.

Summary: Would prevent a county from denying an eligible veteran county mental or behavioral health services while the veteran is waiting for a determination of eligibility for, and availability of, mental or behavioral health services provided by the United States Department of Veterans Affairs. The bill would make specific findings and declarations about the county's duty to provide mental and behavioral health services to veterans.

Status/Location: Scheduled to be heard by the Assembly Health Committee on April 24, 2018 at 1:30 p.m.

Senate Bill 215 (Beall)

Title: Diversion: mental disorders.

Summary: 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.

Status/Location: Assembly Desk

Senate Bill 688 (Moorlach)

Title: Mental Health Services Act: revenue and expenditure reports.

Summary: Current 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. Current law requires counties to electronically submit the report to the department and the commission. This bill would require counties to prepare the reports in accordance with generally accepted accounting principles, as specified.

Status/Location: Assembly Desk

Senate Bill 906 (Beall)

Title: Medi-Cal: mental health services: peer, parent, transition-age, and family support specialist certification.

Summary: 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.

Status/Location: Senate Appropriations

Senate Bill 1004 (Wiener)

Title: Mental Health Services Act: prevention and early intervention.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, on or before January 1, 2020, to establish priorities for the use of prevention and early intervention funds and to develop a statewide strategy for monitoring implementation of prevention and early intervention services, including enhancing public understanding of prevention and early intervention and creating metrics for assessing the effectiveness of how prevention and early intervention funds are used and the outcomes that are achieved. The bill would also prohibit funding for county prevention and early intervention programs from being distributed until after the approval of the county's prevention and early intervention plan by the commission.

Status/Location: Senate Appropriations

Under Review

Assembly Bill 2287 (Kiley)

Title: Mental Health Services Act.

Summary: Would establish the Office of Mental Health Services within the California Health and Human Services Agency, as specified. The bill would transfer various functions of the State Department of Health Care Services under the act to the office. Under this bill, the office would succeed to, and be vested with, all the duties, powers, responsibilities, and jurisdiction, vested in the department, regarding oversight of the Mental Health Services Fund, as specified. The bill would also require the office to assume certain duties, including, among others, initiating investigations, advising counties, conducting research, and reporting to the Legislature, by December 31, 2020, of any additional authority it deems necessary to complete its duties and to ensure county compliance with the act, as specified.

Status/Location: Scheduled to be heard by the Assembly Health Committee on April 24, 2018 at 1:30 p.m.

Assembly Bill 2619 (Allen)

Title: Mental health services funding: homeless persons.

Summary: Would appropriate $10,000,000 from the General Fund to the State Department of Health Care Services to be distributed to counties for the purpose of funding innovative programs to provide mental health services to California's homeless population.

Status/Location: Scheduled to be heard by the Assembly Health Committee on April 17, 2018 at 1:30 p.m.

Assembly Bill 2843 (Gloria)

Title: Mental Health Services Fund.

Summary: Would state the intent of the Legislature to enact legislation that would require a county that receives reallocated funds from the Mental Health Services Fund to spend those funds within 2 years of adopting an expenditure plan for those funds. It would further state the intent of the Legislature that any funds not expended by a county within those 2 years would revert to the Mental Health Services Fund to be redistributed to cities, special districts, school districts, or other public entities for the provision of mental health services consistent with the intent of the MHSA.

Status/Location: Scheduled to be heard by the Assembly Health Committee on April 17, 2018 at 1:30 p.m.

Senate Bill 1101 (Pan)

Title: Mental health.

Summary: In addition to the Commission's existing duties, this bill would require the commission, on or before January 1, 2020, to establish 5 statewide objectives for the treatment and prevention of mental illness and metrics by which progress toward each of those objectives may be measured.

Status/Location: Scheduled to be heard by the Senate Health Committee on April 25, 2018 at 1:30 p.m.

Senate Bill 1134 (Newman)

Title: Mental health services fund.

Summary: This bill would make technical, non-substantive changes.

Status/Location: Senate Rules.

Senate Bill 1206 (de León)

Title: Mental health services fund.

Summary: Would enact the No Place Like Home Act of 2018 and provide for submission of that act to the voters at the November 6, 2018, statewide general election. The bill would specify that the service contracts between the California Health Facilities Financing Authority and the Department of Housing and Community Development may be single-year or multiyear contracts and provide for payments to the department from amounts on deposit in the Supportive Housing Program Subaccount. The bill would declare that the voters ratify as being consistent with and in furtherance of the MHSA, and approve for purposes of specified provisions of the California Constitution relating to debt, specified statutes related to the No Place Like Home Program and related financial provisions.

Status/Location: Senate Health.

Senate Bill 1458 (Hueso)

Title: County mental health plans.

Summary: Would state the intent of the Legislature to enact legislation that would require compliance from county mental health programs regarding reporting requirements established pursuant to the MHSA.

Status/Location: Senate Rules.

AMENDED IN SENATE APRIL 2, 2018

SENATE BILL No. 1019

Introduced by Senator Beall
(Coauthor: Senator Hertzberg)
(Coauthors: Assembly Members Acosta, Lackey, Maienschein, and Mathis)

February 7, 2018

An act to amend Section 5848.5 of, and to add Part 5.5 (commencing with Section 5920) to Division 5 of, the Welfare and Institutions Code, relating to youth mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1019, as amended, Beall. Youth mental health and substance use disorder services.

(1) Existing law establishes the Investment in Mental Health Wellness Act of 2013. Existing law provides that funds appropriated by the Legislature to the California Health Facilities Financing Authority and the Mental Health Services Oversight and Accountability Commission for the purposes of the act be made available to selected counties or counties acting jointly, except as otherwise provided, and used to provide, among other things, a complete continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state. The act requires the commission to allocate funds to triage personnel, as specified.

This bill would require the commission, when making these funds available, to allocate at least ~~onehalf~~ *one-half* of those funds for services or programs targeted at children and youth 18 years of age and under.

(2) Existing law requires school districts, county offices of education, and special education local plan areas (SELPAs) to comply with state

laws that implement the federal Individuals with Disabilities Education Act, in order that the state may qualify for federal funds available for the education of individuals with exceptional needs. Existing law requires school districts, county offices of education, and SELPAs to identify, locate, and assess individuals with exceptional needs and to provide those pupils with a free appropriate public education in the least restrictive environment, and with special education and related services, including mental health services, as reflected in an individualized education program.

This bill would authorize a county, or a qualified provider operating as part of the county mental health plan network, and a local educational agency to enter into a partnership to create a program that includes, among other things, targeted interventions for pupils with identified social-emotional, behavioral, and academic needs and an agreement that establishes a Medi-Cal mental health provider that is county-operated or county-contracted for the provision of mental health and substance use disorder services to pupils of the local educational agency and in which there are provisions for the delivery of campus-based mental health and substance use disorder services through qualified providers or qualified professionals to provide on-campus support to identify pupils with an individualized education program (IEP), and pupils who do not have an IEP, but who a teacher believes may require mental health or substance use disorder services and, with parental consent, to provide those services to those pupils.

The bill would require the Mental Health Services Oversight and Accountability Commission, in consultation with the State Department of Education and the State Department of Health Care Services, to develop guidelines for the use of funds from the Mental Health Services Fund by a county for innovative programs and prevention and early intervention programs to enter into and support the above-mentioned partnerships. The bill would additionally require the commission to develop guidelines for the use of funds appropriated for the Investment in Mental Health Wellness Act of 2013 by a county to enter into and support these partnerships. The bill would create the County and Local Educational Agency Partnership Fund in the State Treasury, which would be available, upon appropriation by the Legislature, to the State Department of Education for the purpose of funding these partnerships, as specified, and would require the State Department of Education to fund these partnerships through a competitive grant program. The bill would also make related findings and declarations.

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. The Legislature finds and declares all of the following:

(a) Student mental health and substance use problems are often manifestations of childhood trauma, such as exposure to family and community violence.

(b) Included among the numerous long-term negative health, social, and educational outcomes associated with childhood trauma are special health care needs, suicide attempts and depression, alcoholism and injection drug use, learning difficulties and delays on cognitive and social-emotional indicators, low school engagement and attendance problems, repeating a grade and academic failure, bullying, dating violence, delinquent behavior, physical fighting, and weapon carrying.

(c) Investing in helping students effectively cope with and overcome trauma is particularly important for addressing substance use problems given the strong link between early adversity and substance use. For example, compared to individuals with zero Adverse Childhood Experiences (ACEs), individuals with four or more ACEs are 10.3 times as likely to have ever injected drugs, 7.4 times as likely to consider themselves an alcoholic, and 4.7 times as likely to have ever used illicit drugs.

(d) Mental illness and substance use disorders are so often cooccurring that a joint statement by the American Psychiatric Association and the American Society for Addiction Medicine concluded that it should be the expectation and not the exception. According to the Surgeon General, nearly 50 percent of people with substance use disorders have a cooccurring mental illness. The joint statement also concluded that when there is a cooccurring condition, it should be treated in an integrated program that simultaneously addresses both conditions.

(e) Schools are the best place for early identification and alleviation of behavioral health challenges that are likely to lead to serious mental illness or substance use disorders if not addressed early in their onset.

(f) Multitiered models to improve school climate and culture and to ensure prompt referral for support for students showing any level of challenge and comprehensive integrated services for those with serious emotional disturbances or substance use disorders have been demonstrated to have the best outcomes in improving student health and academic performance.

(g) These integrated models, when able to leverage public or private health insurance funds, demonstrate that early investments pay for themselves in reduced special education costs and improved academic success with reducing school dropout rates and related problems.

SEC. 2. Section 5848.5 of the Welfare and Institutions Code is amended to read:

5848.5. (a) The Legislature finds and declares all of the following:

(1) California has realigned public community mental health services to counties and it is imperative that sufficient community-based resources be available to meet the mental health needs of eligible individuals.

(2) Increasing access to effective outpatient and crisis stabilization services provides an opportunity to reduce costs associated with expensive inpatient and emergency room care and to better meet the needs of individuals with mental health disorders in the least restrictive manner possible.

(3) Almost one-fifth of people with mental health disorders visit a hospital emergency room at least once per year. If an adequate array of crisis services is not available, it leaves an individual with little choice but to access an emergency room for assistance and, potentially, an unnecessary inpatient hospitalization.

(4) Recent reports have called attention to a continuing problem of inappropriate and unnecessary utilization of hospital emergency rooms in California due to limited community-based services for individuals in psychological distress and acute psychiatric crisis. Hospitals report that 70 percent of people taken to emergency rooms for psychiatric evaluation can be stabilized and transferred to a less intensive level of crisis care. Law enforcement personnel report that their personnel need to stay with people in the emergency room waiting area until a placement is found, and that less intensive levels of care tend not to be available.

(5) Comprehensive public and private partnerships at both local and regional levels, including across physical health services, mental health, substance use disorder, law enforcement, social services, and related supports, are necessary to develop and maintain high quality, patient-centered, and cost-effective care for individuals with mental health disorders that facilitates their recovery and leads towards wellness.

(6) The recovery of individuals with mental health disorders is important for all levels of government, business, and the local community.

(b) This section shall be known, and may be cited, as the Investment in Mental Health Wellness Act of 2013. The objectives of this section are to do all of the following:

(1) Expand access to early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.

(2) Expand the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness, resiliency, and recovery oriented.

(3) Add at least 25 mobile crisis support teams and at least 2,000 crisis stabilization and crisis residential treatment beds to bolster capacity at the local level to improve access to mental health crisis services and address unmet mental health care needs.

(4) Add at least 600 triage personnel to provide intensive case management and linkage to services for individuals with mental health care disorders at various points of access, such as at designated community-based service points, homeless shelters, and clinics.

(5) Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services and improving access to timely assistance.

(6) Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.

(7) Provide local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for individuals with mental health disorders.

(8) Provide a complete continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state. The funds included in the ~~2016 Budget Act~~ *Budget*

Act of 2016 for the purpose of developing the continuum of mental health crisis services for children and youth 21 years of age and under shall be for the following objectives:

(A) Provide a continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state.

(B) Provide for early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.

(C) Expand the continuum of community-based services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness-, resiliency-, and recovery-oriented.

(D) Add at least 200 mobile crisis support teams.

(E) Add at least 120 crisis stabilization services and beds and crisis residential treatment beds to increase capacity at the local level to improve access to mental health crisis services and address unmet mental health care needs.

(F) Add triage personnel to provide intensive case management and linkage to services for individuals with mental health care disorders at various points of access, such as at designated community-based service points, homeless shelters, schools, and clinics.

(G) Expand family respite care to help families and sustain caregiver health and well-being.

(H) Expand family supportive training and related services designed to help families participate in the planning process, access services, and navigate programs.

(I) Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services.

(J) Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.

(K) Provide local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for children and youth 21 years of age and under with mental health disorders.

(c) Through appropriations provided in the annual Budget Act for this purpose, it is the intent of the Legislature to authorize the California Health Facilities Financing Authority, hereafter referred to as the authority, and the Mental Health Services Oversight and Accountability Commission, hereafter referred to as the

commission, to administer competitive selection processes as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, and specified personnel resources.

(d) Funds appropriated by the Legislature to the authority for purposes of this section shall be made available to selected counties, or counties acting jointly. The authority may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively supports this designation and collaboration in lieu of a county government directly receiving grant funds.

(1) Grant awards made by the authority shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase capacity for client assistance and services in the following areas:

(A) Crisis intervention, as authorized by Sections 14021.4, 14680, and 14684.

(B) Crisis stabilization, as authorized by Sections 14021.4, 14680, and 14684.

(C) Crisis residential treatment, as authorized by Sections 14021.4, 14680, and 14684 and as provided at a children's crisis residential program, as defined in Section 1502 of the Health and Safety Code.

(D) Rehabilitative mental health services, as authorized by Sections 14021.4, 14680, and 14684.

(E) Mobile crisis support teams, including personnel and equipment, such as the purchase of vehicles.

(2) The authority shall develop selection criteria to expand local resources, including those described in paragraph (1), and processes for awarding grants after consulting with representatives and interested stakeholders from the mental health community, including, but not limited to, the County Behavioral Health Directors Association of California, service providers, consumer organizations, and other appropriate interests, such as health care providers and law enforcement, as determined by the authority. The authority shall ensure that grants result in cost-effective expansion of the number of community-based crisis resources in regions and communities selected for funding. The authority shall

also take into account at least the following criteria and factors when selecting recipients of grants and determining the amount of grant awards:

(A) Description of need, including, at a minimum, a comprehensive description of the project, community need, population to be served, linkage with other public systems of health and mental health care, linkage with local law enforcement, social services, and related assistance, as applicable, and a description of the request for funding.

(B) Ability to serve the target population, which includes individuals eligible for Medi-Cal and individuals eligible for county health and mental health services.

(C) Geographic areas or regions of the state to be eligible for grant awards, which may include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(D) Level of community engagement and commitment to project completion.

(E) Financial support that, in addition to a grant that may be awarded by the authority, will be sufficient to complete and operate the project for which the grant from the authority is awarded.

(F) Ability to provide additional funding support to the project, including public or private funding, federal tax credits and grants, foundation support, and other collaborative efforts.

(G) Memorandum of understanding among project partners, if applicable.

(H) Information regarding the legal status of the collaborating partners, if applicable.

(I) Ability to measure key outcomes, including improved access to services, health and mental health outcomes, and cost benefit of the project.

(3) The authority shall determine maximum grants awards, which shall take into consideration the number of projects awarded to the grantee, as described in paragraph (1), and shall reflect reasonable costs for the project and geographic region. The authority may allocate a grant in increments contingent upon the phases of a project.

(4) Funds awarded by the authority pursuant to this section may be used to supplement, but not to supplant, existing financial and

resource commitments of the grantee or any other member of a collaborative effort that has been awarded a grant.

(5) All projects that are awarded grants by the authority shall be completed within a reasonable period of time, to be determined by the authority. Funds shall not be released by the authority until the applicant demonstrates project readiness to the authority's satisfaction. If the authority determines that a grant recipient has failed to complete the project under the terms specified in awarding the grant, the authority may require remedies, including the return of all or a portion of the grant.

(6) A grantee that receives a grant from the authority under this section shall commit to using that capital capacity and program expansion project, such as the mobile crisis team, crisis stabilization unit, or crisis residential treatment program, for the duration of the expected life of the project.

(7) The authority may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, for purposes of implementing this section.

(8) The authority may adopt emergency regulations relating to the grants for the capital capacity and program expansion projects described in this section, including emergency regulations that define eligible costs and determine minimum and maximum grant amounts.

(9) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before May 1, 2014, and on or before May 1, 2015, on the progress of implementation, that include, but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(10) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

(e) Of the funds specified in paragraph (8) of subdivision (b), it is the intent of the Legislature to authorize the authority and the commission to administer competitive selection processes as provided in this section for capital capacity and program expansion

to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, family respite care, family supportive training and related services, and triage personnel resources for children and youth 21 years of age and under.

(f) Funds appropriated by the Legislature to the authority to address crisis services for children and youth 21 years of age and under for the purposes of this section shall be made available to selected counties or counties acting jointly. The authority may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively support this designation and collaboration in lieu of a county government directly receiving grant funds.

(1) Grant awards made by the authority shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase capacity for client assistance and crisis services for children and youth 21 years of age and under in the following areas:

(A) Crisis intervention, as authorized by Sections 14021.4, 14680, and 14684.

(B) Crisis stabilization, as authorized by Sections 14021.4, 14680, and 14684.

(C) Crisis residential treatment, as authorized by Sections 14021.4, 14680, and 14684 and as provided at a children's crisis residential program, as defined in Section 1502 of the Health and Safety Code.

(D) Mobile crisis support teams, including the purchase of equipment and vehicles.

(E) Family respite care.

(2) The authority shall develop selection criteria to expand local resources, including those described in paragraph (1), and processes for awarding grants after consulting with representatives and interested stakeholders from the mental health community, including, but not limited to, county mental health directors, service providers, consumer organizations, and other appropriate interests, such as health care providers and law enforcement, as determined by the authority. The authority shall ensure that grants result in cost-effective expansion of the number of community-based crisis resources in regions and communities selected for funding. The

authority shall also take into account at least the following criteria and factors when selecting recipients of grants and determining the amount of grant awards:

(A) Description of need, including, at a minimum, a comprehensive description of the project, community need, population to be served, linkage with other public systems of health and mental health care, linkage with local law enforcement, social services, and related assistance, as applicable, and a description of the request for funding.

(B) Ability to serve the target population, which includes individuals eligible for Medi-Cal and individuals eligible for county health and mental health services.

(C) Geographic areas or regions of the state to be eligible for grant awards, which may include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the California Behavioral Health Directors Association.

(D) Level of community engagement and commitment to project completion.

(E) Financial support that, in addition to a grant that may be awarded by the authority, will be sufficient to complete and operate the project for which the grant from the authority is awarded.

(F) Ability to provide additional funding support to the project, including public or private funding, federal tax credits and grants, foundation support, and other collaborative efforts.

(G) Memorandum of understanding among project partners, if applicable.

(H) Information regarding the legal status of the collaborating partners, if applicable.

(I) Ability to measure key outcomes, including utilization of services, health and mental health outcomes, and cost benefit of the project.

(3) The authority shall determine maximum grant awards, which shall take into consideration the number of projects awarded to the grantee, as described in paragraph (1), and shall reflect reasonable costs for the project, geographic region, and target ages. The authority may allocate a grant in increments contingent upon the phases of a project.

(4) Funds awarded by the authority pursuant to this section may be used to supplement, but not to supplant, existing financial and

resource commitments of the grantee or any other member of a collaborative effort that has been awarded a grant.

(5) All projects that are awarded grants by the authority shall be completed within a reasonable period of time, to be determined by the authority. Funds shall not be released by the authority until the applicant demonstrates project readiness to the authority's satisfaction. If the authority determines that a grant recipient has failed to complete the project under the terms specified in awarding the grant, the authority may require remedies, including the return of all, or a portion, of the grant.

(6) A grantee that receives a grant from the authority under this section shall commit to using that capital capacity and program expansion project, such as the mobile crisis team, crisis stabilization unit, family respite care, or crisis residential treatment program, for the duration of the expected life of the project.

(7) The authority may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, for the purposes of implementing this section.

(8) The authority may adopt emergency regulations relating to the grants for the capital capacity and program expansion projects described in this section, including emergency regulations that define eligible costs and determine minimum and maximum grant amounts.

(9) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before January 10, 2018, and annually thereafter, on the progress of implementation, that include, but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(10) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

(g) Funds appropriated by the Legislature to the commission for purposes of this section shall be allocated for triage personnel to provide intensive case management and linkage to services for individuals with mental health disorders at various points of access.

These funds shall be made available to selected counties, counties acting jointly, or city mental health departments, as determined by the commission through a selection process. It is the intent of the Legislature for these funds to be allocated in an efficient manner to encourage early intervention and receipt of needed services for individuals with mental health disorders, and to assist in navigating the local service sector to improve efficiencies and the delivery of services.

(1) Triage personnel may provide targeted case management services face to face, by telephone, or by telehealth with the individual in need of assistance or his or her significant support person, and may be provided anywhere in the community. These service activities may include, but are not limited to, the following:

(A) Communication, coordination, and referral.

(B) Monitoring service delivery to ensure the individual accesses and receives services.

(C) Monitoring the individual's progress.

(D) Providing placement service assistance and service plan development.

(2) The commission shall take into account at least the following criteria and factors when selecting recipients and determining the amount of grant awards for triage personnel as follows:

(A) Description of need, including potential gaps in local service connections.

(B) Description of funding request, including personnel and use of peer support.

(C) Description of how triage personnel will be used to facilitate linkage and access to services, including objectives and anticipated outcomes.

(D) Ability to obtain federal Medicaid reimbursement, when applicable.

(E) Ability to administer an effective service program and the degree to which local agencies and service providers will support and collaborate with the triage personnel effort.

(F) Geographic areas or regions of the state to be eligible for grant awards, which shall include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(3) The commission shall determine maximum grant awards, and shall take into consideration the level of need, population to

be served, and related criteria, as described in paragraph (2), and shall reflect reasonable costs.

(4) Funds awarded by the commission for purposes of this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, counties acting jointly, or city mental health department that received the grant.

(5) Notwithstanding any other law, a county, counties acting jointly, or city mental health department that receives an award of funds for the purpose of supporting triage personnel pursuant to this subdivision is not required to provide a matching contribution of local funds.

(6) Notwithstanding any other law, the commission, without taking any further regulatory action, may implement, interpret, or make specific this section by means of informational letters, bulletins, or similar instructions.

(7) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation no later than March 1, 2014.

(h) Funds appropriated by the Legislature to the commission ~~pursuant to~~ *as described in* paragraph (8) of subdivision (b) for the purposes of addressing children's crisis services shall be allocated to support triage personnel and family supportive training and related services. These funds shall be made available to selected counties, counties acting jointly, or city mental health departments, as determined by the commission through a selection process. The commission may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively supports this designation and collaboration in lieu of a county government directly receiving grant funds.

(1) These funds may provide for a range of crisis-related services for a child in need of assistance, or his or her parent, guardian, or caregiver. These service activities may include, but are not limited to, the following:

(A) Intensive coordination of care and services.

(B) Communication, coordination, and referral.

(C) Monitoring service delivery to the child or youth.

(D) Monitoring the child's progress.

(E) Providing placement service assistance and service plan development.

(F) Crisis or safety planning.

(2) The commission shall take into account at least the following criteria and factors when selecting recipients and determining the amount of grant awards for these funds, as follows:

(A) Description of need, including potential gaps in local service connections.

(B) Description of funding request, including personnel.

(C) Description of how personnel and other services will be used to facilitate linkage and access to services, including objectives and anticipated outcomes.

(D) Ability to obtain federal Medicaid reimbursement, when applicable.

(E) Ability to provide a matching contribution of local funds.

(F) Ability to administer an effective service program and the degree to which local agencies and service providers will support and collaborate with the triage personnel effort.

(G) Geographic areas or regions of the state to be eligible for grant awards, which shall include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(3) The commission shall determine maximum grant awards, and shall take into consideration the level of need, population to be served, and related criteria, as described in paragraph (2), and shall reflect reasonable costs.

(4) Funds awarded by the commission for purposes of this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, counties acting jointly, or a city mental health department that received the grant.

(5) Notwithstanding any other law, a county, counties acting jointly, or a city mental health department that receives an award of funds for the purpose of this section is not required to provide a matching contribution of local funds.

(6) Notwithstanding any other law, the commission, without taking any further regulatory action, may implement, interpret, or make specific this section by means of informational letters, bulletins, or similar instructions.

(7) The commission may waive requirements in this section for counties with a population of 100,000 or less, if the commission determines it is in the best interest of the state and meets the intent of the law.

(8) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation no later than January 10, 2018, and annually thereafter.

(i) When making funds appropriated by the Legislature available pursuant to this section, the commission shall allocate at least one–half of the funds for services or programs targeted at children and youth 18 years of age and under.

SEC. 3. Part 5.5 (commencing with Section 5920) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 5.5. COUNTY AND LOCAL EDUCATIONAL AGENCY PARTNERSHIPS

5920. (a) Notwithstanding any other law, a county, or a qualified provider operating as part of the county mental health plan network that provides substance use disorder services, and a local educational agency may enter into a partnership to create a program that, in addition to reflecting each school's specified culture and needs, includes all of the following:

(1) Leveraging of school and community resources to offer comprehensive multitiered interventions on a sustainable basis.

(2) An initial school climate assessment that includes information from multiple stakeholders, including school staff, pupils, and families, that is used to inform the selection of strategies and interventions that reflect the culture and goals of the school.

(3) A coordination of services team that considers referrals for services, oversees schoolwide efforts, and uses data-informed processes to identify struggling pupils who require early interventions.

(4) Whole school strategies that address school climate and universal pupil well-being, such as positive behavioral interventions and supports, as well as comprehensive professional development opportunities, that build the capacity of the entire school community to recognize and respond to the unique social-emotional, behavioral, and academic needs of pupils.

(5) Targeted interventions for pupils with identified social-emotional, behavioral, and academic needs, such as therapeutic group interventions, functional behavioral analysis and plan development, targeted skill groups, and eligible services

specified by the School-Based Early Mental Health Intervention and Prevention Services Matching Grant Program pursuant to subdivision (h) of Section 4380.

(6) Intensive services, such as wraparound, behavioral intervention, or one-on-one support, that can reduce the need for a pupil's referral to special education or placement in more restrictive, isolated settings.

(7) Specific strategies and practices that ensure parent engagement with the school and provide parents with access to resources that support their children's educational success.

(8) Utilization of designated governmental funds for eligible Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services provided to pupils enrolled in Medi-Cal for mental health and substance use disorder service costs, for non-Medi-Cal enrolled pupils with an individualized education program (IEP) pursuant to the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.), and for pupils who do not have an IEP if the services are provided by a provider specified in paragraph (9).

(9) (A) An agreement between the county mental health plan, or the qualified provider, and the local educational agency that establishes a Medi-Cal mental health provider that is county-operated or county-contracted for the provision of mental health and substance use disorder services to pupils of the local educational agency. The agreement may include provisions for the delivery of campus-based mental health and substance use disorder services through qualified providers or qualified professionals to provide on-campus support to identify pupils with an IEP adopted pursuant to Section 504 of the federal Rehabilitation Act of 1973 (29 U.S.C. Sec. 794(a)) and pupils who do not have an IEP, but who a teacher believes may require those services and, with parental consent, to provide mental health or substance use disorder services to those pupils.

(B) The local educational agency, with the permission of the pupil's parent, shall provide the county mental health plan provider with the information of the health insurance carrier for each pupil.

(C) The agreement shall address how to cover the costs of mental health and substance use disorder provider services not covered by funds pursuant to paragraph (8) in the event that mental health and substance use disorder service costs exceed the

agreed-upon funding outlined in the partnership agreement between the county mental health plan, or the qualified provider, and the local educational agency following a yearend cost reconciliation process, and in the event that the local educational agency does not elect to provide the services through other means. Nothing in this subparagraph shall hold the local educational agency liable for any costs that exceed the agreed-upon funding outlined in the partnership agreement.

(D) The agreement shall fulfill reporting and all other requirements under state and federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and Medi-Cal EPSDT provisions, and measure the effect of the mental health and substance use disorder intervention and how that intervention meets the goals in a pupil's IEP or relevant plan for non-IEP pupils.

(E) The agreement shall include a process for resolving disagreements between the local educational agency and county mental health plan network related to any of the elements of the agreement described in this paragraph.

(F) The agreement shall include strategies to support the educational success of pupils who have repeated or prolonged absences from school due to mental illness or substance abuse disorders.

(10) A plan to establish a program described in this section in at least one school within the local educational agency in the first year and to expand the partnership to three additional schools within three years.

(b) The partnership shall participate in the performance outcome system established by the State Department of Health Care Services pursuant to Section 14707.5 to measure results of services provided under the partnership between the county mental health plan, or the qualified provider, and the local educational agency.

(c) For purposes of this section, "local educational agency" has the same meaning as that term is defined in Section 56026.3 of the Education Code.

(d) When applicable, and to the extent mutually agreed to by a school district and a plan or insurer, it is the intent of the Legislature that a health care service plan or a health insurer be authorized to participate in the partnerships described in this part.

5921. (a) (1) The Mental Health Services Oversight and Accountability Commission, in consultation with the State

Department of Education and the State Department of Health Care Services, shall develop guidelines for the use of funds appropriated from the Mental Health Services Fund by a county for innovative programs and prevention and early intervention programs to enter into and support the partnerships described in this part.

(2) The guidelines shall include provisions for integration with funds and services supplemented with funds from the Youth Education, Prevention, Early Intervention and Treatment Account, created pursuant to subdivision (f) of Section 34019 of the Revenue and Taxation Code, to the extent that funds from that account are appropriated for purposes of this part.

(b) The Mental Health Services Oversight and Accountability Commission shall develop guidelines for the use of funds appropriated by the Legislature for the purposes of Section 5848.5 by a county to enter into and support the partnerships described in this part.

(c) The State Department of Education shall develop guidelines for local educational agencies on the manner in which to enter into partnerships described in this part.

(d) The State Department of Health Care Services shall develop guidelines for county behavioral health departments on the manner in which to use funds from the Mental Health Services Fund and funds from the Medi-Cal program to enter into and support the partnerships described in this part.

5922. (a) The County and Local Educational Agency Partnership Fund is hereby created in the State Treasury. Moneys in the fund are available, upon appropriation by the Legislature, to the State Department of Education for the purpose of funding the partnerships described in this part. The State Department of Education shall fund partnerships described in this part through a competitive grant program. Priority in funding shall be given to partnerships with local educational agencies that have demonstrated high levels of childhood adversity, including, but not limited to, high-poverty local educational agencies and schools eligible under the Community Eligibility Provision of the Healthy, Hunger-Free Kids Act of 2010 (Public Law 111-296) and local educational agencies and schools identified in the California Longitudinal Pupil Achievement Data System as having high rates of foster youth and homeless children and youth.

(b) (1) For the 2019–20 fiscal year and each fiscal year thereafter, to the extent there is an appropriation in the annual Budget Act or another act made for purposes of this part, the Superintendent of Public Instruction shall allocate funds from that appropriation to the County and Local Educational Agency Partnership Fund.

(2) Other funds identified and appropriated by the Legislature may also be deposited into the County and Local Educational Agency Partnership Fund and used for the purposes specified in subdivision (a).

(c) Funds made available in the annual Budget Act for the purpose of providing educationally related mental health and substance use disorder services, including out-of-home residential services for emotionally disturbed pupils, whether required or not by an individualized education program, shall be used only for that purpose and shall not be deposited into the County and Local Educational Agency Partnership Fund. Nothing in this subdivision shall require the use of funds included in the minimum funding obligation under Section 8 of Article XVI of the California Constitution for the partnerships established by this part.

SEC. 4. It is the intent of the Legislature that, commencing with the 2019–20 fiscal year, the State Department of Health Care Services utilize funds from the Youth Education, Prevention, Early Intervention and Treatment Account created pursuant to subdivision (f) of Section 34019 of the Revenue and Taxation Code to support the partnerships created pursuant to this act, and to allocate a portion of those funds only to counties that also provide funds from the Mental Health Services Fund and Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment mental health and substance use disorder funds for the purposes of this act.

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SENATE COMMITTEE ON HEALTH
Senator Ed Hernandez, O.D., Chair

BILL NO:	SB 1019
AUTHOR:	Beall
VERSION:	February 7, 2018
HEARING DATE:	March 14, 2018
CONSULTANT:	Reyes Diaz

SUBJECT: Youth mental health and substance use disorder services

SUMMARY: Permits a county or a qualified provider, as specified, and a local educational agency to enter into a partnership to create a program, as specified, that targets pupils with mental health and substance use disorders, to be supported by specified funds. Creates the County and Local Educational Agency Partnership Fund from which moneys will be made available, as specified, to fund the partnerships. Requires specified entities to develop guidelines on how to enter into the described partnerships. Gives preference for funding to partnerships that maximize and use existing specified funds to support the partnerships.

Existing law:

1) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which qualified low-income persons receive health care benefits. [WIC §14001.1]

2) Establishes the Investment in Mental Health Wellness Act of 2013 (MHWA), which requires funds appropriated by the Legislature to be made available to specified entities to be used, among other things, for a complete continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state. States the objectives of the MHWA as expanding access to early intervention and treatment; expanding continuum of services to address such things as crisis stabilization, intervention, and residential treatment; adding at least 600 triage personnel; and providing local communities with increased financial resources to leverage additional public and private funds to improve networks for those with mental health disorders. [WIC §5848.5]

3) Requires the Mental Health Services Oversight and Accountability Commission (MHSOAC) to allocate grant funds from the MHWA for triage personnel, using specified criteria, to provide intensive case management and linkage to services, as specified, for individuals with mental health disorders at various access points, including schools. [WIC §5848.5]

4) Establishes the Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for eligible people under 21 years of age to provide periodic screenings to determine health care needs, and based upon the identified health care need and diagnosis, treatment services are provided. Requires EPSDT services to be administered through local county mental health plans under contract with the DHCS. [WIC §14132]

5) Defines "local educational agency" (LEA) as a school district, a county office of education, a nonprofit charter school participating as a member of a special education local plan area (SELPA). [EDC §56026.3]

6) Sets forth the process for the development, review, and revision of a pupil's individualized education program (IEP). [EDC §56340, et seq.]

7) Establishes the School-based Early Mental Health Intervention and Prevention Services for Children Act (EMHI) and authorizes the Director of the Department of Mental Health, in consultation with the Superintendent of Public Instruction, to award matching grants to LEAs to pay the state share of the costs of providing school-based early mental health intervention and prevention services to eligible students, subject to the availability of funding each year. [WIC §4370, et seq.]

8) Establishes the Primary Intervention Program, using EMHI funds, to provide school-based early detection and prevention of emotional, behavioral, and learning problems in students in kindergarten and grades 1-3, with services provided by child aides under the supervision of a school-based mental health professional. [WIC §4343]

9) Establishes the MHSOAC to oversee the implementation of the Mental Health Services Act (MHSA), enacted by voters in 2004 as Proposition 63, which provides funds to counties to expand services, and develop innovative programs and integrated service plans, for mentally ill children, adults, and seniors through a 1% income tax on personal income above $1 million. [WIC §5845, et seq.]

10) Requires DHCS, in collaboration with the California Health and Human Services Agency (CHHS), and in consultation with the MHSOAC, to create a plan for a performance outcome system for EPSDT mental health services provided to eligible Medi-Cal beneficiaries under the age of 21. [WIC §14707.5]

11) Creates the Youth Education, Prevention, Early Intervention and Treatment Account, pursuant to the 2016 ballot initiative Proposition 64, the Control, Regulate and Tax Adult Use of Marijuana Act (AUMA)," to be administered by DHCS for programs for youth that are designed to educate about and to prevent substance use disorders (SUDs) and to prevent harm from substance abuse. [Revenue and Taxation Code §34019]

This bill:

1) Permits a county, or a qualified provider operating as part of the county mental health plan network that provides SUD services, and a LEA to enter into a partnership to create a program that, in addition to reflecting each school's specified culture and needs, includes all of the following:

    a) Leveraging of school and community resources to offer comprehensive multitiered interventions on a sustainable basis;
    b) An initial school climate assessment that includes information from multiple specified stakeholders that is used to inform the selection of strategies and interventions that reflect the culture and goals of the school;
    c) A coordination of services team that considers referrals for services, oversees schoolwide efforts, and uses data-informed processes to identify struggling pupils who require early interventions;
    d) Whole school strategies that address school climate and universal pupil well-being, as specified;
    e) Targeted interventions for pupils with identified social-emotional, behavioral, and academic needs, as specified;
    f) Intensive services, as specified, that can reduce the need for a pupil's referral to special education or placement in more restrictive, isolated settings;

g) Specified strategies and practices that ensure parent engagement with the school, as specified;
h) Utilization of designated governmental funds, as specified; and,
i) An agreement between the county mental health plan, or the qualified provider, and a LEA that establishes a Medi-Cal mental health provider that is county operated or county contracted for the provision of mental health and SUD services to pupils of the LEA. Permits the agreement to include the provision of campus-based services through qualified providers or qualified professionals to provide on-campus support to identify pupils with an IEP, as specified, and pupils who do not have an IEP but who a teacher believes may require such services and, with parental consent, to provide services to those pupils. Requires the agreement to:

   i. Address how to cover the costs of mental health and SUD provider services not covered by specified government funds in the event costs exceed the agreed-upon funding outlined in the partnership agreement, as specified. Prohibits an LEA from being held liable for any costs that exceed the agreed-upon funding in the partnership agreement;
   ii. Fulfill reporting and all other requirements under state and federal Individuals with Disabilities Education Act (IDEA) and EPSDT provisions, and measure the effect of the mental health and SUD intervention, as specified;
   iii. Include a process for resolving disagreements between the LEA and the county mental health plan network, as specified; and,
   iv. Include strategies to support educational success of pupils that have repeated or prolonged absences from school due to mental illness or SUDs.

j) A plan to establish a program set forth by the provisions in this bill in at least one school within the LEA in the first year and to expand the partnership to three additional schools within three years.

2) Requires an LEA, with the permission of the pupil's parent, to provide the county mental health plan provider with the information of the health insurance carrier for each pupil.

3) Requires an established partnership, as specified, to participate in the EPSDT performance outcome system established by DHCS to measure results of services provided through the partnership.

4) Requires the MHSOAC, when issuing grants pursuant to the MHWA, to allocate at least one-half of the funds for services or programs targeted at children and youth 18 years of age and under.

5) Requires the MHSOAC, in consultation with the Department of Education (CDE) and DHCS, to develop guidelines for the use of funds from the Mental Health Services Fund by a county for innovative programs and prevention and early intervention programs to enter into and support the partnerships. Requires the guidelines to include provisions for integration with funds and services supplemented with funds from AUMA, as specified, to the extent funds from the account are appropriated for purposes described by provisions of this bill.

6) Requires the MHSOAC to develop guidelines for the use of funds available for triage personnel, pursuant to the MHWA. Requires CDE to develop guidelines for LEAs on how to enter into the described partnerships. Requires DHCS to develop guidelines for county

behavioral health departments on how to use funds from the Mental Health Services Fund and from the Medi-Cal program to enter into and support the described partnerships.

7) Creates the County and LEA Partnership Fund in the State Treasury from which moneys will be made available, upon appropriation by the Legislature, to CDE for the purpose of funding the described partnerships through a competitive grant program. Requires priority in funding to be given to partnerships with LEAs that have demonstrated high levels of childhood adversity, as specified.

8) Requires the Superintendent of Public Instruction, for Fiscal Year 2019-20 and each fiscal year thereafter, as specified, to allocate appropriated funds to the County and LEA Partnership Fund for the partnerships. Permits other funds identified and appropriated by the Legislature to also be deposited into this fund.

9) Requires funds made available in the annual Budget Act for purposes of providing educationally related mental health and SUD services, as specified, whether required or not by an IEP to be used only for that purpose, and prohibits those funds from being deposited into the County and LEA Partnership Fund.

10) Declares the intent of the Legislature that where applicable, and to the extent mutually agreed to by a school district and a plan or insurer, a health care service plan or a health insurer to be authorized to participate in the partnerships set forth by this bill.

11) Declares the intent of the Legislature that commencing with Fiscal Year 2019-20 DHCS use funds from AUMA to support the partnerships created pursuant to this bill and to allocate a portion of those funds only to counties that also provide funds from the Mental Health Services Fund and EPSDT mental health and SUD funds.

12) Makes findings and declarations related to student mental health and SUDs, including individuals who have experienced adverse childhood experiences, and that school settings, particularly those with multitiered models that ensure prompt support for students, demonstrate that early investments result in savings and improved academic success.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, SB 1019 is a critical step in providing equity in triage grant funds for youth mental health services. The funding parity set forth in this bill will open up more resources to provide more robust mental health services in California schools. According to the MHSOAC, in the first round of the triage grants, 50 applications for program funds were received. Only six of these proposed programs were specific to youth, and only three of those met or exceeded the minimum threshold for funding. Therefore, the grantees with youth-centric programs received just over 15% of the total available triage funds. This disparity undermines the well-being of our youth and prevents critical outreach where it is needed the most.

2) *Background.* The federal IDEA provides that students with exceptional needs identified as having emotional disturbance may be eligible to receive mental health services, which are considered related services and include counseling, psychological services, parent counseling and training, and residential placement, among others. Prior to 2012, a student with

exceptional needs, who also had mental health needs and services documented in their IEP, was referred by the LEAs to county mental health agencies for treatment, pursuant to AB 3632 (Brown, Chapter 26, Statutes of 1984). AB 114 (Committee on Budget Chapter 43, Statutes of 2011) shifted responsibility for providing and funding IDEA-related mental health services from county mental health agencies to LEAs (the Superintendent of Public Instruction is responsible for monitoring LEAs to ensure compliance). Any and all services identified in a student's IEP must be provided, whether directly by LEA employees or through contract with outside providers, such as county mental health agencies. LEAs are required to ensure services are provided to students regardless of who provides or pays for those services.

3) *EPSDT.* The EPSDT program is a Medi-Cal benefit for people under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs and, based upon the identified health care need and diagnosis, treatment services are provided. EPSDT services include all services otherwise covered by Medi-Cal, and EPSDT beneficiaries can receive additional medically necessary services. EPSDT provides eligible children access to a range of mental health services that include, among other things, mental health assessment, mental health services, therapy, rehabilitation, therapeutic behavioral services, crisis intervention/stabilization, day rehabilitation/day treatment, medication support, and case management.

4) *LEAs.* LEAs are responsible for educationally necessary mental health services that are identified in a student's IEP, but are prohibited from directly providing or billing for EPSDT services unless the county mental health department chooses to contract with the LEA for those services (EPSDT is considered specialty mental health). LEAs are required to ensure services identified in a student's IEP are provided, regardless of whether the county directly provides services, denies services, or reimburses the school for any costs if the LEA provides services (in cases where the LEA provides services covered under general Medi-Cal that overlap with EPSDT services). LEAs may use one or more of the following options for sourcing mental health services to Medi-Cal eligible students (including EPSDT and other mental health services):

    a) Provide and pay for services without seeking Medi-Cal reimbursement;
    b) Use the LEA Medi-Cal Billing Option Program. Through this program, the LEA employs or contracts with qualified practitioners to provide the services pursuant to the IEP, pays for the services, and submits a claim for reimbursement. In order to use this option, the LEA must meet a number of administrative conditions, including enrollment as a Medi-Cal provider; and,
    c) For EPSDT services, collaborate with county mental health departments to secure the specialty mental health services through the county mental health plan. There are two ways an LEA can secure these services:

        i. Enter into a contract or Memorandum of Understanding with the mental health plan for a specialty mental health service or an array of specialty mental health services. In this case, county mental health plans provide the service and incur the cost, and bill Medi-Cal for federal reimbursement; or,
        ii. Request to be a certified provider of Medi-Cal specialty mental health services from the county mental health plan. If the county mental health plan certifies the LEA as an organizational provider, the LEA would provide the specialty

mental health service through an LEA qualified employee and submit a claim to the county mental health plan for reimbursement.

5) *MHWA triage grants.* The purpose of the triage grants is to increase triage personnel in various settings, including schools, to provide intense case management and linkage to services for individuals with mental health disorders at various points of access, with a focus on children and youth. Triage personnel are authorized to provide services anywhere in the community and provide services that include monitoring service delivery to ensure individuals access and receive services, monitoring an individual's progress, and providing placement service assistance. The MHSOAC began an information-gathering process in early 2017 to receive input from counties and stakeholders about the rollout of initial triage grants, and to explore options in improving the process of distributing future grants. The 2016 Budget Act allocated $27 million to the MHWA, which included nearly $3 million for family respite, such as additional triage personnel. These personnel are authorized to provide the following services: coordination, referral, monitoring service delivery, and providing placement service assistance. The MHSOAC found that there was confusion among counties and stakeholders. Of 50 initial applications for triage grants that the MHSOAC received, only six proposed programs were specific to youth services, and only three of the six met or exceeded the minimum threshold score for funding, resulting in only 15% of the initial triage grant funds going to youth-centric programs. The MHSOAC recommends a percentage of future triage grant funds be dedicated to mental health crisis intervention services geared toward youth. The MHSOAC states that because schools are a major access point for children to receive mental health services in their county, the triage grant funds may increase collaboration between schools and county behavioral health departments.

6) *Student mental health services audit.* In January 2016, the California State Auditor released report 2015-112 which reviewed the effect of AB 114 of mental health services provided to pupils through IEPs. Among the findings were: 1) the mental health services and providers did not change at the four LEAs reviewed; 2) in some cases LEAs removed mental health services from student IEPs because of AB 114 and for other students, the LEAs could not explain why services were removed; 3) CDE had not performed an analysis of the education outcomes to determine if pupil outcomes had improved; 4) CDE did not require LEAs to track total expenditures for mental health services; 5) none of the four LEAs could determine their total costs to provide mental health services; and 6) only one of the four LEAs had contracted with its county to access certain funding for mental health services through Medi-Cal. The audit, among other things, recommended the Legislature require counties to enter into agreements with SELPAs to allow SELPAs and their LEAs to access federal funding.

7) *DHCS performance outcome system.* The performance outcome system for EPSDT mental health services is intended to improve outcomes at the individual, program, and system levels and inform fiscal decision-making related to the purchase of services, and is part of the reporting effort for the implementation of a performance outcome system for Medi-Cal specialty mental health services for children and youth. The performance outcome system is used to evaluate the domains of access, engagement, service appropriateness to need, service effectiveness, linkages, cost effectiveness, and satisfaction. Three reports are provided: statewide aggregate data; population-based aggregate data; and county-level aggregate data.

8) *AUMA.* In November 2016, voters passed the Control, Regulate, and Tax Adult Use of Marijuana Act, which, among other things, allocates 60% of taxes on marijuana, by July 15 of each fiscal year beginning in Fiscal Year 2018-19, to the Youth Education, Prevention,

Early Intervention and Treatment Account to be administered by DHCS, as specified, for programs for youth that are designed to educate about and to prevent SUDs and to prevent harm from substance abuse. AUMA contains a provision that prohibits the Legislature, prior to July 1, 2028, from changing this allocation to DHCS for its stated purposes.

9) *Double referral.* Should this bill pass out of this committee, it will be referred to the Senate Education Committee.

10) *Related legislation.* SB 906 (Beall) requires DHCS to establish a program for certifying peer, parent, transition-age youth, and family support specialists who would be trained in areas of specialization, including youth services, family supports, trauma-informed care, and co-occurring mental health and SUDs, and work collaboratively with other providers to facilitate early intervention for mental health services. *SB 906 is set to be heard in this committee on March 14, 2018.*

11) *Prior legislation.* SB 191 (Beall of 2017) was substantially similar to this bill. *SB 191 was held in the Senate Appropriations Committee.*

AB 1315 (Mullin, Chapter 414, Statutes of 2017) establishes an advisory committee to the MHSOAC for purposes of creating an early psychosis and mood disorder detection and intervention competitive selection process to, among other things, improve access to effective services for transition-aged youth and young adults at high risk for, or experiencing, psychotic symptoms, as specified.

SB 1113 (Beall of 2016) was substantially similar to this bill. *SB 1113 was vetoed by the Governor, whose veto message stated that the bill created an unfunded new program, and given the precarious balance of the state budget, establishing new programs with the expectation of funding in the future is counterproductive to the Administration's efforts to sustain a balanced budget and to fully fund the Local Control Funding Formula. The Governor further stated that additional spending to support new programs must be considered in the annual budget process.*

AB 1018 (Cooper of 2015) would have required DHCS and CDE to convene a joint taskforce to examine the delivery of mental health services to children. *AB 1018 was held in the Senate Appropriations Committee.*

SB 276 (Wolk, Chapter 653, Statutes of 2015) requires DHCS to seek federal financial participation for covered services that are provided by a LEA to a child who is an eligible Medi-Cal beneficiary, regardless of whether the child has an IEP or an individualized family service plan, or whether those same services are provided at no charge to the beneficiary or to the community at large, if the LEA takes all reasonable measures to ascertain and pursue claims for payment of covered services against legally liable third parties.

AB 1644 (Bonta of 2016) would have required the Department of Public Health (DPH) to establish a four-year program to support local decisions to provide funding for early mental health support services, required DPH to provide technical assistance to local educational agencies, and required DPH to select and support school sites to participate in the program. *AB 1644 was held in the Senate Appropriations Committee.*

AB 1133 (Achadjian of 2015) would have established a four-year pilot program, the School-Based Early Mental Health Intervention and Prevention Services Support Program to provide outreach, free regional training, and technical assistance for LEAs in providing mental health services at school sites. *AB 1133 was held in the Assembly Appropriations Committee.*

AB 1025 (Thurmond of 2015) would have required CDE to establish a three-year pilot program in school districts to encourage inclusive practices that integrate mental health, special education, and school climate interventions following a multi-tiered framework. *AB 1025 was held in the Senate Appropriations Committee.*

AB 1018 (Cooper of 2015) would have required DHCS and CDE to convene a joint taskforce to examine the delivery of mental health services to children. *AB 1018 was held in the Senate Appropriations Committee.*

AB 580 (O'Donnell of 2015) would have required CDE to develop model referral protocols for voluntary use by schools to address the appropriate and timely referral by school staff of students with mental health concerns. *AB 580 was vetoed by the Governor, whose veto message stated that California does not currently have specific model referral protocols for addressing student mental health as outlined by the bill; however, the California Department of Education recently received a grant from the federal Department of Health and Human Services, Substance Abuse and Mental Health Services Administration to identify and address critical student and family mental health needs. The Governor further stated that it's premature to impose an additional and overly prescriptive requirement until the current efforts are completed and the state can strategically target resources to best address student mental health.*

SB 1009 (Committee on Budget and Fiscal Review, Chapter 34, Statutes of 2012) requires DHCS, in collaboration with CHHS, and in consultation with the MHSOAC and a stakeholder advisory committee to develop a plan for a performance outcomes system for EPSDT specialty mental health services provided to eligible Medi-Cal beneficiaries under the age of 21. The purpose of the system is to improve beneficiary outcomes and inform decisions regarding the purchase of services.

AB 2608 (Bonilla, Chapter 755, Statutes of 2012) made permanent and expanded provisions relating to program improvement activities in the Medi-Cal Local Billing Option program, through which LEAs can draw down federal funding for health care services provided to Medi-Cal-eligible students. AB 2608 also expanded the scope of transportation services for which Medicaid reimbursements can be received.

AB 114 (Committee on Budget) shifted responsibility for mental health services for students from counties to LEAs.

AB 3632 (Brown) required the referral of student with exceptional needs, who also had mental health needs and services documented in their IEP, by LEAs to county mental health agencies for treatment.

12) *Support.* MHSOAC, sponsor of this bill, states that the allocation of funds from the MHWA helps correct the underrepresentation of children and youth by providing an equitable amount of funds to youth who are experiencing a mental health crisis and their families and caregivers. MHSOAC argues that the effects of mental health crisis are evident on school

campuses, and the first point of contact to reach students is in a school setting, resulting in an increase in the quality and quantity of services for children and youth. Disability Rights California agrees with the points raised by MHSOAC, and also states that this bill creates and supports shared goals of improving educational outcomes and the provision of mental health services, as well as allows for the prompt identification of mental health needs of students and coordination with mental health professionals. The Western Center on Law and Poverty (WCLP) cites information from the California Health Care Foundation, stating that approximately 700,000 students (7.5% of all school-age children in California) have a serious behavioral health disorder but only 120,000 receive services as part of an IEP. WCLP states that a lack of coordination between counties and LEAs to address student mental health and SUDs, despite demonstrated need for services and resulting positive outcomes, contributes to students' needs not being met.

SUPPORT AND OPPOSITION:

Support: Mental Health Services Oversight and Accountability Commission (sponsor)
Disability Rights California
Western Center on Law and Poverty

Oppose: None received

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AMENDED IN SENATE APRIL 9, 2018

SENATE BILL No. 1113

Introduced by Senator Monning

February 13, 2018

An act to amend Section 5845 of the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1113, as amended, Monning. Mental health in the workplace: voluntary standards.

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, and authorizes the commission to take specified actions, including developing strategies to overcome stigma and discrimination and accomplish the objectives of the Mental Health Services Act.

This bill would authorize the commission to establish a framework and voluntary standard for mental health in the workplace that serves to reduce mental health stigma, increase public, employee, and employer awareness of the recovery goals of the Mental Health Services Act, and provide guidance to California's employer community to put in place strategies and programs, determined by the commission, to support the mental health and wellness of employees.

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. Section 5845 of the Welfare and Institutions Code is amended to read:

5845. (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act; Part 3.1 (commencing with Section 5820), Human Resources, Education, and Training Programs; Part 3.2 (commencing with Section 5830), Innovative Programs; Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs; and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act. The commission shall replace the advisory committee established pursuant to Section 5814. The commission shall consist of 16 voting members as follows:

(1) The Attorney General or his or her designee.

(2) The Superintendent of Public Instruction or his or her designee.

(3) The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate.

(4) The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.

(5) Two persons with a severe mental illness, a family member of an adult or senior with a severe mental illness, a family member of a child who has or has had a severe mental illness, a physician specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees, a representative of an employer with more than 500 employees, and a representative of a health care ~~services~~ *service* plan or insurer, all appointed by the Governor. In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness. At least one ~~of the persons~~ *person* appointed pursuant to this paragraph shall have a background in auditing.

(b) Members shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(c) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(d) In carrying out its duties and responsibilities, the commission may do all of the following:

(1) Meet at least once each quarter at any time and location convenient to the public as it may deem appropriate. All meetings of the commission shall be open to the public.

(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including any clerical, legal, and technical assistance necessary. The commission shall administer its operations separate and apart from the State Department of Health Care Services and the California Health and Human Services Agency.

(3) Establish technical advisory committees, such as a committee of consumers and family members.

(4) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to an officer or employee of state government.

(5) Enter into contracts.

(6) Obtain data and information from the State Department of Health Care Services, the Office of Statewide Health Planning and Development, or other state or local entities that receive Mental Health Services Act funds, for the commission to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with Mental Health Services Act funds.

(7) Participate in the joint state-county decisionmaking process, as contained in Section 4061, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.

(8) Develop strategies to overcome stigma and discrimination, and accomplish all other objectives of Part 3.2 (commencing with Section 5830), 3.6 (commencing with Section 5840), and the other provisions of the Mental Health Services Act.

(9) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.

(10) If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the State Department of Health Care Services pursuant to Section 5655.

(11) Assist in providing technical assistance to accomplish the purposes of the Mental Health Services Act, Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) in collaboration with the State Department of Health Care Services and in consultation with the ~~California Mental Health Directors Association.~~ *County Behavioral Health Directors Association of California.*

(12) Work in collaboration with the State Department of Health Care Services and the California Behavioral Health Planning Council, and in consultation with the ~~California Mental Health Directors Association,~~ *County Behavioral Health Directors Association of California,* in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in subdivision (a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.

(13) Establish a framework and voluntary standard for mental health in the workplace that serves to reduce mental health stigma, increase public, employee, and employer awareness of the recovery goals of the Mental Health Services Act, and provide guidance to California's employer community to put in place strategies and programs, as determined by the commission, to support the mental health and wellness of employees.

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SENATE COMMITTEE ON HEALTH
Senator Ed Hernandez, O.D., Chair

BILL NO:	SB 1113
AUTHOR:	Monning
VERSION:	February 13, 2018
HEARING DATE:	April 4, 2018
CONSULTANT:	Reyes Diaz

SUBJECT: Mental health in the workplace: voluntary standards

SUMMARY: Permits the Mental Health Services Oversight and Accountability Commission to establish a framework and voluntary standard for mental health in the workplace, as specified, and to provide guidance to California's employer community to support the mental health and wellness of employees.

Existing law:

1) Establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC) to oversee the implementation of the Mental Health Services Act (MHSA), enacted by voters in 2004 as Proposition 63 to provide funds to counties to expand services, develop innovative programs, and integrate service plans for mentally ill children, adults, and seniors through a one percent income tax on personal income above $1 million. [WIC §5845]

2) Permits the MHSOAC to perform various functions in carrying out its duties and responsibilities, such as:

    a) Meeting at least once quarterly in locations convenient and open to the public;
    b) Establishing technical advisory committees, such as a committee of consumers and family members;
    c) Obtaining data and information from state or local entities that receive MHSA funds, as specified, to allow the MHSOAC to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity, as specified;
    d) Assisting in providing technical assistance to accomplish the purposes of the MHSA; and,
    e) Working in collaboration with the Department of Health Care Services (DHCS), the California Behavioral Health Planning Council, and the California Mental Health Directors Association, as specified, to design a joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, as specified. [WIC §5845]

3) Requires DHCS, in coordination with counties, to establish a program designed to prevent mental illnesses from becoming severe and disabling, including an emphasis on improving timely access to services for underserved populations. Requires the program to include, among other things, outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses. [WIC §5840]

This bill:

1) Permits the MHSOAC to establish a framework and voluntary standard for mental health in the workplace that serves to:

a) Reduce mental health stigma;
b) Increase public, employee, and employer awareness of the recovery goals of the MHSA; and,
c) Provide guidance to California's employer community to put in place strategies and programs, as determined by the MHSOAC, to support the mental health and wellness of employees.

2) Makes other technical changes.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, the MHSOAC is charged with supporting the implementation of the MHSA. Among other responsibilities, the MHSOAC provides technical assistance to California's counties, which operate the state's public mental health system. The MHSOAC also is charged with addressing stigma and discrimination that often creates a barrier to accessing mental health services and supports. Under current statute, it is unclear if the MHSOAC has the authority to develop a voluntary standard for mental health in the workplace. SB 1113 would clarify this authority, and create a new, expansive opportunity to improve access to mental health services, reduce stigma, and build support for mental health.

2) *Current state efforts.* The MHSOAC oversees the implementation of the MHSA, develops strategies to overcome stigma, and advises the Governor and the Legislature on ways the state can improve care and services to people with mental illness. The MHSOAC consists of 16 voting members, including statewide elected officials, members of the legislature, and Governor appointees, such as individuals with mental illness and their family members, health care professionals, and employers. DHCS currently does not have a specific program directed at employers to improve mental health but does provide general information and referral to county mental health plans on its Internet Web site for individuals and businesses to obtain further assistance. DHCS also states that counties are permitted to use MHSA funds to support outreach activities to identify and engage those with mental illness in MHSA-funded programs. Counties are also permitted to outreach to employers in order to facilitate the hiring of persons with mental illness. The MHSOAC states that California's employer community is increasingly recognizing the value of robust strategies to support those with mental illness in their workforce, including access to high quality care. The MHSOAC intends to convene a workgroup to explore how the state can encourage employers to support mental health awareness, access to care, and improved mental health outcomes, including reducing unemployment.

3) *Mental illness in California.* According to the federal Substance Abuse and Mental Health Services Administration's *Behavioral Health Barometer: California, Volume 4*, in 2014-15 an annual average of about 1.12 million adults, or about 3.8%, had serious suicidal thoughts in the past year, and an annual average of about one million adults, or about 3.5%, had a serious mental illness. Of adults with any reported mental illness in California, only about 1.87 million, or about 37.2%, received mental health services in the past year between 2011-15. The national annual average rate for those who received mental health services in the past year was 42.9%. In 2015, of mental health consumers aged 21 to 64 who received services in

the public mental health system in California, 8.5% were employed and 12.8% were unemployed. Of those aged 18-20, 8.2% were employed and 12.4% were unemployed.

4) *Mental health in the workplace and federal protections.* A September 2017 information sheet, "Mental Health in the Workplace," issued by the World Health Organization (WHO) states that more than 300 million people suffer depression and anxiety disorders, which cost the global economy $1 trillion each year in lost productivity. A workplace that promotes mental health and supports people with mental disorders is more likely to reduce absenteeism, increase productivity, and benefit from associated economic gains. The WHO states that risks to mental health include inadequate health and safety policies, low levels of support for employees, and inflexible work hours. The WHO also suggests that access to evidence-based treatments has shown to be beneficial for depression and other mental disorders. The WHO states that, because of the stigma associated with mental disorders, employers need to ensure that individuals feel supported and able to ask for support in continuing with or returning to work.

   A December 2016 press release from the U.S. Equal Employment Opportunity Commission (EEOC) explains that job applicants and employees with mental health conditions are protected from employment discrimination and harassment based on their conditions. Data shows that in 2016 the EEOC resolved almost 5,000 charges of discrimination based on mental health conditions, and obtained approximately $20 million for individuals who were unlawfully denied employment and reasonable accommodation. The EEOC states that many people with common mental health conditions have important protections under federal law, and that employers, job applicants, and employees should know mental health conditions are no different than physical health conditions under the law.

5) *Related legislation.* SB 1101 (Pan) requires the MHSOAC to establish five statewide objectives for the treatment and prevention of mental illness and metrics, to be reviewed and revised, as specified, by which progress toward each of those objectives may be measured. Requires all counties to annually submit a report to the MHSOAC and the Legislature that documents their progress toward the statewide objectives, as specified. *SB 1101 is pending in the Senate Rules Committee.*

6) *Prior legislation.* AB 1134 (Gloria, Chapter 412, Statutes of 2017) permits the MHSOAC to establish a fellowship program, in accordance with specified principles, for the purpose of providing an experiential learning opportunity for a mental health consumer and a mental health professional.

   AB 860 (Cooley of 2017) would have permitted the MHSOAC to conduct a fact-finding tour of a facility or location that is not open to the public, as specified. *AB 860 was vetoed by the Governor who stated that individual MHSOAC members can and do visit locked mental health facilities, jails, psychiatric hospitals, and schools to observe mental health care services firsthand, and that this bill could disrupt treatment programs or compromise the privacy of those receiving services.*

   AB 850 (Chau of 2017) would have added a Governor-appointed member to the MHSOAC who has knowledge and experience in reducing mental health disparities, especially for racial and ethnic communities. *AB 850 was vetoed by the Governor who stated that the MHSOAC as currently constituted is up to the task entrusted to it.*

AB 462 (Thurmond, Chapter 403, Statutes of 2017) permits the Director of the Employment Development Department to share information with the MHSOAC related to quarterly wage data to assist the MHSOAC in fulfilling its duties under the MHSA, as specified.

AB 745 (Chau of 2015) would have added a Governor-appointed member to the MHSOAC who has experience providing supportive housing to persons with a severe mental illness. *AB 745 was vetoed by the Governor who stated that while supportive housing can help improve the lives of those with serious mental illness the current 16 members of the MHSOAC are adequate to the task.*

AB 253 (Roger Hernández of 2015) would have required specified government entities responsible for administering the Veterans Housing and Homeless Prevention Act of 2014 (VHHP) to give preference to applicants for funding from the VHHP for supportive housing projects, as specified. Required the Governor to appoint two additional members to the MHSOAC with mental health experience, including mental health disparities. Required DHCS to post specified information from mental health plans to a dedicated Internet Web page and to notify appropriate committees of the Legislature, as specified. *AB 253 was not heard in the Senate Transportation and Housing Committee.*

7) *Support.* The MHSOAC, cosponsor of this bill, states that its mission is to provide vision and leadership to ensure Californians understand that mental health is essential to overall health, and that it is tasked with promoting wellness, recovery, and resiliency to improve outcomes for people with mental health needs. The MHSOAC states that the voluntary standards developed pursuant to this bill will tap into the excellent work that a number of organizations have already started relative to workplace mental health, and will help achieve the goals of increasing awareness, combating stigma, and promoting mental health through workplace strategies. The Steinberg Institute, another cosponsor, states that misconceptions about mental health persist in our country, and mental illnesses are not a concern for leaders of public, private, and non-profit organizations. Yet, the impact of these conditions on organizations of all sizes is significant and affects the health, wealth, and success of employees and employers alike. The Steinberg Institute and the California Medical Association (CMA) argue that the costs of untreated depression far outweigh the costs of treatment. Productivity losses are the most significant drivers of these costs: depressed employees miss between six and 25 more days per year and suffer from impaired performance between 13% and 29% of the time at work. The Steinberg Institute and CMA further state that in this country one in four people in the general population are living with a mental health condition, and it is time that we accommodate mental health in the workplace with the same urgency and attention that we give to physical health conditions. The California Access Coalition states that mental health symptoms are often first noticed in schools and in the workplace, and that this bill allows for increased early intervention with employees of businesses in California by helping individuals seek the help they need. The California Hospital Association (CHA) states that openness about physical health conditions has improved, but for many, mental wellness remains a topic fraught with shame and stigma. CHA states that as stigma starts to erode, more employers will seek guidance that helps support employee and employer awareness. Disability Rights California states that this effort to encourage the private sector to foster mental health and psychological safety by crafting a standard will assist in improving the mental health of their workers. The California Council of Community Behavioral Health Agencies (CCCBHA) states that for many years employers have recognized the importance of physical health in the workplace by promoting healthy lifestyles, such as exercise space and funding health club memberships. CCCBHA argues

that employers are just starting to realize the value of making similar investment in employee mental health and psychological safety in the workplace.

8) *Technical amendment.* The author may wish to consider the following technical amendment to reflect a statutory name change for the following organization:

   a) On page 4, lines 13 and 14, strike "California Mental Health Directors Association," and insert:

      County Behavioral Health Directors Association of California

SUPPORT AND OPPOSITION:

Support: Mental Health Services Oversight and Accountability Commission (cosponsor)
Steinberg Institute (cosponsor)
California Access Coalition
California Council of Community Behavioral Health Agencies
California Hospital Association
California Medical Association
Disability Rights California

Oppose: None received

-- END --

ASSEMBLY BILL No. 2325

Introduced by Assembly Member Irwin

February 13, 2018

An act to amend Section 5600.3 of the Welfare and Institutions Code, relating to mental health services.

LEGISLATIVE COUNSEL'S DIGEST

AB 2325, as introduced, Irwin. County mental health services: veterans.

Existing law contains provisions governing the operation and financing of community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs. Existing law further provides that, to the extent resources are available, the primary goal of the use of funds deposited in the mental health account of the local health and welfare trust fund should be to serve specified target populations, including, among others, California veterans in need of mental health services who meet specified eligibility requirements. Existing law prohibits a county from denying county mental health services to an eligible veteran based solely on his or her status as a veteran. Existing law requires a county to refer a veteran to the county veterans service officer, if any, to determine the veteran's eligibility for, and the availability of, mental health services provided by the United States Department of Veterans Affairs or any other federal health care provider.

This bill would prevent a county from denying an eligible veteran county mental or behavioral health services while the veteran is waiting for a determination of eligibility for, and availability of, mental or

behavioral health services provided by the United States Department of Veterans Affairs. The bill would make specific findings and declarations about the county's duty to provide mental and behavioral health services to veterans.

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

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

SECTION 1. (a) It is the intent of the Legislature to do both of the following:

(1) Enact legislation to make statutory changes to address the mental and behavioral health needs of veterans in California and to explore the opportunities for meeting those needs by improving access to mental health services for veterans in California.

(2) Improve access for veterans by connecting them to mental and behavioral health care services closer to home regardless of insurance coverage or eligibility for Medi-Cal or any other federal health care services, including, but not limited to, federal Veterans Administration eligibility.

(b) The Legislature finds and declares all of the following:

(1) Veterans in the counties are eligible for county mental and behavioral health services in the same manner as any other adult in the county, whether or not they are eligible for mental and behavioral health services from the federal Department of Veterans Affairs.

(2) The process of determining eligibility for services through the federal Department of Veterans Affairs can sometimes be a time-consuming process. Veterans should not have to wait to receive needed mental and behavioral health care while they await federal eligibility determination if another similarly situated adult could receive those services in his or her county.

(3) Mental and behavioral health services may not be available in a timely manner or in an accessible location when a veteran is eligible for benefits from the federal Department of Veterans Affairs. Veterans who need services in a county and cannot receive them in an adequate, timely, or accessible manner from another source should be treated like any other adult in the county and provided with those services through county mental health.

(4) Veterans who are eligible for and in need of county mental and behavioral health services should be treated in the same manner as any other adult in need of those services and should be provided those services through county mental health programs, irrespective of funding source.

SEC. 2. Section 5600.3 of the Welfare and Institutions Code is amended to read:

5600.3. To the extent resources are available, the primary goal of the use of funds deposited in the mental health account of the local health and welfare trust fund should be to serve the target populations identified in the following categories, which shall not be construed as establishing an order of priority:

(a) (1) Seriously emotionally disturbed children or adolescents.

(2) For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child has been assessed pursuant to Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of Division 4 of Title 2 of the Education Code and determined to have an emotional disturbance, as defined in paragraph (4) of subdivision (c) of Section 300.8 of Title 34 of the Code of Federal Regulations.

(b) (1) Adults and older adults who have a serious mental disorder.

(2) For the purposes of this part, "serious mental disorder" means a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.

(3) Members of this target population shall meet all of the following criteria:

(A) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).

(B) (i) As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.

(ii) For the purposes of this part, "functional impairment" means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.

(C) As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.

(4) For the purpose of organizing outreach and treatment options, to the extent resources are available, this target population includes, but is not limited to, persons who are any of the following:

(A) Homeless persons who are mentally ill.

(B) Persons evaluated by appropriately licensed persons as requiring care in acute treatment facilities including state hospitals, acute inpatient facilities, institutes for mental disease, and crisis residential programs.

(C) Persons arrested or convicted of crimes.

(D) Persons who require acute treatment as a result of a first episode of mental illness with psychotic features.

(5) California veterans in need of mental health services and who meet the existing eligibility requirements of this section, shall be provided services to the extent services are available to other adults pursuant to this section. Veterans who may be eligible for mental health services through the United States Department of Veterans Affairs should be advised of these services by the county and assisted in linking to those ~~services.~~ *services, but the eligible veteran shall not be denied county mental or behavioral health services while waiting for a determination of eligibility for, and availability of, mental or behavioral health services provided by the United States Department of Veterans Affairs.*

(A) ~~No~~ *An* eligible veteran shall *not* be denied county mental health services based solely on his or her status as a ~~veteran.~~ *veteran, including whether or not the person is eligible for services provided by the United States Department of Veterans Affairs.*

(B) Counties shall refer a veteran to the county veterans service officer, if any, to determine the veteran's eligibility for, and the availability of, mental health services provided by the United States Department of Veterans Affairs or other federal health care provider.

(C) Counties should consider contracting with community-based veterans' services agencies, where possible, to provide high-quality, veteran specific mental health services.

(c) Adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence.

(d) Persons who need brief treatment as a result of a natural disaster or severe local emergency.

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AMENDED IN SENATE JANUARY 25, 2018

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 *Anderson,* Bradford, Hertzberg, *Nielsen, Portantino, Skinner, Stone,* 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 violent felony, as defined in subdivision (c) of Section 667.5.~~

~~(F)~~

(E) A violation of Section 273a, 273.5, 368, 597, or 646.9.

~~(G)~~

(F) An offense resulting in damages of more than five thousand dollars ($5,000).

~~(H)~~

(G) 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.

(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 ~~(H),~~ *(G),* 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 ~~(H),~~ *(G),* 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~~ *and* 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) 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.

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SENATE RULES COMMITTEE
Office of Senate Floor Analyses
(916) 651-1520 Fax: (916) 327-4478

THIRD READING

Bill No: SB 215
Author: Beall (D), et al.
Amended: 1/25/18
Vote: 21

SENATE PUBLIC SAFETY COMMITTEE: 7-0, 1/9/18
AYES: Skinner, Anderson, Bradford, Jackson, Mitchell, Stone, Wiener

SENATE APPROPRIATIONS COMMITTEE: 7-0, 1/18/18
AYES: Lara, Bates, Beall, Bradford, Hill, Nielsen, Wiener

SUBJECT: Diversion: mental disorders

SOURCE: California Public Defenders Association

DIGEST: This bill creates a pretrial diversion program for defendants who commit a misdemeanor or jail-eligible felony who suffer from a mental disorder if the mental disorder played a significant role in the commission of the charged offense.

Senate Floor Amendments of 1/25/18 clarify the list of offenses that requires the prosecutor's consent for a grant of diversion.

ANALYSIS:

Existing law:

1) States that pretrial diversion refers to the procedure of postponing prosecution of an offense filed as a misdemeanor either temporarily or permanently at any point in the judicial process from the point at which the accused is charged until adjudication. (Pen. Code § 1001.1.)

2) Provides for diversion of misdemeanors when the defendant is a person with cognitive disabilities. (Pen. Code § 1001.20 et seq.)

3) Provides for diversion of non-driving under the influence (DUI) misdemeanor offenses. (Pen. Code § 1001 et seq., Pen. Code § 1001.50 et seq.)

4) Provides for diversion of bad check cases. (Pen. Code § 1001.60 et seq.)

5) Establishes the Law Enforcement Assisted Diversion program for offenses related to controlled substances, alcohol and prostitution. (Pen. Code § 1001.85 et seq.)

6) Provides pretrial diversion for veterans who commit misdemeanors who are suffering from service-related trauma or substance abuse, as specified. (Pen. Code § 1001.80 et seq.)

This bill:

1) Authorizes the court, notwithstanding any other law and except as specified, in any case charging a misdemeanor offense or felony offense punishable in county jail, after considering the positions of the defense and prosecution, to grant pretrial diversion to a defendant who meets all of the specified requirements.

2) Provides that diversion is not available without the consent of the prosecution for the following offenses:

   a) Any felony, with the exception of specified property and drug offenses;

   b) Any offense involving the unlawful use or unlawful possession of a firearm;

   c) Manslaughter or vehicular manslaughter;

   d) An offense for which a person, if convicted, would be required to register as a sex offender, except for indecent exposure;

   e) Child endangerment, corporal injury on a spouse or cohabitant, elder abuse, animal cruelty, and stalking;

   f) An offense resulting in damages of more than $5,000; and,

   g) An offense that occurs within 10 years of three separate referrals to diversion under the provisions of this bill. 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.

3) States that specified driving under the influence offenses are ineligible for diversion.

4) States that it is the intent of the Legislature that the consent of the prosecution be required prior to a court granting diversion for the specified offenses listed above. If the provisions in this bill requiring the consent of the prosecutor are invalidated for any reason, the offenses listed above shall not be eligible for diversion.

5) Provides that pretrial diversion may be granted if all of the following criteria are met:

   a) 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. 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 records, or any other reliable evidence;

   b) The court is satisfied that the defendant's mental disorder played a significant role in the commission of the charge offense;

   c) The court is satisfied that the defendant would benefit from mental health treatment; and,

   d) The defendant consents to diversion and waives his or her right to a speedy trial.

6) Defines "pretrial diversion" to mean 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:

   a) 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 and prosecution, the needs of the divertee and the community;

b) 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 of 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;

c) 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 defense, or upon the recommendation of the divertee's mental health treatment provider;

d) 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, the defense counsel and prosecution, hold a hearing to determine whether the criminal proceedings should be reinstituted or whether the treatment program should be modified;

e) The period during which criminal proceedings against the defendant may be diverted shall be no longer than two years; and,

f) Upon request, the court shall conduct a hearing to determine whether restitution 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 failed to comply with the terms of diversion.

7) States that 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.

8) States that a court may conclude that a divertee has performed satisfactorily if, in the court's judgement, the divertee:

a) Has substantially complied with the requirements of the treatment program;

b) Has avoided significant new violations of law unrelated to the defendant's mental health condition; and,

c) Has a plan in place for long-term mental health care.

9) Provides that upon dismissal of the charges, a record shall be filed with the Department of Justice indicating the disposition of the case diverted. Upon successful completion of the 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 records of arrest restricted, except as specified. 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 required for a peace officer application request. The divertee shall be advised of the requirements to disclose the arrest when applying for a position as a peace officer.

10) States that any 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 or for use at a hearing on the defendant's eligibility for diversion 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 the provisions of this bill, a court may consider previous records of arrest for which the defendant was granted diversion under the provisions of this bill.

11) States the following legislative findings and declarations:

a) Despite never being designed for the treatment or housing of those with mental health needs, jails have become 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; and,

e) Courts, as one of the first points of contact between the mentally ill and the state, can serve as a useful function in identifying defendants with mental disorders and connecting them to existing services, thereby reducing recidivism.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee:

- Court: Ongoing, unknown court costs likely over $50,000 annually (General Fund) to the extent the court uses this pretrial diversion option. Workload increases include conducting assessments to determine defendant eligibility, assessing appropriate program placements, holding periodic hearings, reviewing progress reports, and collaborating with various agencies.

- Local: Unknown, ongoing potentially-reimbursable costs (local funds, General Fund) to county district attorney's and public defender's offices to review progress reports and attend progress hearings at least every month or every three months depending on the diverted charge. There would be additional, but unknown, local costs (local funds, General Fund) for publicly-funded defense counsel to arrange for a mental health treatment program to the court's satisfaction and to present evidence of a mental disorder. These costs could be offset by savings achieved through reduced workload in not preparing for and litigating cases to trial.

  Additionally, there could be potentially-significant county mental health services costs (local funds), but these likely would not be reimbursable, as placements with county mental health agencies are authorized only if the agencies accept responsibility for the treatment of the defendants.

- Savings: Potentially-significant future cost savings to the criminal justice system, to state and local agencies, in averted court proceedings and reduced local incarceration, supervision, and prosecution costs to the extent participation in diversion programs is successful.

SUPPORT: (Verified 1/18/18)

California Public Defenders Association (source)
American Civil Liberties Union of California
California Attorneys for Criminal Justice
California Behavioral Health Directors Association
California Council of Community Behavioral Health Agencies

California Psychiatric Association
Californians for Safety and Justice
Disability Rights California
Drug Policy Alliance
Friends Committee on Legislation of California
Mental Health America of California
National Association of Social Workers – California Chapter
National Union of Healthcare Workers
Western Regional Advocacy Project

OPPOSITION: (Verified 1/18/18)

None received

ARGUMENTS IN SUPPORT: According to Disability Rights California, "There is an urgent need for specific and targeted efforts to reduce the rates of incarceration of people with mental illness, and to facilitate successful diversion and reentry. The current situation is dire. Jails are not therapeutic environments. They are not designed to be mental health treatment centers. Prisoners with mental illness are significantly more likely than those without mental illness to be abused. Further, it costs significantly more to incarcerate prisoners with mental illness than prisoners without this condition.

. . . .

"SB 215 provides a tool for trial courts to use in appropriate cases when diversion is the best option and treatment resources are available. It is crafted in a manner to ensure that treatment resource will be available and the best interests of the community are considered. Further, the bill recognizes that a crucial part of successful treatment is one that diverts individuals who can safely and effectively be treated and supervised outside of jail and prison settings. The diversion of criminal defendants with mental illness can improve both mental health and criminal justice outcomes."

Prepared by: Stella Choe / PUB. S. /
1/29/18 17:28:34

****** END ******

AMENDED IN SENATE JANUARY 23, 2018

AMENDED IN SENATE JANUARY 3, 2018

SENATE BILL No. 688

Introduced by Senator Moorlach

February 17, 2017

An act to amend Section 5899 of the Welfare and Institutions Code, relating to mental health services.

LEGISLATIVE COUNSEL'S DIGEST

SB 688, as amended, Moorlach. Mental Health Services 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 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.

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.~~ *principles, as specified.* 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: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: 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. Each county shall prepare the report in accordance with generally accepted accounting principles, *as determined by the department,* 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 *in a machine-readable format* 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.

O

SENATE RULES COMMITTEE
Office of Senate Floor Analyses
(916) 651-1520 Fax: (916) 327-4478

THIRD READING

Bill No: SB 688
Author: Moorlach (R)
Amended: 1/23/18
Vote: 21

SENATE HEALTH COMMITTEE: 8-0, 1/10/18
AYES: Hernandez, Nguyen, Mitchell, Monning, Newman, Nielsen, Pan, Roth
NO VOTE RECORDED: Leyva

SENATE APPROPRIATIONS COMMITTEE: Senate Rule 28.8

SUBJECT: Mental Health Services Act: revenue and expenditure reports

SOURCE: Author

DIGEST: This bill requires each county to prepare its Annual Mental Health Services Act Revenue and Expenditure Report in accordance with generally accepted accounting principles (GAAP), as specified, and requires specified entities to post county reports in a machine-readable format on their respective Internet Web sites.

Senate Floor Amendments of 1/23/18 clarify that county reports are required to be prepared in accordance with GAAP, as determined by the Department of Health Care Services (DHCS), and that DHCS and the Mental Health Services Oversight and Accountability Commission (MHSOAC) are required to post county reports on their respective Internet Web sites in a machine-readable format.

ANALYSIS:

Existing law:

1) Establishes the Mental Health Services Act (MHSA), enacted by voters in 2004 as Proposition 63, which provides funds to counties to expand services and develop innovative programs and integrated service plans for mentally ill

children, adults, and seniors through a 1% income tax on personal income above $1 million to be deposited to the Mental Health Services Fund (the Fund), administered by DHCS.

2) Requires DHCS, in consultation with the MHSOAC and the County Behavioral Health Directors Association of California (CBHDAC), to develop and administer instructions for the Annual MHSA Revenue and Expenditure Report (ARER), as specified.

3) Requires counties to submit ARERs electronically to DHCS and the MHSOAC, and for DHCS and the MHSOAC to post each county's ARER on their respective Internet Web sites in a timely manner.

4) Establishes the MHSOAC to oversee the implementation of the MHSA, develop strategies to overcome stigma, and advise the Governor and the Legislature on ways the state can improve care and services to people with mental illness.

This bill:

1) Requires each county to prepare its ARER in accordance with GAAP, as determined by DHCS.

2) Requires DHCS and the MHSOAC to post each county's ARER in a machine-readable format on their respective Internet Web sites.

Background

1) *MHSA.* The MHSA requires each county mental health department to prepare and submit a three-year plan to DHCS that must be updated each year and approved by DHCS after review and comment by the MHSOAC. Some counties make ARERs available to the public on their own Web sites while others do not. In their three-year plans, counties are required to include a list of all programs for which MHSA funding is being requested and identify how the funds will be spent and what populations will be served. Counties must submit their plans for approval to the MHSOAC before they may spend MHSA funds for innovative projects.

   Additionally, counties are annually required to submit electronically ARERs to DHCS and the MHSOAC. The purpose of the ARERs is to identify the expenditures of MHSA funds that were distributed to each county, quantify the amount of additional funds generated for the mental health system as a result of the MHSA, identify unexpended funds and interest earned on MHSA funds, and

determine reversion amounts, if applicable, from prior fiscal year distributions. An ARER is intended to provide information that allows for the evaluation of all of the following:

a) Children's system of care;

b) Prevention and early intervention strategies;

c) Innovative projects;

d) Workforce education and training;

e) Adults and older adults systems of care; and,

f) Capital facilities and technology needs.

2) *GAAP.* GAAP are accounting standards developed and established by the Financial Accounting Foundation's (FAF) standard-setting boards, both the Financial Accounting Standards Board and the Governmental Accounting Standards Board, for public and private companies, not-for-profit organizations, and state and local governments in the United States. According to the FAF, one of the objectives of GAAP applies to financial reporting for state and local governments in order to provide information that enables taxpayers and others who use governmental financial statements to hold governments accountable. According to the FAF, GAAP includes principles on:

a) *Recognition:* what items should be recognized in financial statements;

b) *Measurement:* what amounts should be reported for each of the elements in financial statements;

c) *Presentation:* what line items, subtotals, and totals should be displayed in financial statements; and,

d) *Disclosure:* what specific information is most important to the users of the financial statements.

3) *ARER compliance with GAAP.* According to DHCS, ARER instructions issued by DHCS to counties for MHSA expenditure reporting currently require reports to adhere to the "Accounting Standards and Procedures for Counties, March 2013 Edition," issued by the California State Controller's Office. The standards and procedures require governmental accounting systems to make it possible both:

a) To present fairly and with full disclosure the financial position and results of financial operations of the governmental unit in conformity with GAAP; and,

b) To determine and demonstrate compliance with finance-related legal and contractual provisions.

One exception, according to DHCS, is the Capital Facility Technological Needs (CFTN) component of the MHSA, which is not required to adhere to GAAP reporting. DHCS states that GAAP requirements applied to the CFTN component would not allow for accurate reporting of funds that would be subject to reversion under MHSA rules. DHCS's current reporting requirement for the CFTN component allows for purchases to be reported as one-time expenses, whereas GAAP reporting, according to DHCS, would create problems for the MHSA as funds that could be subject to reversion would be reported as being spent.

Comments

1) *Author's statement.* According to the author, each county utilizes MHSA funds in their own unique way, in furtherance of the goal of providing mental health services to those in need. While the vast diversity of counties makes this flexibility vital for the success of the funded programs, lack of consistent reporting standards makes data collection and analysis extremely difficult. More than $1.5 billion of MHSA funds have been available in recent years, and up to 5% of the funds may be used for state administrative purposes. While some focused evaluation has shown MHSA programming is implemented with good intentions, there is a question about the effectiveness of some programs within the counties and a comprehensive evaluation is needed. Annually, each county must submit to DHCS an ARER. This report is required be submitted six months after the end of the fiscal year so DHCS may update its Web site with each county's report. This bill improves reporting standards by requiring the ARER to comply with GAAP, and to be submitted electronically in machine-readable format to DHCS. This will ensure a consistency and transparency in reporting, and allows for further evaluation and analysis of the reports.

Related/Prior Legislation

SB 742 (Moorlach, Chapter 77, Statutes of 2017) required, among other things, the city treasurer, if the city has issued bonds, to use a system of accounting and auditing that adheres to GAAP.

AB 2279 (Cooley, 2016) would have required DHCS, based on the ARER, to compile information that includes, among other things, the total amount of MHSA revenue, the amount of MHSA money received and expended for each specified component of the MHSA program, and the amount of MHSA money spent on program administration, as specified. *AB 2279 was vetoed by Governor Brown who stated that DHCS was already in the process of collecting and posting ARERs as well as updated three year program expenditure plans, which would provide much of the information outlined in AB 2279.*

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

SUPPORT: (Verified 1/23/18)

County Behavioral Health Directors Association of California

OPPOSITION: (Verified 1/23/18)

None received

ARGUMENTS IN SUPPORT: The CBHDAC writes in support and states that GAAP is the accounting standard adopted by the Federal Securities and Exchange Commission. CBHDAC argues that in the past, it has been difficult for the state to consistently classify MHSA programs and services and that this bill will remedy this challenge by requiring these financial industry GAAP standards. CBHDAC states that this bill will help provide additional oversight of MHSA funds, and through this increased clarity, counties will more effectively demonstrate the value of the state's investment in these critical services.

Prepared by: Reyes Diaz / HEALTH / (916) 651-4111
1/24/18 15:33:30

****** END ******

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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SENATE COMMITTEE ON HEALTH
Senator Ed Hernandez, O.D., Chair

BILL NO:	SB 906
AUTHOR:	Beall
VERSION:	January 17, 2018
HEARING DATE:	March 14, 2018
CONSULTANT:	Reyes Diaz

SUBJECT: Medi-Cal: mental health services: peer, parent, transition-age, and family support specialist certification

SUMMARY: Requires the Department of Health Care Services (DHCS) to establish a program for certifying peer, parent, transition-age youth, and family support specialists and to collaborate with interested stakeholders, as specified; requires DHCS to amend its Medicaid state plan, as specified, and permits DHCS to seek any federal waivers or amendments to implement the certification program; and permits DHCS to implement, interpret, and make specific the certification program through available means, as specified, until regulations are adopted.

Existing law:

1) Establishes the Medi-Cal program, administered by DHCS, under which qualified low-income individuals receive health care services. [WIC §14001.1]

2) Grants DHCS the sole authority in state government to determine the qualifications, including the appropriate skills, education, training, and experience of personnel working within substance use disorder (SUD) recovery and treatment programs licensed and/or certified by DHCS. [HSC§11833]

3) Authorizes DHCS to require an individual providing counseling services in SUD programs licensed and/or certified by DHCS to be registered with or certified by a certifying organization (CO) approved by DHCS to register and certify counselors. [HSC §11833]

4) Grants DHCS the authority to conduct periodic reviews of COs to determine compliance with all applicable laws and regulations and to take actions for non-compliance, including revocation of DHCS's approval. [HSC §11833]

5) Requires, through regulations, the certification of SUD counselors to be based on specific counseling competencies, training, and education, including understanding addiction and knowledge of treatment methods. [CCR, Title 9, Division 4, Chapter 8]

This bill:

1) Requires DHCS, no later than July 1, 2019, to establish a certified peer, parent, transition-age youth, and family support specialist (or certified support specialist [CSS]) program that, at a minimum:

    a) Establishes a body to certify a CSS;
    b) Provides for statewide certification of the following CSS categories: adult peer support specialist, parent peer support specialist, transition-age youth peer support specialist, and family peer support specialist, as specified;
    c) Defines the range of responsibilities and practice guidelines for a CSS, as specified;

d) Determines curriculum and core competencies, including areas of specialization for each CSS category, such as older adults, foster youth, veterans, sexual orientation, gender identity, and family support, and core competencies that include trauma-informed care, co-occurring mental health and SUDs, and navigation of, and referral to, other services;
e) Specifies training requirements, allowing for multiple training entities and requiring training to include individuals with lived experience as consumers and family members, as well as continuing education requirements for certification;
f) Determines clinical supervision requirements for a CSS, as specified;
g) Establishes a code of ethics and processes for revocation of certification;
h) Determines a process for certification renewal; and,
i) Determines a process for allowing existing personnel employed in the peer support field to obtain certification at their option.

2) Defines "peers support specialist services" as services that 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 CSS, as specified.

3) Prohibits the certification program to be construed as permitting a CSS to diagnose an illness, prescribe medication, or provide clinical services.

4) Requires DHCS to collaborate closely 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 SUD 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 CSS certification program.

5) Requires DHCS to amend its Medicaid state plan to include each CSS category as a provider type and include CSS services as a distinct service type. Specifies that it is not the intent of the Legislature to modify the Medicaid state plan in a manner that changes or nullifies existing state plan requirements, billing, or reimbursement of the "other qualified provider" provider type.

6) Permits community health workers to partner with each CSS category for engagement, outreach, and education in order to facilitate early intervention for mental health services.

7) Permits DHCS to use Mental Health Services Act and OSHPD Workforce Education and Training Program resources and funding to develop and administer the certification program.

8) Permits DHCS to contract to obtain technical assistance for development of the CSS certification program for the purposes of meeting the mission and goals of DHCS's mental health and SUD services system.

9) Permits DHCS to enter into exclusive or non-exclusive contracts on a bid or negotiated basis, including contracts to obtain subject matter expertise or other technical assistance. Allows contracts to be statewide or on a more limited geographic basis.

10) Permits DHCS, after utilizing all specified funding resources, to establish a certification fee schedule to support the activities associated with the ongoing state administration of the certification program. States the intent of the Legislature that any fees charged be reasonable and reflect the expenditures directly applicable to the ongoing state administration of the certification program.

11) Requires DHCS, by July 1, 2021, to adopt regulations for the CSS certification program. Permits DHCS to implement, interpret, or make specific the requirements of the CSS certification program through plan letters, plan or provider bulletins, or similar instructions until the time regulations are adopted.

12) Requires the CSS certification program and Medi-Cal reimbursement for CSS services to be implemented only to the extent that federal financial participation (FFP) is available and all necessary federal approvals have been obtained.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, California lags behind the nation in implementing a peer support specialist certification program. The U.S. Department of Veterans Affairs and approximately 40 states have a certification process in place for mental health peer support specialists. Thirteen states have a certification process for SUD peer recovery coaches. The federal Centers for Medicare and Medicaid Services (CMS) released guidance in 2007 and 2013 for establishing a certification program for peers to enable the use of federal Medicaid financial participation with a 50% match. Yet California has not acted. Research is clear that the use of a formal certification program to train peer supporters offers enormous benefits, including allowing providers to make use of the federal match, allowing for standardization of the peer support practice to ensure the highest quality care, and establishing core competencies that allow certified peers to transfer skills across county lines. Although DHCS anticipates there will be substantial growth in the demand for peer support specialists, there is no statewide scope of practice, training standards, supervision standards, or certification. SB 906 creates these standards and establishes a code of ethics and processes for revocation of certification.

2) *CSS.* According to DHCS, a substantial number of studies demonstrate that the CSS improves patient functioning, increases patient satisfaction, reduces family burden, alleviates depression and other symptoms, reduces hospitalizations and hospital days, increases patient activation, and enhances patient self-advocacy. CSS are used in at least 36 states and throughout the Veterans Health Administration. CSS participating in SUD treatment activities are currently a recognized Medicaid service provider in California for SUD services; however, these providers are often limited in the services they are able to provide in traditional health care settings. DHCS states that expanded use of CSS in mental health and SUD as part of a care team can improve care coordination between behavioral health and physical health care needs of patients. DHCS included CSS as a component to the most recent Section 1115 Waiver Renewal, known as Medi-Cal 2020. Counties are able to seek reimbursement for CSS services under the "other qualified provider" provider type in the current Medicaid state plan.

3) *CSS certification.* CMS released guidance for establishing a CSS certification program to enable FFP in an effort to more fully incorporate and expand the use of peers. CMS requires

peer support providers to complete training and certification as defined by each state, and specified that services can be offered for mental illness and/or SUDs. Substantive work has been conducted in California by the Working Well Together Statewide Technical Assistance Center, a collaborative of peer and client-oriented organizations, which culminated in a final report of recommendations to proceed with peer certification. This effort identified key issues for laying the foundation of certification, including training recommendations and core components for a statewide certification program; establishing a standard of practice and core competencies; defining the level of care and services; integrating services across physical health, mental health, and SUD services; and allowing for portability from one county to another.

4) *DHCS certification duties.* DHCS ensures that registered and certified SUD counselors provide quality treatment to clients by enforcing counselor certification regulations. DHCS approves COs that register and certify SUD counselors who provide counseling services in an SUD program licensed or certified by DHCS. There are approximately 28,000 SUD counselors, of which roughly half are certified and half are registered while working towards certification. DHCS's oversight authority of COs includes periodic reviews of the COs to monitor adherence to state requirements.

5) *Prior legislation.* SB 614 (Leno of 2015) was identical to this bill. *SB 614 was amended on August 18, 2016, on the Assembly Floor to a new purpose.*

   AB 2374 (Mansoor, Chapter 815, Statutes of 2014) requires DHCS to, among other things, conduct periodic reviews of COs and requires COs to contact other COs before registering or certifying a person as an SUD counselor to determine if the person's registration or certification has ever been revoked.

6) *Support.* The Steinberg Institute, sponsor of this bill, and other supporters, largely mental health and youth advocates, argue that peer providers are those who use lived experience with mental health and SUD experience, as well as formal training, to provide measurable benefits to mental health and SUD clients, including reduced hospitalizations, improved functioning, alleviation of depression and other symptoms, and enhanced self-advocacy. Supporters also argue that a peer support program creates a career ladder so that consumers and family members working in mental health care have the opportunity to fully contribute, translating their experience into meaningful employment. Supporters further state that nearly 6,000 peer specialists in California are already used in many settings, such as community-based organizations, county clinics, schools, and primary care. However, there is currently no statewide standard of practice, consistent curriculum, training or supervision standards, or opportunity for portability across counties. Supporters argue that a certification program is crucial for obtaining FFP for the state and allows for peer services to become a sustainable piece of the state's mental health care delivery system. The Association of California Healthcare Districts states that workforce development remains a priority for its members, and health care districts support innovative ways to increase the health care workforce in medically underserved communities and increase access to care, such as the use of peer support specialists.

SUPPORT AND OPPOSITION:

Support: Steinberg Institute (sponsor)
American Civil Liberties Union of California
Association of California Healthcare Districts

Association of Community Human Service Agencies
Bay Area Community Services
California Alliance of Child and Family Services
California Association of Mental Health Peer-Run Organizations
California Behavioral Health Planning Council
California Disability Community Action Network
California State Association of Counties
California Youth Empowerment Network
County Behavioral Health Directors Association of California
Disability Rights California
Massage Garage Pit Crew
Mental Health America of California
Mental Health Services Oversight and Accountability Commission
Pool of Consumer Champions
Self-Help and Recovery Exchange
Steinberg Institute
The Village Family Services
United Advocates for Children and Families
United Advocates for Children and Families Action Alliance
Western Center on Law and Poverty
Several individuals

Oppose: None received

-- END --

AMENDED IN SENATE MARCH 22, 2018

SENATE BILL **No. 1004**

Introduced by Senators Wiener and Moorlach
(Principal coauthor: Assembly Member Mullin)
(Coauthor: Senator Portantino)
(Coauthors: Assembly Members Arambula, Chiu, Eggman, ~~and Mayes~~)
Kiley, Maienschein, Mayes, and Waldron)

February 6, 2018

An act to add ~~Section 5840.4 to~~ *a heading to Chapter 1 (commencing with Section 5840) of, and to add Chapter 2 (commencing with Section 5840.5) to, Part 3.6 of Division 5 of* the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1004, as amended, Wiener. Mental Health Services Act: prevention and early ~~diagnosis.~~ *intervention.*

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 to be expended pursuant to a local plan for specified purposes, including, but not limited to, prevention and early ~~diagnosis.~~ *intervention.* Existing law specifies that prevention and early ~~diagnosis~~ *intervention* services include outreach, ~~access~~ *access,* and linkage to medically necessary care, reduction in stigma, and reduction in discrimination. 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 *require the commission, on or before January 1, 2020, to establish priorities for the use of prevention and early intervention funds and to develop a statewide strategy for monitoring implementation of prevention and early intervention services, including enhancing public understanding of prevention and early intervention and creating metrics for assessing the effectiveness of how prevention and early intervention funds are used and the outcomes that are achieved. The bill would* amend the Mental Health Services Act by requiring ~~counties to expend Mental Health Services Act prevention and early intervention funds on early psychosis and mood disorder detection and intervention, college mental health outreach, engagement, and service delivery, and childhood trauma prevention and early intervention, as specified.~~ *a county, commencing with the 2020–21 fiscal year, to focus the prevention and early intervention portion of its local plan on the priorities established by the commission. The bill would authorize a county to include other priorities, as determined through the stakeholder process, either in place of, or in addition to, the established priorities. If the county chooses to include other programs, the bill would require the plan to include a description of why those programs are included and metrics by which the effectiveness of those programs are to be measured. The bill would require the commission to review the plans and approve them if they meet specified requirements. The bill would prohibit funding for county prevention and early intervention programs from being distributed until after the approval of the county's prevention and early intervention plan by the commission.* This bill would declare that its provisions further the intent of the MHSA.

~~By requiring counties to provide specified services, this bill would impose a state-mandated local program.~~

By requiring counties to include additional information in their local plans, this bill would impose a state-mandated local program.

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

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

Vote: 2/3. 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) Mental illness affects one in four people in the United States and is the leading cause of disability worldwide.

(b) Every year, 100,000 young adults in the United States experience their first psychotic episode, frequently involving debilitating hallucinations and delusions.

(c) The average delay in receiving appropriate diagnosis and treatment is an astonishing 18.5 months after the illness takes root and the patient suffers their first psychotic break.

(d) The longer a mental illness goes untreated, the more likely it is that a young person will spiral down a damaging course and find themselves unable to graduate, form relationships, or hold a job.

(e) Fifty percent of all mental illness begins by 14 years of age and 75 percent by 24 years of age, yet young people are often reluctant and afraid to seek help.

(f) One in 10 college students has considered suicide. Suicide is the second leading cause of death among college students, claiming more than 1,100 lives nationally every year.

(g) The Adverse Childhood Experiences Study, an observational study of the relationship between trauma in early childhood and morbidity, disability, and mortality in the United States, demonstrated that trauma and other adverse experiences are associated with lifelong problems in mental health, addiction, and general health.

(h) In the United States, more than six in 10 young people have been exposed to violence within the past year, including witnessing violence, assault with a weapon, sexual victimization, child maltreatment, and dating violence. Nearly one in 10 was injured.

(i) Early intervention in mental illness comes with a measurable cost benefit. A joint analysis by The National Academies of Sciences, Engineering, and Medicine determined that every $1 invested in prevention and early intervention for mental illness and addiction programs yields $2 to $10 in savings related to

health costs, criminal and juvenile justice costs, and low productivity.

(j) A multiyear review by the National Institute of Mental Health found that patients with first episode psychosis who received early intervention, with coordinated specialty care, experienced greater improvement in their symptoms, relationships, and quality of life. They were also more involved in work or school compared with patients who did not receive these services.

SEC. 2. The heading of Chapter 1 (commencing with Section 5840) is added to Part 3.6 of Division 5 of the Welfare and Institutions Code, to read:

CHAPTER 1. PREVENTION AND EARLY INTERVENTION PROGRAMS

SEC. 3. Chapter 2 (commencing with Section 5840.5) is added to Part 3.6 of Division 5 of the Welfare and Institutions Code, to read:

CHAPTER 2. PREVENTION AND EARLY INTERVENTION PROGRAM PLANNING

5840.5. It is the intent of the Legislature that this chapter achieve all of the following:

(a) Expand the provision of high quality Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) programs at the county level in California.

(b) Reduce unnecessary hospitalizations, homelessness, suicides, and inpatient days by appropriately utilizing community-based services and improving timely access to prevention and early intervention services.

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

(d) Create a more focused approach for PEI requirements.

(e) Increase programmatic and fiscal oversight of county MHSA-funded PEI programs.

5840.6. For purposes of this chapter, the following definitions shall apply:

(a) "Childhood trauma prevention and early intervention" refers to a program that targets children exposed to, or who are at risk of exposure to, adverse and traumatic childhood events. This may include, but is not limited to, all of the following:

(1) Focused outreach to at-risk and in-need populations.

(2) Implementation of appropriate trauma-related screening and assessment tools.

(3) Collaborative, strengths-based approaches that appreciate the resilience of trauma survivors.

(4) Peer support.

(5) Family education and support.

(6) Leveraging the healing value of traditional cultural connections, including policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served and recognition of historical trauma.

(b) "College mental health outreach, engagement, and service delivery" refers to a program that educates and engages students and provides either on-campus, off-campus, or linkages to mental health services not provided through the campus to students who are attending colleges and universities, including, but not limited to, public community colleges. This may include, but is not limited to, all of the following:

(1) Meeting the mental health needs of students that cannot be met through existing education funds.

(2) Establishing direct linkages for students to community-based mental health services.

(3) Addressing direct services, including, but not limited to, increasing college mental health staff-to-student ratios and decreasing wait times.

(4) Participating in evidence-based and community-defined best practice programs for mental health services.

(5) Serving underserved and vulnerable populations, including, but not limited to, lesbian, gay, bisexual, transgender, and queer persons, victims of domestic violence and sexual abuse, and veterans.

(6) Establishing direct linkages for students to community-based mental health services for which reimbursement is available through the students' health coverage.

(7) Reducing racial disparities in access to mental health services.

(8) Funding mental health stigma reduction training and activities.

(9) Providing college employees and students with education and training in early identification, intervention, and referral of students with mental health needs.

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

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

(e) "Early psychosis and mood disorder detection and intervention" has the same meaning as set forth in paragraph (2) of subdivision (b) of Section 5835.

(f) "Prevention and early intervention funds" means funds from the Mental Health Services Fund allocated for prevention and early intervention programs pursuant to paragraph (3) of subdivision (a) of Section 5892.

5840.7. (a) On or before January 1, 2020, the commission shall establish priorities for the use of prevention and early intervention funds. These priorities shall include, but are not limited to, the following:

(1) Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.

(2) Outreach and engagement strategies that target transition age youth, with a priority on partnership with college mental health programs. As the program evolves, the commission shall include outreach to college age individuals who are not in college.

(3) Early psychosis and mood disorder detection and intervention.

(4) Other programs the commission identifies that are proven effective in achieving the goals stated in Section 5840.

(b) On or before January 1, 2020, the commission shall develop a statewide strategy for monitoring implementation of this part, including enhancing public understanding of prevention and early intervention and creating metrics for assessing the effectiveness of how prevention and early intervention funds are used and the outcomes that are achieved. If the commission requires additional resources for these purposes, it may prepare a proposal for consideration by the appropriate policy committees of the Legislature.

5840.8. (a) Commencing with the 2020–21 fiscal year, the portion of the county plans required pursuant to Section 5847 that specifies programs for prevention and early intervention, as required pursuant to paragraph (1) of subdivision (b) of Section 5847, shall be reviewed by the commission and approved if the plan meets the requirements of subdivision (b).

(b) The portion of the county plan relating to prevention and early intervention shall focus on the priorities established by the commission pursuant to Section 5840.7. A county may include other priorities, as determined through the stakeholder process, either in place of, or in addition to, the established priorities. If the county chooses to include other programs, the plan shall include a description of why those programs are included and metrics by which the effectiveness of those programs are to be measured.

(c) Commencing with the 2020–21 fiscal year, funding for county prevention and early intervention programs distributed pursuant to Section 5892 shall be distributed only after the commission approves the county's prevention and early intervention plan.

5840.9. Notwithstanding the rulemaking provisions of the Administrative Procedures 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 chapter without taking regulatory action until regulations are adopted. The commission may use information notices or related communications to implement this chapter.

SEC. 4. The Legislature finds and declares that this act furthers the intent of the Mental Health Services Act, enacted by Proposition 63 at the November 2, 2004, statewide general election.

SEC. 5. 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 5840.4 is added to the Welfare and Institutions Code, to read:~~

~~5840.4. (a) Notwithstanding any other law, counties shall expend Mental Health Services Act prevention and early intervention funds in at least one of the following areas:~~

~~(1) Early psychosis and mood disorder detection and intervention.~~

~~(2) College mental health outreach, engagement, and service delivery.~~

~~(3) Childhood trauma prevention and early intervention.~~

~~(b) For the purposes of this section, the following terms have the following meaning:~~

~~(1) "Prevention and early intervention funds" means funds from the Mental Health Services Fund allocated for prevention and early intervention programs pursuant to paragraph (3) of subdivision (a) of Section 5892.~~

~~(2) "County" also includes a city receiving funds pursuant to Section 5701.5.~~

~~(3) "Early psychosis and mood disorder detection and intervention" has the same meaning as set forth in paragraph (2) of subdivision (b) of Section 5835.~~

~~(4) "College mental health outreach, engagement, and service delivery" refers to a program that educates and engages students and provides on-campus mental health services at colleges and universities, including, but not limited to public community colleges.~~

~~(5) "Childhood trauma prevention and early intervention" refers to a program that targets children exposed to, or who are at risk of exposure to, adverse and traumatic childhood events.~~

~~SEC. 2. The Legislature finds and declares that this act furthers the intent of the Mental Health Services Act, enacted by Proposition 63 at the November 2, 2004, statewide general election.~~

~~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.~~

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SENATE COMMITTEE ON HEALTH
Senator Ed Hernandez, O.D., Chair

BILL NO:	SB 1004
AUTHOR:	Wiener and Moorlach
VERSION:	March 22, 2018
HEARING DATE:	April 11, 2018
CONSULTANT:	Reyes Diaz

SUBJECT: Mental Health Services Act: prevention and early intervention

SUMMARY: Requires the Mental Health Services Oversight and Accountability Commission (MHSOAC) to establish priorities for the use of Mental Health Services Act prevention and early intervention (PEI) funds, as specified, and to develop a statewide strategy for monitoring the implementation of PEI programs, as specified. Requires, commencing with fiscal year 2020-2021, funding for PEI programs to be distributed only after the MHSOAC approves the PEI plans, as specified.

Existing law:

1) Establishes the MHSOAC to oversee the implementation of the Mental Health Services Act (MHSA), enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs, and integrate service plans for mentally ill children, adults, and seniors through a one percent income tax on personal income above $1 million. [WIC §5845]

2) Permits the MHSOAC to perform various functions in carrying out its duties and responsibilities, such as:

    a) Meeting at least once quarterly in locations convenient and open to the public;
    b) Establishing technical advisory committees, such as a committee of consumers and family members;
    c) Obtaining data and information from state or local entities that receive MHSA funds, as specified, to allow the MHSOAC to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity, as specified;
    d) Assisting in providing technical assistance to accomplish the purposes of the MHSA; and,
    e) Working in collaboration with the Department of Health Care Services (DHCS), the California Behavioral Health Planning Council, and the California Mental Health Directors Association, as specified, to design a joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, as specified. [WIC §5845]

3) Requires each county mental health program (also known as local mental health agencies, or LMHAs) to prepare and submit a three-year program and expenditure plan, and annual updates, as specified, to the MHSOAC and DHCS within 30 days after adoption by the county board of supervisors. [WIC §5847]

4) Requires 20% of funds distributed to LMHAs from the Mental Health Services Fund, as specified, to be used for PEI programs, as specified. [WIC §5892]

5) Requires, through regulations, at least 51% of PEI funds to be used to serve individuals who are 25 years old or younger, as specified. [9 CCR §3706]

6) Requires LMHAs to develop plans for Innovation programs and to expend Innovation funds upon approval by the MHSOAC. [WIC §5830]

This bill:

1) Requires, on or before January 1, 2020, the MHSOAC to establish priorities for the use of PEI funds that include, but are not limited to:

    a) Childhood trauma prevention and early intervention, as defined, to deal with the early origins of mental health needs;
    b) Outreach and engagement strategies that target transition-age youth, with priority on partnerships with college mental health programs. Requires, as the program evolves, outreach to college-age individuals who are not in college;
    c) Early psychosis and mood disorder detection and intervention, as defined; and,
    d) Other programs the MHSOAC identifies that are proven effective in achieving the PEI component goals stated in the MHSA.

2) Requires, on or before January 1, 2020, the MHSOAC to develop a statewide strategy for monitoring the implementation of MHSA PEI programs, including enhancing public understanding of PEI and creating metrics for assessing the effectiveness of how PEI funds are used and the outcomes that are achieved. Permits the MHSOAC to prepare a proposal to the Legislature, as specified, if it requires additional resources for these purposes.

3) Requires the MHSOAC, commencing with fiscal year (FY) 2020-2021, to review and approve the PEI portion of LMHAs' three-year plans if the plan meets the requirements in 1) above.

4) Requires the PEI portion of LMHAs' plans to focus on the priorities established by the MHSOAC as required in 1) above. Permits LMHAs to include other priorities, as determined through the stakeholder process, either in place of or in addition to the established priorities. Requires LMHAs that choose other programs to describe in the three-year plans why those other programs are included, as specified.

5) Requires, commencing with FY 2020-2021, funding for PEI programs to be distributed to LMHAs only after the MHSOAC approves the LMHA's PEI plan.

6) Permits the MHSOAC to implement the provisions of this bill through information notices or related communications until regulations are adopted through the rulemaking process.

7) Defines "childhood trauma prevention and early intervention" as programs that target children exposed to, or at risk of exposure to, adverse and traumatic childhood events that provide services such as: focused outreach to at-risk and in-need populations; appropriate trauma-related screening and assessment; peer support and family education and support; and policies, protocols, and processes that are responsive to cultural needs and recognize historical trauma.

8) Defines "college mental health outreach, engagement, and service delivery" as programs that educate and engage students on-campus or off campus; provide linkages to mental health

services not provided through the campus, as specified; serve underserved and vulnerable populations; reduce racial disparities in access to mental health services; and provide college employees and students with education and training in early identification, intervention, and referral of students with mental health needs.

9) Defines "early psychosis and mood disorder detection and intervention" as programs 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, as specified.

10) Declares the intent of the Legislature that the provisions in this bill expand the provision of high quality MHSA PEI programs; reduce unnecessary hospitalizations, homelessness, suicide, and inpatient days by using community-based services and improving timely access to PEI services; increase participation in school attendance, social interactions, and physical health, including employment and daily living function; create a more focused approach for PEI requirements; and increase programmatic and fiscal oversight of MHSA-funded PEI programs.

11) Makes findings and declarations related to mental illness; the effects of delayed treatment or untreated mental illness; the effects of exposure to violence, assault, and sexual victimization; and improved outcomes from investing in prevention and early intervention, as well as from the early detection of first episode psychosis.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Authors' statement.* According to the authors, SB 1004 aims to standardize and scale up high-quality PEI programs funded by the MHSA, ensuring access to effective, quality care in counties across the state. SB 1004 provides essential structure and guidance to ensure counties are using their PEI funds on programs that have proven effective. Lack of standardization has resulted in a marked disparity in how counties are spending their PEI funds and broad inequities in the quality of mental health care families can access. For example, though experts know how to effectively intervene in the early stages of psychosis and serious mood disorders using model services backed by years of research, fewer than half of the counties in the state offer these models of care. Standardizing our PEI approaches will lower the likelihood that a young person will experience the negative outcomes associated with untreated mental illness including incarceration, hospitalization, homelessness, and prolonged suffering.

2) *PEI.* The 2017-18 fiscal year Governor's Budget projected that $1.888 billion would be deposited into the Mental Health Services Fund, with an estimated $340.9 million dedicated to the PEI component. The MHSA requires each LMHA to prepare and submit a three-year plan to DHCS and the MHSOAC that must be updated each year and approved by DHCS after review and comment by the MHSOAC. (LMHAs are those entities that receive MHSA funds and consist of the City of Berkeley, Tri-City Mental Health Services [Claremont, La Verne, and Pomona], Sutter-Yuba Behavioral Services [counties of Sutter and Yuba], and agencies representing the 56 other counties.) In the three-year plans, LMHAs are required to include a list of all programs for which MHSA funding is being requested, to identify how

the funds will be spent, and which populations will be served. The goal of PEI is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. The PEI component requires collaboration with consumers and family members in the development of PEI projects. According to DHCS's MHSA Expenditure Report for 2017-18, the MHSOAC is responsible for providing PEI policy direction in the form of regulations to support the following key MHSA-intended outcomes: increased recognition of and response to early signs of mental illness; increased access and linkage to treatment for people with serious mental illness; improved timely access to services for underserved communities; reduced stigma associated with either being diagnosed with a mental illness or seeking mental health services; and reduced discrimination against people with mental illness.

3) *Early psychosis and interventions.* According to the National Institute of Mental Health (NIMH), mental health disorders are common among children in the U.S. and can be particularly difficult for the children themselves and their caregivers. While mental disorders are widespread, the main burden of illness is concentrated among those suffering from a seriously debilitating mental illness. Just over 20% (or one in five) children either currently or at some point during their life have had a seriously debilitating mental disorder. Fifty percent of all mental illness begins by the age of 14 and 75% by the age of 24, yet young people are often reluctant and afraid to seek help. About 100,000 adolescents and young adults experience first episode psychosis each year. The NIMH Web Site states that results from the Recovery After an Initial Schizophrenia Episode project and related studies highlight the value of early intervention for reducing the duration of untreated illness, speeding patients' and family members' access to appropriate care, and restoring normal school and work trajectories among individuals who receive evidence-based treatment. NIMH estimates that approximately 100 clinics in the U.S. currently offer evidence-based early detection, prevention, and treatment services to individuals in the earliest stages of psychotic illness.

4) *Student mental health data.* According to national data compiled by the Center for Collegiate Mental Health at Penn State over six academic years (2009-15) from over 93 participating institutions, on average, the growth in the number of students seeking services at campus counseling centers (+29.6%) was more than five times the rate of institutional enrollment (+5.6%). Further, the growth in counseling center appointments (+38.4) is more than seven times the rate of institutional enrollment. The lifetime prevalence rate for serious suicidal ideation among college students (i.e., "I have seriously considered suicide") has increased substantially over the last five years from 23.8% to more than 32.9%. According to the Anxiety and Depression Association of America's (ADAA) Web site, anxiety disorders are one of the most common mental health problems on college campuses. Forty million adults in the U.S. suffer from an anxiety disorder and 75% experience the first episode by age 22. ADAA states that 30% of college students reported that stress negatively affected their academic performance, and 85% reported they had felt overwhelmed by everything in their lives at some point within the past year. ADAA also states that 41.6% of college students rated anxiety as the top presenting concern, and 24.5% reported they were taking psychotropic medication.

5) *California State Auditor report.* In February 2018, the California State Auditor (CSA) issued Report 2017-117, "The State Could Better Ensure the Effective Use of Mental Health Services Act Funding," and noted that a general lack of oversight from the state, particularly DHCS, resulted in LMHAs amassing unspent MHSA funds. For FY 2015-16, LMHAs had

accumulated $2.5 billion in unspent funds of which $231 million should have been returned to the state to be redistributed among the LMHAs. For the same fiscal year, LMHAs cumulatively held reserves of $535 million in MHSA funds of which the CSA estimated between $157 million and $274 million were excessive and should have been returned to the state. The CSA attributed this to DHCS not having developed a process for recovering the unspent funds, known as reversion, or developed a prudent reserve formula. The CSA stated that a lack of enforcement from DHCS, such as withholding funds, does not incentivize LMHAs to submit required annual revenue and expenditure reports, which would assist DHCS in tracking unspent funds. The CSA noted that in the same fiscal year, only one of the 59 LMHAs submitted the annual report by the regulatory deadline.

The CSA also noted that the MHSOAC is taking steps to implement its responsibility to evaluate the effectiveness of MHSA PEI and Innovation projects. In August 2017, the MHSOAC launched an online MHSA fiscal transparency tool that uses an interactive map to display the LMHAs' annual MHSA revenues, expenditures, and year-end balances of unspent funds. The CSA notes, however, that the effectiveness of this tool is contingent upon LMHAs submitting their annual revenue and expenditure reports on time, and DHCS has not enforced regulatory deadlines, and instead has regularly extended the timeframes for when LMHAs could submit the reports. The CSA recommended that the MHSOAC finalize its internal processes by July 2018 in order to track LMHAs' funding, services, and outcomes as it intends. The MHSOAC responded to that recommendation by saying it anticipates delays in receiving required reports from LMHAs.

The CSA report also highlights the requirement in the MHSA that the MHSOAC review and approve LMHAs' uses of Innovation funds before they can spend those funds. Of the $231 million in FY 2015-16 that should have been reverted to the state, 63%, or $146 million, of that amount was Innovation funds. LMHAs told the CSA that several factors have led to difficulty getting Innovation projects approved, including the lack of clarity on the types of projects MHSOAC commissioners consider innovative. The MHSOAC formed a subcommittee in response to develop a flowchart for LMHAs and a template for them to present their projects, and also held a statewide meeting for LMHAs to share their innovative projects. The CSA report stated that from December 2015 through August 2017 the MHSOAC approved 83% of Innovation projects within three months of receipt. The MHSOAC stated that often the approval process is delayed because LMHAs submit and then withdraw their plans based on the readiness for review. The CSA stated that the MHSOAC's efforts to provide technical assistance and improve dialogue with LMHAs should help reduce any delays in the approval process.

6) *Related legislation.* SB 1101 (Pan) requires the MHSOAC to establish five statewide objectives for the treatment and prevention of mental illness and metrics, to be reviewed and revised, as specified, by which progress toward each of those objectives may be measured. Requires all counties to annually submit a report to the MHSOAC and the Legislature that documents their progress toward the statewide objectives, as specified. *SB 1101 is pending in the Senate Health Committee.*

7) *Prior legislation.* AB 1315 (Mullin, Chapter 414, Statutes of 2017) establishes the Early Psychosis Intervention Plus Program whereby specified programs use 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 and mood disorders, as specified.

AB 917 (Arambula of 2017) would have required the Board of Governors of the California Community Colleges and the Trustees of the California State University, and encouraged the Regents of the University of California, to adopt policies on student suicide prevention. *AB 917 was held was held on the Assembly Appropriations suspense file.*

AB 2017 (McCarty of 2016) would have required the MHSOAC, subject to appropriation by the Legislature, to create a grant program for public colleges and universities to improve access to mental health services on those campuses, as specified, and would have required the MHSOAC to submit a report to the Legislature evaluating the impact of the program, as specified. *AB 2017 was vetoed by the Governor who stated that while well-intentioned the bill was premature as it commits to a particular program structure without specifying the amount or source of funding.*

AB 253 (Roger Hernández of 2015) would have required specified government entities responsible for administering the Veterans Housing and Homeless Prevention Act of 2014 (VHHP) to give preference to applicants for funding from the VHHP for supportive housing projects, as specified. Required the Governor to appoint two additional members to the MHSOAC with mental health experience, including mental health disparities. Required DHCS to post specified information from mental health plans to a dedicated Internet Web page and to notify appropriate committees of the Legislature, as specified. *AB 253 was not heard in the Senate Transportation and Housing Committee.*

8) *Support.* The Steinberg Institute, sponsor of this bill, and other supporters, made up of mental health and youth advocates, students, colleges, and health care providers, argue that this bill will establish a strategic, statewide focus for how counties use PEI funds from the MHSA, and that this bill helps ensure children, transition-age youth, and young adults have access to effective, research-based treatments that can stem the progression of a serious brain illness well before it becomes disabling. Supporters argue that more than $400 million are set aside for PEI programs, but there is a marked and inequitable disparity across the state as to how each county spends these funds and the quality of services provided. Supporters state that 50% of all serious mental illness manifests by age 14 and 75% by age 24. Research also shoes that early intervention with intensive, comprehensive services dramatically improves outcomes for young people in the early stages of mental illness, and that they can learn to manage and even thrive with their illness. The Steinberg Institute states that the bulk of $230 million that the CSA faulted DHCS for failing to recover was targeted for PEI and Innovation programs, underscoring the confusion in many counties about how best to spend these dollars, and the state's failure to provide clear and consistent guidance. The California State Student Association argues that with the majority of college students being under the age of 24, and 76.9% of California State University students reporting they experienced a life issue or event that was traumatic or very difficult to deal with in the past 12 months, this bill would help earmark funds for counties to support students' mental health. Supporters further argue that this bill provides essential structure and guidance to ensure counties are using PEI funds on programs that have proven effective.

9) *Oppose unless amended.* The County Behavioral Health Directors Association of California (CBHDAC) writes in opposition that this bill focuses too narrowly to reflect the reality of California communities. CBHDAC states that PEI programming has saved lives and helped millions in the state to live healthier and more fulfilling lives through PEI activities provided following intense local planning and articulation of local priorities and needs. CBHDAC

argues that this bill will result in the elimination of PEI programming for communities of color; lesbian, gay, bisexual, and transgender people; veterans; foster youth; adults; and older adults. CBHDAC states that there are many potential target populations for PEI efforts and a variety of strategies that can improve mental health outcomes. CBHDAC states this bill should include broader categories of PEI programming to protect important investments that counties and community-based provider organizations are making with PEI funds. CBHDAC also opposes efforts that create further barriers to funding programs for vulnerable communities and is concerned about significant delays that may be caused by the MHSOAC PEI plan approval process proposed in this bill. CBHDAC requests this provision be deleted from the bill.

10) *Technical amendments.* The authors are requesting the committee approve the following technical amendments:

a) In Section 5840.5, clarify the intent of the Legislature that this bill reflects the stated goals as outlined in the PEI component of the MHSA.

b) In Section 5840.6(b), change the term to "outreach and engagement" and clarify that this term means a program that targets transition-age youth, with a priority on partnerships with college mental health programs.

c) In Section 5840.7(a)(2), broaden the population served beyond college-age individuals and clarify that partnerships with college mental health programs are a priority.

d) In Section 5840.7(a)(4), clarify that the MHSOAC would identify other programs after stakeholder participation, and those programs would be reflective of current stated goals of the MHSA.

e) In Section 5840.8(b), clarify that the MHSOAC is required to consider an LMHA's current spending on the required PEI priorities outlined in this bill when reviewing and approving a plan that includes other priorities.

f) In Section 5840.8(c), clarify that PEI funds can only be expended after the MHSOAC reviews and approves an LMHA's PEI plan.

SUPPORT AND OPPOSITION:

Support: Steinberg Institute (Sponsor)
America's Physician Groups
American Foundation for Suicide Prevention
California Association of Veteran Service Agencies
California Hospital Association
California Medical Association
California State Student Association
California State University
Californians for Safety and Justice
Children Now
Children's Defense Fund-California
Disability Rights California
Jed Foundation
JERICHO

Juvenile Court Judges of California
National Center for Youth Law
One Mind

Oppose: County Behavioral Health Directors Association of California (unless amended)

-- END --

ASSEMBLY BILL No. 2287

Introduced by Assembly Member Kiley

February 13, 2018

An act to amend Sections 5813.5, 5821, 5840, 5840.2, 5845, 5846, 5847, 5848, 5878.3, 5890, 5891, 5892, 5897, 5898, and 5899 of, to amend the heading of Part 3.7 (commencing with Section 5845) of Division 5 of, and to add Section 5841 to, the Welfare and Institutions Code, relating to mental health services.

LEGISLATIVE COUNSEL'S DIGEST

AB 2287, as introduced, Kiley. Mental Health Services Act.

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. Existing law requires the department to conduct program reviews of performance contracts to determine compliance, as specified. If a county mental health program is not in compliance with its performance contract, existing law authorizes the department to request a plan of correction with a specific timeline to achieve improvements.

Existing law establishes the Mental Health Services Oversight and Accountability Commission to oversee various parts of the act, as specified. Existing law authorizes the commission to, among other things, obtain data and information from specified entities to utilize in

its oversight, review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with MHSA funds.

Existing law requires each county mental health program to prepare and submit a 3-year program and expenditure plan, and annual updates, as specified, to the commission and the department within 30 days after adoption. Existing law authorizes the commission, if it identifies a critical issue related to the performance of a county mental health program, to refer the issue to the State Department of Health Care Services. Existing law authorizes the department to withhold mental health funding, upon a determination of noncompliance by the county, as specified, or if a county does not submit a specified annual revenue and expenditure report by the required deadline.

Existing law requires that funds be reserved for administrative costs, not to exceed 5% of the total of annual revenues received for the Mental Health Services Fund, for the department and the commission, among other specified entities, to implement duties pursuant to programs under the act, as specified. Existing law requires that those funds be subject to appropriation in the annual Budget Act.

This bill would establish the Office of Mental Health Services within the California Health and Human Services Agency, as specified. The bill would transfer various functions of the State Department of Health Care Services under the act to the office. Under this bill, the office would succeed to, and be vested with, all the duties, powers, responsibilities, and jurisdiction, vested in the department, regarding oversight of the Mental Health Services Fund, as specified. The bill would also require the office to assume certain duties, including, among others, initiating investigations, advising counties, conducting research, and reporting to the Legislature, by December 31, 2020, of any additional authority it deems necessary to complete its duties and to ensure county compliance with the act, as specified. The bill would make conforming changes to other provisions to reflect the transfer of those mental health responsibilities.

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.

This bill would make legislative findings and declarations relating to mental health services in California and stating that the provisions of this bill are consistent with, and further the intent of, the act. By

amending the provisions of the act, this bill would require a ⅔ vote of the Legislature.

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

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

(a) Proposition 63 (2004) is an important initiative to improve the lives and health of Californians by reducing the adverse impacts from untreated serious mental illness.

(b) Left untreated, mental illness may result in prolonged suffering and is the leading cause of suicide and disability. Without intervention, those suffering from untreated mental illness may be incarcerated, drop out of school, or become unemployed or homeless.

(c) Since 2004, the Mental Health Services Act has generated $14.6 billion and now comprises almost one-quarter of the state's mental health care budget.

(d) Currently, over 2.2 million Californians have a mental health need, and just over one-half of those with these needs reported that they did not receive any treatment from a primary care doctor or a mental health professional.

(e) Since 2013, and as recently as September 2016, the California State Auditor's Office and the Little Hoover Commission, respectively, have reported a continued failure to keep promises made to voters in 2004 with the passage of Proposition 63, the Mental Health Services Act, largely due to an ineffective governance system that has no oversight or accountability structure.

(f) The State Department of Health Care Services has been slow to publicly post county plans and reports of fiscal transparency. Currently, no state agency reviews, analyzes, or summarizes information supplied by local governments to ensure compliance with the Mental Health Services Act.

SEC. 2. Section 5813.5 of the Welfare and Institutions Code is amended to read:

5813.5. Subject to the availability of funds from the Mental Health Services Fund, the state shall distribute funds for the

provision of services under Sections 5801, 5802, and 5806 to county mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3. For purposes of this act, seniors means older adult persons identified in ~~Part 3 (commencing with Section 5800) of this division.~~ *this part.*

(a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this part with the medically necessary mental health services, medications, and supportive services set forth in the applicable treatment plan.

(b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds including other mental health funds, public and private insurance, and other local, state, and federal funds.

(c) Each county mental health program's plan shall provide for services in accordance with the system of care for adults and seniors who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3.

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

(2) To promote consumer-operated services as a way to support recovery.

(3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.

(4) To plan for each consumer's individual needs.

(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5 (commencing with Section 5890) of this division, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.

(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those

established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons. When included in county plans pursuant to Section 5847, funds may be used for the provision of mental health services under Sections 5347 and 5348 in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of Part 1).

(g) The ~~department~~ *Office of Mental Health Services* shall contract for services with county mental health programs pursuant to Section 5897. After the effective date of this section, the term grants referred to in Sections 5814 and 5814.5 shall refer to ~~such~~ *those* contracts.

SEC. 3. Section 5821 of the Welfare and Institutions Code is amended to read:

5821. (a) The California Behavioral Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development.

(b) The Office of Statewide Health Planning and Development shall work with the California Behavioral Health Planning Council and the ~~State Department of Health Care Services~~ *Office of Mental Health Services* so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

SEC. 4. Section 5840 of the Welfare and Institutions Code is amended to read:

5840. (a) The ~~State Department of Health Care Services,~~ *Office of Mental Health Services,* in coordination with counties, shall establish a program designed to prevent mental illnesses from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations.

(b) The program shall include *all of* the following components:

(1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

(2) Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable.

(3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.

(4) Reduction in discrimination against people with mental illness.

(c) The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.

(d) The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

(1) Suicide.

(2) Incarcerations.

(3) School failure or dropout.

(4) Unemployment.

(5) Prolonged suffering.

(6) Homelessness.

(7) Removal of children from their homes.

(e) Prevention and early intervention funds may be used to broaden the provision of community-based mental health services by adding prevention and early intervention services or activities to these services.

(f) In consultation with mental health stakeholders, and consistent with regulations from the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5846, the ~~department~~ *Office of Mental Health Services* shall revise the program elements in ~~Section 5840~~ *this section* applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults, and seniors.

SEC. 5. Section 5840.2 of the Welfare and Institutions Code is amended to read:

5840.2. The ~~department~~ *Office of Mental Health Services* shall contract for the provision of services pursuant to this part with each county mental health program in the manner set forth in Section 5897.

SEC. 6. Section 5841 is added to the Welfare and Institutions Code, immediately preceding Section 5845, to read:

5841. (a) The Office of Mental Health Services is hereby established within the California Health and Human Services Agency.

(b) The office is under the control of an executive officer, known as the Director of the Office of Mental Health Services, who shall be appointed by the Governor, subject to confirmation by the Senate, and hold office at the pleasure of the Governor.

(c) The office shall succeed to, and be vested with, all the duties, powers, responsibilities, and jurisdiction, vested in the State Department of Health Care Services, regarding oversight of the Mental Health Services Fund. All existing positions within the State Department of Health Care Services concerning those duties, powers, responsibilities, and jurisdiction shall be transferred to the office. The director shall have authority to hire persons for those positions.

(d) In addition to any duties set forth pursuant to subdivision (c), the office shall assume the following duties:

(1) Oversee the allocation of funds from the Mental Health Services Fund.

(2) Initiate investigations, at its own discretion or upon request, concerning potential county noncompliance with the Mental Health Services Act (MHSA) or concerning other critical issues related to the performance of a county mental health program.

(3) Ensure that public transparency is provided for the Mental Health Services Fund, that funding is allocated to those with mental health needs, that the public's safety is protected, and that the required data to track performance outcomes are reported to the public in a practical and usable manner.

(4) Perform outreach to counties, advise counties, and conduct research, relating to the Mental Health Services Fund.

(5) (A) By December 31, 2020, report to the Legislature of any additional authority the office deems necessary to complete its designated duties and to ensure county compliance with the MHSA, including, but not limited to, broader authority to sanction, to withhold MHSA funds, or to assess a fine for misreported data or data reported late.

(B) This paragraph does not grant the office the authority to create new types of penalties. It is the intent of the Legislature that, based on the findings and reporting by the office, future legislation be enacted to impose automatic, nondiscretionary

penalties, to be gradually applied to noncompliant counties, beginning with minor penalties, and increasing in severity as noncompliance is continued after collaboration and technical assistance have been offered.

(C) A report to the Legislature pursuant to this paragraph shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 7. The heading of Part 3.7 (commencing with Section 5845) of Division 5 of the Welfare and Institutions Code is amended to read:

PART 3.7. ~~OVERSIGHT~~ *TRANSPARENCY, OVERSIGHT,* AND ACCOUNTABILITY

SEC. 8. Section 5845 of the Welfare and Institutions Code is amended to read:

5845. (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act; Part 3.1 (commencing with Section 5820), Human Resources, Education, and Training Programs; Part 3.2 (commencing with Section 5830), Innovative Programs; Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs; and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act. The commission shall replace the advisory committee established pursuant to Section 5814. The commission shall consist of 16 voting members as follows:

(1) The Attorney General or his or her designee.

(2) The Superintendent of Public Instruction or his or her designee.

(3) The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate.

(4) The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.

(5) Two persons with a severe mental illness, a family member of an adult or senior with a severe mental illness, a family member of a child who has or has had a severe mental illness, a physician

specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees and a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer, all appointed by the Governor. In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness. At least one of the persons appointed pursuant to this paragraph shall have a background in auditing.

(b) Members shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(c) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(d) In carrying out its duties and responsibilities, the commission may do all of the following:

(1) Meet at least once each quarter at any time and location convenient to the public as it may deem appropriate. All meetings of the commission shall be open to the public.

(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including any clerical, legal, and technical assistance as may appear necessary. The commission shall administer its operations separate and apart from the ~~State Department of Health Care Services~~ *Office of Mental Health Services* and the California Health and Human Services Agency.

(3) Establish technical advisory committees such as a committee of consumers and family members.

(4) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to any officer or employee of state government.

(5) Enter into contracts.

(6) Obtain data and information from the ~~State Department of Health Care Services,~~ *Office of Mental Health Services,* the Office of Statewide Health Planning and Development, or other state or local entities that receive Mental Health Services Act funds, for

the commission to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with Mental Health Services Act funds.

(7) Participate in the joint state-county decisionmaking process, as contained in Section 4061, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.

(8) Develop strategies to overcome stigma and discrimination, and accomplish all other objectives of Part 3.2 (commencing with Section 5830), *Part* 3.6 (commencing with Section 5840), and the other provisions of the act establishing this commission.

(9) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.

(10) If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the ~~State Department of Health Care Services~~ *Office of Mental Health Services* pursuant to Section 5655. *For purposes of this paragraph, the office shall succeed to, and be vested with, all the duties, powers, responsibilities, and jurisdiction that are described in Section 5655 and vested in the State Department of Health Care Services.*

(11) Assist in providing technical assistance to accomplish the purposes of the Mental Health Services Act, Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) in collaboration with the ~~State Department of Health Care Services~~ *Office of Mental Health Services* and in consultation with the California Mental Health Directors Association.

(12) Work in collaboration with the ~~State Department of Health Care Services~~ *Office of Mental Health Services* and the California Behavioral Health Planning Council, and in consultation with the California Mental Health Directors Association, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in subdivision (a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.

SEC. 9. Section 5846 of the Welfare and Institutions Code is amended to read:

5846. (a) The commission shall adopt regulations for programs and expenditures pursuant to Part 3.2 (commencing with Section 5830), for innovative programs, and Part 3.6 (commencing with Section 5840), for prevention and early intervention.

(b) Any regulations adopted by the ~~department~~ *Office of Mental Health Services* pursuant to Section 5898 shall be consistent with the commission's regulations.

(c) The commission may provide technical assistance to any county mental health plan as needed to address concerns or recommendations of the commission or when local programs could benefit from technical assistance for improvement of their plans.

(d) The commission shall ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.

SEC. 10. Section 5847 of the Welfare and Institutions Code is amended to read:

5847. Integrated Plans for Prevention, Innovation, and System of Care Services.

(a) Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the Mental Health Services Oversight and Accountability Commission and the ~~State Department of Health Care Services~~ *Office of Mental Health Services* within 30 days after adoption.

(b) The three-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements as required in Section 5848. The three-year program and expenditure plan and annual updates shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).

(2) A program for services to children in accordance with Part 4 (commencing with Section 5850), to include a program pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 or provide substantial evidence that it is not feasible to establish a wraparound program in that county.

(3) A program for services to adults and seniors in accordance with Part 3 (commencing with Section 5800).

(4) A program for innovations in accordance with Part 3.2 (commencing with Section 5830).

(5) A program for technological needs and capital facilities needed to provide services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting, such as permanent supportive housing.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the education and training programs established pursuant to Part 3.1 (commencing with Section 5820).

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors that it is currently serving pursuant to Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act, Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs, and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act, during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(8) Certification by the county behavioral health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements.

(9) Certification by the county behavioral health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the ~~State Department of Health Care Services,~~ *Office of Mental Health Services,* and that all expenditures are consistent with the requirements of the Mental Health Services Act.

(c) The programs established pursuant to paragraphs (2) and (3) of subdivision (b) shall include services to address the needs of transition age youth 16 to 25 years of age. In implementing this

subdivision, county mental health programs shall consider the needs of transition age foster youth.

(d) Each year, the ~~State Department of Health Care Services~~ *Office of Mental Health Services* shall inform the County Behavioral Health Directors Association of California and the Mental Health Services Oversight and Accountability Commission of the methodology used for revenue allocation to the counties.

(e) Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800) for adults and seniors, Part 3.2 (commencing with Section 5830) for innovative programs, Part 3.6 (commencing with Section 5840) for prevention and early intervention programs, and Part 4 (commencing with Section 5850) for services for children, and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (7) of subdivision (b) for services pursuant to paragraphs (2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (e) ~~are~~ *is* not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

(g) The ~~department~~ *Office of Mental Health Services* shall post on its ~~website~~ *Internet Web site* the three-year program and expenditure plans submitted by every county pursuant to subdivision (a) in a timely manner.

SEC. 11. Section 5848 of the Welfare and Institutions Code is amended to read:

5848. (a) Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important

interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.

(c) The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and established jointly by the ~~State Department of Health Care Services~~ *Office of Mental Health Services* and the Mental Health Services Oversight and Accountability Commission, in collaboration with the County Behavioral Health Directors Association of California.

(d) Mental health services provided pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) shall be included in the review of program performance by the California Behavioral Health Planning Council required by paragraph (2) of subdivision (c) of Section 5772 and in the local mental health board's review and comment on the performance outcome data required by paragraph (7) of subdivision (a) of Section 5604.2.

(e) The ~~department~~ *Office of Mental Health Services* shall annually post on its Internet Web site a summary of the performance outcomes reports submitted by counties if clearly and

separately identified by counties as the achievement of performance outcomes pursuant to subdivision (c).

SEC. 12. Section 5878.3 of the Welfare and Institutions Code is amended to read:

5878.3. (a) Subject to the availability of ~~funds~~ *funds,* as determined pursuant to Part 4.5 (commencing with Section ~~5890)~~ ~~of this division,~~ *5890),* county mental health programs shall offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Other entitlement programs ~~include~~ *include,* but are not limited ~~to~~ *to,* mental health services available pursuant to Medi-Cal, child welfare, and special education programs. The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health ~~funds~~ *funds,* or other entitlement programs.

(b) Funding shall be at sufficient levels to ensure that counties can provide each child served all of the necessary services set forth in the applicable treatment plan developed in accordance with this part, including services where appropriate and necessary to prevent an ~~out of home~~ *out-of-home* placement, such as services pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9.

(c) The ~~State Department of Health Care Services~~ *Office of Mental Health Services* shall contract with county mental health programs for the provision of services under this article in the manner set forth in Section 5897.

SEC. 13. Section 5890 of the Welfare and Institutions Code is amended to read:

5890. (a) The Mental Health Services Fund is hereby created in the State Treasury. The fund shall be administered by the state. Notwithstanding Section 13340 of the Government Code, all moneys in the fund are, except as provided in subdivision (d) of Section 5892, continuously appropriated, without regard to fiscal years, for the purpose of funding the following programs and other related activities as designated by other provisions of this division:

(1) Part 3 (commencing with Section 5800), the Adult and Older Adult *Mental Health* System of Care Act.

(2) Part 3.2 (commencing with Section 5830), Innovative Programs.

(3) Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs.

(4) Part 3.9 (commencing with Section 5849.1), No Place Like Home Program.

(5) Part 4 (commencing with Section 5850), the Children's Mental Health Services Act.

(b) The establishment of this fund and any other provisions of the act establishing it or the programs funded shall not be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health parity. This act shall not ~~be construed to~~ modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing these obligations of plans and insurance policies.

~~(c) This act shall not be construed to modify or reduce the existing authority or responsibility of the State Department of Health Care Services.~~

~~(d)~~

(c) The ~~State Department of Health Care Services~~ *Office of Mental Health Services* shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care.

~~(e)~~

(d) Share of costs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division, shall be determined in accordance with the Uniform Method of Determining Ability to Pay applicable to other publicly funded mental health services, unless this Uniform Method is replaced by another method of determining copayments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division.

~~(f)~~

(e) The Supportive Housing Program Subaccount is hereby created in the Mental Health Services Fund. Notwithstanding

Section 13340 of the Government Code, all moneys in the subaccount are reserved and continuously appropriated, without regard to fiscal years, to the California Health Facilities Financing Authority to provide funds to meet its financial obligations pursuant to any service contracts entered into pursuant to Section 5849.35. Notwithstanding any other law, including any other provision of this section, no later than the last day of each month, the Controller shall, before any transfer or expenditure from the fund for any other purpose for the following month, transfer from the Mental Health Services Fund to the Supportive Housing Program Subaccount an amount that has been certified by the California Health Facilities Financing Authority pursuant to paragraph (3) of subdivision (a) of Section 5849.35, but not to exceed an aggregate amount of one hundred forty million dollars ($140,000,000) per year. If in any month the amounts in the Mental Health Services Fund are insufficient to fully transfer to the subaccount or the amounts in the subaccount are insufficient to fully pay the amount certified by the California Health Facilities Financing Authority, the shortfall shall be carried over to the next month. Moneys in the Supportive Housing Program Subaccount shall not be loaned to the General Fund pursuant to Section 16310 or 16381 of the Government Code.

SEC. 14. Section 5891 of the Welfare and Institutions Code is amended to read:

5891. (a) The funding established pursuant to this act shall be utilized to expand mental health services. ~~Except as provided in subdivision (j) of Section 5892 due to the state's fiscal crisis, these~~ *These* funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund or from the Local Revenue Fund 2011 in the State Treasury, and formula distributions of dedicated funds as provided in the last fiscal year ~~which~~ *that* ended prior to the effective date of this act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Sections 5890 and 5892.

These funds ~~may~~ *shall* not be used to pay for any other program. These funds ~~may~~ *shall* not be loaned to the General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Sections 5890 and 5892.

(b) (1) Notwithstanding subdivision (a), and except as provided in paragraph (2), the Controller may use the funds created pursuant to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Any such loan shall be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that would interfere with the carrying out of the object for which these funds were created.

(2) This subdivision does not apply to the Supportive Housing Program Subaccount created by subdivision ~~(f)~~ *(e)* of Section 5890 or any moneys paid by the California Health Facilities Financing Authority to the Department of Housing and Community Development as a service fee pursuant to a service contract authorized by Section 5849.35.

(c) Commencing July 1, 2012, on or before the 15th day of each month, pursuant to a methodology provided by the State Department of Health Care Services, the Controller shall distribute to each Local Mental Health Service Fund established by counties pursuant to subdivision (f) of Section 5892, all unexpended and unreserved funds on deposit as of the last day of the prior month in the Mental Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.9 (commencing with Section 5849.1), and Part 4 (commencing with Section 5850).

(d) Counties shall base their expenditures on the county mental health program's three-year program and expenditure plan or annual update, as required by Section 5847. Nothing in this subdivision shall affect subdivision (a) or (b).

SEC. 15. 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~~ *Office of Mental Health Services* 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. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(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,~~ *Office of Mental Health Services,* the California Behavioral 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 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. The amount of funds available for the purposes of this subdivision in any fiscal year shall be 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) (1) 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.

(2) If a county receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until three years after the date of the approval.

(3) Notwithstanding paragraph (1), any funds allocated to a county with a population of less than 200,000 that have not been spent for their authorized purpose within five years shall revert to the state as described in paragraph (1).

(4) Notwithstanding paragraphs (1) and (2), if a county with a population of less than 200,000 receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until five years after the date of the approval.

(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.

~~(j) For the 2011–12 fiscal year, General Fund revenues will be insufficient to fully fund many existing mental health programs, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and mental health services provided for special education pupils. In order to adequately fund those programs for the 2011–12 fiscal year and avoid deeper reductions in programs that serve individuals with severe mental illness and the most vulnerable, medically needy citizens of the state, prior to distribution of funds under paragraphs (1) to (6), inclusive, of subdivision (a), effective July 1, 2011, moneys shall be allocated from the Mental Health Services Fund to the counties as follows:~~

~~(1) Commencing July 1, 2011, one hundred eighty-three million six hundred thousand dollars ($183,600,000) of the funds available as of July 1, 2011, in the Mental Health Services Fund, shall be allocated in a manner consistent with subdivision (c) of Section 5778 and based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California to meet the fiscal year 2011–12 General Fund obligation for Medi-Cal Specialty Mental Health Managed Care.~~

~~(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. 16. Section 5897 of the Welfare and Institutions Code is amended to read:

5897. (a) Notwithstanding any other state law, the ~~State Department of Health Care Services~~ *Office of Mental Health Services* shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. For purposes of this section, a county mental

health program includes a city receiving funds pursuant to Section 5701.5.

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of those mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The ~~department~~ *office* shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) through the annual county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2.

(d) The ~~department~~ *office* shall conduct program reviews of performance contracts to determine compliance. Each county performance contract shall be reviewed at least once every three years, subject to available funding for this purpose.

(e) ~~When~~ *If* a county mental health program is not in compliance with its performance contract, the ~~department~~ *office* may request a plan of correction with a specific timeline to achieve improvements. The ~~department~~ *office* shall post on its Internet Web site any plans of correction requested and the related findings.

(f) Contracts awarded by the ~~State Department of Health Care Services~~, *office,* the State Department of Public Health, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with Section 5800), Part 3.1 (commencing with Section 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and ~~Part 4.5 (commencing with Section 5890)~~, *this part* may be awarded in the same manner in which contracts are awarded pursuant to Section ~~5814~~ *5814,* and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to those contracts.

(g) For purposes of Section 14712, the allocation of funds pursuant to Section 5892 ~~which~~ *that* are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the State

Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.

SEC. 17. Section 5898 of the Welfare and Institutions Code is amended to read:

5898. The ~~State Department of Health Care Services,~~ *Office of Mental Health Services,* in consultation with the Mental Health Services Oversight and Accountability Commission, shall develop regulations, as necessary, for the ~~State Department of Health Care Services,~~ *office,* the Mental Health Services Oversight and Accountability Commission, or designated state and local agencies to implement this act. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments.

SEC. 18. Section 5899 of the Welfare and Institutions Code is amended to read:

5899. (a) The ~~State Department of Health Care Services,~~ *Office of Mental Health 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~~ *office* and to the Mental Health Services Oversight and Accountability Commission. The ~~department~~ *office* and the commission shall annually post each county's report on ~~its~~ *their* Internet Web site in a timely manner.

(b) The ~~department,~~ *office,* 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~~ *office* 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~~ *office* 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. 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.

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AMENDED IN ASSEMBLY MARCH 23, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2619

Introduced by Assembly Member Travis Allen

February 15, 2018

An act ~~to amend Section 5878.1 of the Welfare and Institutions Code,~~ relating to mental health ~~services.~~ *services, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2619, as amended, Travis Allen. ~~Severely mentally ill children.~~ *Mental health services funding: homeless persons.*

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, funds a system of county mental health plans for the provision of mental health services, as specified. *The act 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 act requires the State Department of Health Care Services to implement specified mental health services provided under the act through contracts with county mental health programs or counties acting jointly, as prescribed.* 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. ~~Among other provisions, the existing act declares the intent to establish programs that ensure services are provided to severely mentally ill children, as defined, and that those services are part of the children's system of care, as specified.~~ *Existing*

law requires county mental health programs to develop plans for innovative programs, and provides for funding for these programs from the Mental Health Services Fund.

This bill would ~~make technical, nonsubstantive changes to those provisions.~~ *appropriate $10,000,000 from the General Fund to the State Department of Health Care Services to be distributed to counties for the purpose of funding innovative programs to provide mental health services to California's homeless population.*

Vote: ~~majority~~ *2/3*. Appropriation: ~~no~~ *yes*. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

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

SECTION 1. The sum of ten million dollars ($10,000,000) is hereby appropriated from the General Fund to the State Department of Health Care Services. The department shall allocate the appropriated funds to county mental health programs for the purpose of funding innovative programs, consistent with Section 5830 of the Welfare and Institutions Code, to provide mental health services to California's homeless population.

~~SECTION 1. Section 5878.1 of the Welfare and Institutions Code is amended to read:~~

~~5878.1. (a) It is the intent of this article to establish programs that ensure services will be provided to severely mentally ill children, as defined in Section 5878.2, and that they be part of the children's system of care established pursuant to this part. It is the intent of this act that services provided under this chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and his or her family.~~

~~(b) This act does not authorize any services to be provided to a minor without the consent of the child's parent or legal guardian beyond those already authorized by existing statute.~~

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Date of Hearing: April 17, 2018

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 2619 (Travis Allen) – As Amended March 23, 2018

SUBJECT: Mental health services funding: homeless persons.

SUMMARY: Appropriates $10 million from the General Fund to the California Department of Health Care Services (DHCS) to allocate the appropriated funds to county mental health programs for the purpose of funding innovative programs to provide mental health services to California's homeless population.

EXISTING LAW:

1) Establishes the Mental Health Services Act (MHSA), enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs, and integrated service plans for mentally ill children, adults, and seniors through a 1% income tax on personal income above $1 million.

2) Establishes the Mental Health Services Oversight and Accountability Commission (Commission) to oversee the implementation of MHSA, made up of 16 individuals appointed by the Governor, as specified.

3) Establishes the Mental Health Services Fund (Fund) to be disbursed as follows:
   a) Twenty percent of funds distributed to counties to be used for prevention and early intervention programs;
   b) Five percent of the total funding for each county mental health program to be utilized for innovative programs;
   c) Requires the balance of funds to be distributed to county mental health programs for services to persons with severe mental illnesses, for the children's system of care, and for the adult and older adult system of care;
   d) Permits no more than 20% of the average amount of funds allocated to a county for the previous five years to be used for technological needs and capital facilities, human resource needs, and for counties to establish 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;
   e) Permits up to 5% of funds to be used for planning costs including 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; and,
   f) Requires, prior to making the allocations in a) through d) above, up to 5% of funds to be reserved for the costs for DHCS, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development), the Commission, the California Department of Public Health, and any other state agency to implement all duties pursuant to the MHSA.

4) Requires DHCS, pursuant to the MHSA and in coordination with counties, to establish a program designed to prevent mental illnesses from becoming severe and disabling and requires the program to emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

a) Suicide;
b) Incarcerations;
c) School failure or dropout;
d) Unemployment;
e) Prolonged suffering;
f) Homelessness; and,
g) Removal of children from their homes.

5) Requires all expenditures for county mental health programs to be consistent with a currently approved mental health plan or update.

6) Requires any funds allocated to a county that have not been spent for their authorized purpose within three years to revert to the state to be deposited into the Fund and be made available for other counties in future years.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) BACKGROUND.

a) Proposition 63 Commission. The MHSA creates the 16 member Commission charged with overseeing the implementation of MHSA. The 2017-18 Governor's Budget projected that $1.34 billion would be deposited into the Fund in fiscal year 2015-16. The MHSA addresses a broad continuum of prevention, early intervention and service needs as well as providing funding for infrastructure, technology and training needs for the community mental health system. The MHSA requires each county mental health department to prepare and submit a three-year plan to DHCS that must be updated each year and approved by DHCS after review and comment by the Commission. In their three-year plans, counties are required to include a list of all programs for which MHSA funding is being requested and that identifies how the funds will be spent and which populations will be served. Counties must submit their plans for approval to the Commission before the counties may spend certain categories of funding.

b) Funding. The MHSA provides funding for programs within five components:
i) Community Services and Supports: Provides direct mental health services to the severely and seriously mentally ill, such as mental health treatment, cost of health care treatment, and housing supports. Regulation requires counties to direct the majority of its Community Services and Supports funds to Full-Service Partnerships (FSPs). FSPs are county coordinated plans, in collaboration with the client and the family to provide the full spectrum of community services. These services consist of mental health services and supports, such as peer support and crisis intervention services; and non-mental health services and supports, such as food, clothing, housing, and the cost of medical treatment;
ii) Prevention and Early Intervention: Provides services to mental health clients in order to help prevent mental illness from becoming severe and disabling;
iii) Innovation: Provides services and approaches that are creative in an effort to address mental health clients' persistent issues, such as improving services for underserved or unserved populations within the community;

iv) **Capital Facilities and Technological Needs**: Creates additional county infrastructure such as additional clinics and facilities and/or development of a technological infrastructure for the mental health system, such as electronic health records for mental health services; and,

v) **Workforce Education and Training**: Provides training for existing county mental health employees, outreach and recruitment to increase employment in the mental health system, and financial incentives to recruit or retain employees within the public mental health system.

c) **California Mental Health Planning Council (Council).** The Council is a majority consumer and family member advisory body to state and local government, the Legislature, and residents of California on mental health services in California. According to its Website, the vision and mission of the Council guides its evaluation of California's system of mental health care through targeted committee studies, community site visits, and General Session forums and presentations. The Council informs the Administration and the Legislature on priority issues through publications and reports, provides feedback on mental health policy and regulations, and on legislative actions based on its Policy Platform. The Council is currently working on the 2017 Data Notebook project with the county mental health boards statewide. The data notebook is a snapshot of current mental health indicators that is compared to statewide indicators. It is anticipated that the 2017 Data Notebook will be released in late 2017.

d) **State Auditor Report and Recommendations.** On February 27, 2018, the State Auditor released a report entitled "Mental Health Services Act: The State Could Better Ensure the Effective Use of Mental Health Services Act Funding" (Audit Report), at the request of the Joint Legislative Audit Committee. The Audit Report concluded that despite having significant responsibility for the MHSA program since 2012, DHCS has not developed a process to recover unspent MHSA funds from local mental health agencies after the statutory time frames for spending the funds have elapsed, known as reversion. As a result, the local mental health agencies have had less incentive to spend MHSA funds in a timely manner and had amassed unspent funds of $231 million as of the end of fiscal year 2015–16 that they should have reverted to the State for it to reallocate to other local mental health agencies. This figure does not include funds held in reserves or interest earned on the unspent funds. However, the Audit Report noted that the Legislature enacted a one-time change in state law in 2017 that allowed local mental health agencies to retain all funds that were subject to reversion as of July 1, 2017. The Audit Report concluded that nevertheless, this one-time allowance did not resolve the larger issue that DHCS has been slow in implementing a process to revert unspent MHSA funds. The State Auditor recommended, in order to ensure that local mental health agencies spend MHSA funds in a timely manner, that DHCS implement a fiscal reversion process to reallocate to other local mental health agencies any MHSA funds that are unspent within the statutory reversion time frames.

e) **2016 "No Place Like Home" Initiative.** On July 1, 2016, Governor Brown signed landmark legislation enacting the No Place Like Home program to dedicate $2 billion in bond funds and leverage additional dollars from other local, state, and federal funding for purposes of providing housing for chronically homeless persons with mental illness. The initiative includes proposals to construct permanent supportive housing for chronically homeless persons with mental illness, provide $200 million over four years in shorter-term, rent subsidies while the permanent housing is constructed or rehabilitated and support for special housing programs that will assist families that are part of the child welfare system or are enrolled in California Work Opportunity and Responsibility to Kids (CalWORKs) Housing Support Program. The bonds

are repaid by funding from the Mental Health Services Act (MHSA). Key features of the program include:

i) Counties will be eligible applicants (either solely or with a housing development sponsor).
ii) Funding for permanent supportive housing must utilize low barrier tenant selection practices that prioritize vulnerable populations and offer flexible, voluntary, and individualized supportive services.
iii) Counties must commit to provide mental health services and help coordinate access to other community-based supportive services.

2) **RELATED LEGISLATION.**

a) AB 2843 (Gloria) adds cities, special districts, school districts, or other public entities to the list of entities eligible to receive an excess of Mental Health Services Act (MHSA) funds subject to reversion for the provision of mental health services consistent with the intent of the MHSA. AB 2843is pending in the Assembly Health Committee.

b) AB 488 (Kiley) establishes the Mental Health Services Fund Transparency and Accountability Office within the California Health and Human Services Agency and transfers various functions of DHCS under the MHSA to the office, as specified. AB 488 is pending in the Assembly Health Committee.

c) AB 1134 (Gloria), Chapter 412, Statutes of 2017, authorizes the Commission to establish a fellowship program for the purpose of providing an experiential learning opportunity for a mental health consumer and a mental health professional.

d) SB 192 (Beall) would require counties, or counties acting jointly, seeking funding from the MHSA Reversion Fund, to demonstrate to the Mental Health Services Oversight and Accountability Commission that funding will be used to create, or expand, existing capacity for services and supports that address unmet community needs. SB 192 is pending in the Assembly Health Committee.

3) **POLICY COMMENT.** As noted above, a recent State Audit Report indicated that local mental health agencies have amassed unspent funds of $231 million as of the end of fiscal year 2015-2016. Additionally, recent proposals such as the "No Place Like Home" Initiative dedicated even more funding specifically to housing individuals experiencing mental health disorders. Therefore, the need for this bill is unclear.

REGISTERED SUPPORT / OPPOSITION:

Support

None on file.

Opposition

None on file.

Analysis Prepared by: Paula Villescaz / HEALTH / (916) 319-2097

AMENDED IN ASSEMBLY MARCH 23, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2843

Introduced by Assembly Member Gloria

February 16, 2018

An act *to amend Sections 5892 and 5899.1 of the Welfare and Institutions Code,* relating to mental ~~health.~~ *health, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2843, as amended, Gloria. Mental Health Services Fund.

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. ~~Existing law reallocates funds back to a county that failed to spend its initial funds within 3 years, and requires the county, by July 1, 2018, to prepare a plan to expend those funds on or before July 1, 2020. Under existing law,~~ *The MHSA requires* funds *allocated to a county that have* not *been* spent within a specified time ~~would~~ *to* revert to the Mental Health Services ~~Fund, as provided.~~ *Fund and to be reallocated to other counties for the purposes for which the unspent funds were initially allocated to the original county.* 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 ~~state the intent of the Legislature to enact legislation that would require a county that receives reallocated funds from the Mental Health Services Fund to spend those funds within 2 years of~~

~~adopting an expenditure plan for those funds. It would further state the intent of the Legislature that any funds not expended by a county within those 2 years would revert to the Mental Health Services Fund to be redistributed to cities within that county.~~ *additionally require those funds subject to reversion to be reallocated to cities, special districts, school districts, or other public entities for the provision of mental health services consistent with the intent of the MHSA. The bill would find and declare that its provisions are consistent with and further the intent of the MHSA. By allocating moneys in the Mental Health Services Fund for new purposes, this bill would make an appropriation.*

Vote: ~~majority~~ *2/3*. Appropriation: ~~no~~ *yes*. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

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

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.~~ *5840)*.

(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. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(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,~~ *5850),* shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.

(b) In any *fiscal* year after ~~2007–08,~~ *the 2007-08 fiscal year,* 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 *fiscal* 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.~~ *5850).*

(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 Behavioral 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 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.~~ *5850)*. The amount of funds available for the purposes of this subdivision in any fiscal year ~~shall be~~ *is* subject to appropriation in the annual Budget Act.

(e) In ~~2004–05,~~ *the 2004-05 fiscal year,* 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.~~ *5820)*.

(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 *fiscal* years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) (1) 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~~ *counties, or cities, special districts, school districts, or other public entities,* 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.

(2) If a county receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until three years after the date of the approval.

(3) Notwithstanding paragraph (1), any funds allocated to a county with a population of less than 200,000 that have not been spent for their authorized purpose within five years shall revert to the state as described in paragraph (1).

(4) Notwithstanding paragraphs (1) and (2), if a county with a population of less than 200,000 receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until five years after the date of the approval.

(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.

(j) For the 2011–12 fiscal year, General Fund revenues will be insufficient to fully fund many existing mental health programs, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and mental health services provided for special education pupils. In order to adequately fund those programs for the 2011–12 fiscal year and avoid deeper reductions in programs that serve individuals with severe mental illness and the most vulnerable, medically needy citizens of the state, prior to distribution of funds under paragraphs (1) to (6), inclusive, of subdivision (a), effective July

1, 2011, moneys shall be allocated from the Mental Health Services Fund to the counties as follows:

(1) Commencing July 1, 2011, one hundred eighty-three million six hundred thousand dollars ($183,600,000) of the funds available as of July 1, 2011, in the Mental Health Services Fund, shall be allocated in a manner consistent with subdivision (c) of Section 5778 and based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California to meet the fiscal year 2011–12 General Fund obligation for Medi-Cal Specialty Mental Health Managed Care.

(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. 2. Section 5899.1 of the Welfare and Institutions Code is amended 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.~~ *county, or to cities, special districts, school districts, or other public entities for the provision of mental health services consistent with the intent of the Mental Health Services Act.*

(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. 3. 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.

~~SECTION 1. It is the intent of the Legislature to enact legislation that would require a county that receives reallocated funds from the Mental Health Services Fund to spend those funds within two years of adopting an expenditure plan for those funds. It is further the intent of the Legislature that any funds not expended by a county within those two years would revert to the~~

~~Mental Health Services Fund to be redistributed to cities within that county.~~

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Date of Hearing: April 17, 2018

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 2843 (Gloria) – As Amended March 23, 2018

SUBJECT: Mental Health Services Fund.

SUMMARY: Adds cities, special districts, school districts, or other public entities to the list of entities eligible to receive an excess of Mental Health Services Act (MHSA) funds subject to reversion for the provision of mental health services consistent with the intent of the MHSA.

EXISTING LAW:

1) Establishes the MHSA, enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs, and integrated service plans for mentally ill children, adults, and seniors through a 1% income tax on personal income above $1 million.

2) Specifies that the MHSA can only be amended by a two-thirds vote of both houses of the Legislature and only as long as the amendment is consistent with and furthers the intent of the MHSA. Permits provisions clarifying the procedures and terms of the MHSA to be added by majority vote.

3) Establishes the Mental Health Services Fund (Fund) to be disbursed as follows:

   a) Twenty percent of funds distributed to counties to be used for prevention and early intervention programs;

   b) Five percent of the total funding for each county mental health program to be utilized for innovative programs;

   c) Requires the balance of funds to be distributed to county mental health programs for services to persons with severe mental illnesses, for the children's system of care, and for the adult and older adult system of care;

   d) Permits no more than 20% of the average amount of funds allocated to a county for the previous five years to be used for technological needs and capital facilities, human resource needs, and for counties to establish 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;

   e) Permits up to 5% of funds to be used for planning costs including 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; and,

f) Requires, prior to making the allocations in a) through d) above, up to 5% of funds to be reserved for the costs for the State Department of Health Care Services (DHCS), the California Mental Health Planning Council, the Office of Statewide Health Planning and Development (OHSPD), the Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the MHSA.

4) Requires all expenditures for county mental health programs to be consistent with a currently approved mental health plan or update.

5) Deems all unspent funds subject to reversion as of July 1, 2017, to have been reverted to the Fund and reallocated to the county of origin for the purposes for which they were originally allocated.

6) Requires DHCS, on or before July 1, 2018, in consultation with counties and other stakeholders, to prepare and submit 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.

7) Requires DHCS to provide to counties the amounts it has determined are subject to reversion, and provide a process for counties to appeal this determination.

8) Requires counties with unspent funds subject to reversion, that are deemed reverted and reallocated, to prepare and submit a plan (by July 1, 2018) to expend these funds on or before July 1, 2020.

9) Restarts the three-year clock on expenditure of Innovation funds when a county's Innovation Plan has received approval by the Mental Health Services Oversight and Accountability Commission (Commission).

10) Authorizes small counties, with a population of less than 200,000, to expend MHSA funds for up to five years before unspent funds will be reverted to the state.

11) Requires DHCS, in consultation with the Commission and the County Behavioral Health Directors Association of California (CBHDA), to develop and administer instructions for the Annual MHSA Revenue and Expenditure Report (Report). Requires that the instructions include a requirement that the county certify the accuracy of this report.

12) Requires counties to submit the report electronically to DHCS and to the Commission. Requires DHCS and the Commission to annually post each county's report on its website in a timely manner. Requires DHCS, in consultation with the commission and CBHDA, to revise these instructions by July 1, 2017, and as needed thereafter, to improve the timely and accurate submission of county revenue and expenditure data. Specifies the purpose of the Report.

13) Requires DHCS, by October 1, 2018, and by October 1 of each subsequent year, in consultation with counties, to publish on its Internet Website a report detailing funds subject to reversion by county and by originally allocated purpose.

14) Requires that, on or after July 1, 2017, funds subject to reversion be reallocated to other counties for the purposes for which the unspent funds were initially allocated to the original county.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, California voters recognized the need to provide mental health services to some of our most vulnerable populations with the passage of Proposition 63 in 2004. They did not expect, however, that over the following decade since its passage, nearly $2.5 billion in MHSA funds would go unspent. More specifically, as of September 2017, $231 million of that $2.5 billion should have been reverted back to the state for reallocation as a result of local mental health agencies' failure to meet expenditure timelines. This bill allows other public entities the opportunity to step up to address our mental health crisis by making reverted MHSA funds – funds that local mental health agencies have not expended nor set aside in reserves – available for uses consistent with the MHSA.

2) **BACKGROUND.**

   a) **Proposition 63.** Proposition 63 was passed by voters in November 2004. The MHSA imposes a 1% income tax on personal income in excess of $1 million and creates the 16 member Commission charged with overseeing the implementation of MHSA. The 2016-17 Governor's Budget projected that $1.9 billion in revenue would be deposited into the Fund in fiscal year 2017-18. The MHSA addresses a broad continuum of prevention, early intervention, and service needs, as well as provided funding for infrastructure, technology, and training needs for the community mental health system. In addition to local programs, the MHSA authorizes up to 5% of revenues for state administrative functions performed by a variety of state entities such as the DHCS and OSHPD. It also funds evaluation of the MHSA by the Commission, which was established by the MHSA. Unspent MHSA funds are required to be placed in a reserve in accordance with an approved plan, and funds allocated to a county that have not been spent for their authorized purpose within three years are required to revert those funds back to the state.

   b) **Commission**. MHSA requires each county mental health department to prepare and submit a three-year plan to DHCS that must be updated each year and approved by DHCS after review and comment by the Commission. In their three-year plans, counties are required to include a list of all programs for which MHSA funding is being requested and that identifies how the funds will be spent and which populations will be served. Counties must submit their plans for approval to the Commission before the counties may spend certain categories of funding.

   c) **Funding**. The MHSA provides funding for programs within five components:

      i) **Community Services and Supports**: Provides direct mental health services to the severely and seriously mentally ill, such as mental health treatment, cost of health care treatment, and housing supports. Regulation requires counties to direct the majority of its Community Services and Supports funds to Full-Service Partnerships (FSPs). FSPs are county coordinated plans, in collaboration with the client and the

family to provide the full spectrum of community services. These services consist of mental health services and supports, such as peer support and crisis intervention services; and non-mental health services and supports, such as food, clothing, housing, and the cost of medical treatment;

ii) **Prevention and Early Intervention**: Provides services to mental health clients in order to help prevent mental illness from becoming severe and disabling;

iii) **Innovation**: Provides services and approaches that are creative in an effort to address mental health clients' persistent issues, such as improving services for underserved or unserved populations within the community;

iv) **Capital Facilities and Technological Needs**: Creates additional county infrastructure such as additional clinics and facilities and/or development of a technological infrastructure for the mental health system, such as electronic health records for mental health services; and,

v) **Workforce Education and Training**: Provides training for existing county mental health employees, outreach and recruitment to increase employment in the mental health system, and financial incentives to recruit or retain employees within the public mental health system.

d) **State Auditor Report and Recommendations.** On February 27, 2018, the State Auditor released a report entitled "Mental Health Services Act: The State Could Better Ensure the Effective Use of Mental Health Services Act Funding" (Audit Report), at the request of the Joint Legislative Audit Committee. The Audit Report concluded that despite having significant responsibility for the MHSA program since 2012, DHCS has not developed a process to recover unspent MHSA funds from local mental health agencies after the statutory time frames for spending the funds have elapsed, known as reversion. As a result, the local mental health agencies have had less incentive to spend MHSA funds in a timely manner and had amassed unspent funds of $231 million as of the end of fiscal year 2015–16 that they should have reverted to the State for it to reallocate to other local mental health agencies. This figure does not include funds held in reserves or interest earned on the unspent funds. However, the Audit Report noted that the Legislature enacted a one-time change in state law in 2017 that allowed local mental health agencies to retain all funds that were subject to reversion as of July 1, 2017. The Audit Report concluded that nevertheless, this one-time allowance did not resolve the larger issue that DHCS has been slow in implementing a process to revert unspent MHSA funds. The State Auditor recommended, in order to ensure that local mental health agencies spend MHSA funds in a timely manner, that DHCS implement a fiscal reversion process to reallocate to other local mental health agencies any MHSA funds that are unspent within the statutory reversion time frames. The State Auditor also recommended that DHCS clarify that the interest that local mental health agencies earn on unspent MHSA funds is also subject to reversion requirements and should establish an MHSA reserve level that is sufficient but not excessive.

3) **SUPPORT.** San Diego City Councilmember Christopher Ward states in support of the bill that California is facing a severe mental health crisis despite the availability of significant funding specific to providing mental health services. The City of San Diego is suffering

from a homelessness crisis and many of those unsheltered on our streets are in need of mental health services. The City's resources are insufficient to fully and appropriately respond to this specific need. This bill could provide additional support services to help handle mental health and social needs where the funds exist but are not otherwise serving the public.

4) **OPPOSITION.** The California Behavioral Health Directors Association, California State Association of Counties, Rural County Representatives of California, Urban Counties of California, write as a coalition (the Coalition) in opposition that the MHSA was created to support counties in addressing the urgent need for expanding accessible, recovery-based community health services. This funding has expanded and transformed the public mental health system to achieve results such as a reduction in incarcerations, school failures, unemployment and homelessness for individual living with mental health issues. The Coalition states that many of the most effective MHSA interventions are accomplished in collaboration with county affiliates, schools, school districts, and other local entities. Nothing in current law hinders such collaboration. In fact, the Coalition notes, there are hundreds of MHSA programs already operating in collaboration with local public schools, city policy departments, and other local public entities. The Coalition argues that this bill sidesteps the leadership role and legal responsibility that counties play in California in meeting the health and human service needs of low-income, vulnerable Californians with mental health needs. Shifting funds away from counties will result in a disruption of local planning and the priorities that have already been set in communities with respect to coordinated efforts between counties, schools, and other local agencies. The Coalition further notes that AB 114 (Committee on Budget), Chapter 38, Statutes of 2017, comprehensively addressed the issue of what happens to funds that remain in county accounts after a certain period of time, also known as "reversion." These recent statutory changes requires counties to submit a plan to DHCS for expending all unallocated funds by July 1, 2018, and the counties have until 2020 to expend these funds. The Coalition concludes that these changes have already established a balanced approach to MHSA reversion for both the past and the future, thereby providing continuity and predictability to counties and their local providers moving forward.

5) **RELATED LEGISLATION.** AB 2619 (Allen) would appropriate $10 million from the General Fund to DHCS to allocate the appropriated funds to county mental health programs for the purpose of funding innovative programs to provide mental health services to California's homeless population. This bill is pending in the Assembly Health Committee and is scheduled to be heard on April 17, 2018.

6) **PREVIOUS LEGISLATION.**

   a) AB 462 (Thurmond), Chapter 403, Statutes of 2017, authorizes the Director of Employment Development Department to share information with the Commission related to quarterly wage data to assist the Commission in fulfilling its duties under the MHSA, to the extent permitted under applicable federal statute and regulation. Declares it the intent of the Legislature to authorize the Commission to receive information held by other state agencies, as it relates to outcomes established under the MHSA, for purposes of monitoring outcomes and improving the mental health system.

b) AB 1134 (Gloria), Chapter 412, Statutes of 2017, authorizes the Commission to establish a fellowship program for the purpose of providing an experiential learning opportunity for a mental health consumer and a mental health professional.

c) SB 192 (Jim Beall) would require counties, or counties acting jointly, seeking funding from the MHSA Reversion Fund, to demonstrate to the Mental Health Services Oversight and Accountability Commission that funding will be used to create, or expand, existing capacity for services and supports that address unmet community needs. SB 192 is pending in the Assembly Health Committee.

d) AB 2279 (Cooley) of 2015 would have required DHCS to develop and administer instructions for the compilation of revenue and expenditure information related to the MHSA by counties, in consultation with the Commission and CBHDA, as specified. AB 2279 was vetoed, by the Governor, who stated:

> "I am returning Assembly Bill 2279 without my signature. This bill requires the DHCS to annually compile and publicly report financial data and program information from counties on their MHSA expenditures. DHCS is already in the process of collecting and posting county revenue and expenditure reports as well as updated three year program expenditure plans, which will provide much of the information outlined in this bill. I encourage the Legislature and interested stakeholders to continue to work with the department to identify useful information that can be integrated into the existing reports to improve transparency and accountability in the use of these funds."

6) **POLICY COMMENT.** As noted above, the State Auditor also recommended that DHCS clarify that the interest that local mental health agencies earn on unspent MHSA funds is also subject to reversion requirements and should establish an MHSA reserve level that is sufficient but not excessive. The author may wish to consider amending the bill to clarify that interest is subject to reversion.

REGISTERED SUPPORT / OPPOSITION:

Support

City of San Diego, Council District Three

Opposition

California Behavioral Health Directors Association
California State Association of Counties
Rural County Representatives of California
Urban Counties of California

Analysis Prepared by: Paula Villescaz / HEALTH / (916) 319-2097

AMENDED IN SENATE MARCH 22, 2018

SENATE BILL **No. 1101**

Introduced by Senator Pan

February 13, 2018

An act to ~~amend Section 5840 of~~ *add Part 7 (commencing with Section 5953) to Division 5 of* the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1101, as amended, Pan. Mental health.

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 Mental Health Services Oversight and Accountability Commission to oversee the administration of various parts of the act.

In addition to its existing duties, this bill would require the commission, on or before January 1, 2020, to establish 5 statewide objectives for the treatment and prevention of mental illness and metrics by which progress toward each of those objectives may be measured. The bill would require the commission to work with appropriate stakeholders in establishing these objectives and metrics. The bill would require the obejectives and metrics to be reviewed at least every 5 years and, if appropriate, revised. The bill would prohibit the commission from using MHSA funding to carry out these additional duties.

The bill, beginning January 1, 2021, would require all counties to annually submit a report to the commission and the Legislature, by the end of each fiscal year, that documents its progress toward the statewide objectives, using the metrics described above. The bill would also require each county to document specified mental health funding

allocations in relation to the statewide objectives. The bill would prohibit counties from encumbering MHSA funding for purposes of complying with these provisions. By requiring counties to submit annual reports, this bill would impose a state-mandated local program.

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

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

~~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, requires the State Department of Health Care Services to establish a program designed to prevent mental illnesses from becoming severe and disabling.~~

~~This bill would make technical, nonsubstantive changes to that provision.~~

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

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

SECTION 1. Part 7 (commencing with Section 5953) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 7. STATEWIDE MENTAL HEALTH OBJECTIVES

5953. (a) On or before January 1, 2020, the Mental Health Services Oversight and Accountability Commission, in addition to its existing duties, shall establish five statewide objectives for the treatment and prevention of mental illness. The commission shall also establish corresponding metrics by which progress toward each objective may be measured. The commission shall work with appropriate stakeholders in establishing these objectives and metrics. Objectives and metrics established pursuant this section shall be reviewed at least every five years and, if appropriate, revised.

(b) The commission shall not use funding allocated for purposes of the Mental Health Services Act to carry out the duties described in this section.

(c) Notwithstanding Section 10231.5 of the Government Code, each county, beginning January 1, 2021, shall annually submit a report to the commission and to the Legislature, by the end of each fiscal year, that documents the county's progress toward the statewide objectives, using the metrics described in subdivision (a). The report shall also document mental health funding allocations from Medi-Cal and the Mental Health Services Act in relation to the statewide objectives. A report submitted pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(d) Counties shall not encumber funding received pursuant to the Mental Health Services Act to comply with the reporting requirements described in this section.

(e) This section shall not be construed to require counties to allocate its mental health funding based on the statewide objectives established pursuant to subdivision (a). It is the intent of the Legislature that these statewide objectives work in concert with locally and regionally established goals to improve mental health outcomes statewide.

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 5840 of the Welfare and Institutions Code is amended to read:~~

~~5840. (a) The State Department of Health Care Services, in coordination with counties, shall establish a program designed to prevent mental illnesses from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations.~~

~~(b) The program shall include all of the following components:~~

~~(1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.~~

~~(2) Access and linkage to medically necessary care provided by county mental health programs for children with severe mental~~

~~illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable.~~

~~(3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.~~

~~(4) Reduction in discrimination against people with mental illness.~~

~~(c) The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.~~

~~(d) The program shall emphasize strategies to reduce all of the following negative outcomes that may result from untreated mental illness:~~

~~(1) Suicide.~~

~~(2) Incarcerations.~~

~~(3) School failure or dropout.~~

~~(4) Unemployment.~~

~~(5) Prolonged suffering.~~

~~(6) Homelessness.~~

~~(7) Removal of children from their homes.~~

~~(e) Prevention and early intervention funds may be used to broaden the provision of community-based mental health services by adding prevention and early intervention services or activities to these services.~~

~~(f) In consultation with mental health stakeholders, and consistent with regulations from the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5846, the department shall revise the program elements in this section applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults, and seniors.~~

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SENATE BILL No. 1134

Introduced by Senator Newman

February 13, 2018

An act to amend Section 5892 of the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1134, as introduced, Newman. Mental Health Services Fund.

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 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.

This bill would make technical, nonsubstantive changes to these provisions.

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

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

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.~~ *3.1 (commencing with Section 5820).*

(2) In 2005–06, 2006–07, and in 2007–08, 10 percent for capital facilities and technological needs *shall be* 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~~ *a* county in which the department determines that the increase will decrease the need and cost for additional services to ~~severely mentally ill persons~~ *persons with severe mental illness* 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. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(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 Behavioral 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 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. The amount of funds available for the purposes of this subdivision in any fiscal year shall be 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) (1) 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 *made* 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.

(2) If a county receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until three years after the date of the approval.

(3) Notwithstanding paragraph (1), ~~any~~ funds allocated to a county with a population of less than 200,000 that have not been spent for their authorized purpose within five years shall revert to the state as described in paragraph (1).

(4) Notwithstanding paragraphs (1) and (2), if a county with a population of less than 200,000 receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until five years after the date of the approval.

(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.

(j) For the 2011–12 fiscal year, General Fund revenues will be insufficient to fully fund many existing mental health programs, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and mental health services provided for special education pupils. In order to adequately fund those programs for the 2011–12 fiscal year and avoid deeper reductions in programs that serve individuals with severe mental illness and the most vulnerable, medically needy citizens of the state, prior to distribution of funds under paragraphs (1) to (6), inclusive, of subdivision (a), effective July 1, 2011, moneys shall be allocated from the Mental Health Services Fund to the counties as follows:

(1) Commencing July 1, 2011, one hundred eighty-three million six hundred thousand dollars ($183,600,000) of the funds available as of July 1, 2011, in the Mental Health Services Fund, shall be allocated in a manner consistent with subdivision (c) of Section 5778 and based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California to meet the fiscal year 2011–12 General Fund obligation for Medi-Cal Specialty Mental Health Managed Care.

(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~~ *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.

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AMENDED IN SENATE APRIL 9, 2018

SENATE BILL **No. 1206**

Introduced by ~~Senator~~ *Senators* De León *and Moorlach*

February 15, 2018

~~An act to amend Section 17002 of the Unemployment Insurance Code, relating to CalWORKs.~~ *An act to amend Sections 5849.35 and 5890 of, and to add Section 5849.15 to, the Welfare and Institutions Code, relating to mental health services, and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1206, as amended, De León. ~~CalWORKs.~~ *No Place Like Home Act of 2018.*

The Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, imposes a 1% tax on that portion of a taxpayer's taxable income that exceeds $1,000,000 and requires that the revenue from that tax be deposited in the Mental Health Services Fund to fund various county mental health programs.

Existing law, known as the No Place Like Home Program, requires the Department of Housing and Community Development to award $2,000,000,000 among counties to finance capital costs, including, but not limited to, acquisition, design, construction, rehabilitation, or preservation, and to capitalize operating reserves, of permanent supportive housing for the target population, as specified. Existing law establishes, and continuously appropriates moneys in, the No Place Like Home Fund for these purposes. Existing law authorizes the California Health Facilities Financing Authority and the department to enter into service contracts pursuant to the program related to

permanent supportive housing, and further authorizes the authority to issue taxable or tax-exempt revenue bonds in an amount not to exceed $2,000,000,000 and to make secured or unsecured loans to the department in connection with financing permanent supportive housing pursuant to the department. Existing law establishes and continuously appropriates the Supportive Housing Program Subaccount in the Mental Health Services Fund and requires the Controller to transfer from that fund to the subaccount an amount necessary to cover the costs the authority is required to pay to the department pursuant to a service contract with the department, as provided.

This bill would enact the No Place Like Home Act of 2018 and provide for submission of that act to the voters at the November 6, 2018, statewide general election. The bill would specify that the service contracts between the authority and the department may be single-year or multiyear contracts and provide for payments to the department from amounts on deposit in the Supportive Housing Program Subaccount. The bill would declare that the voters ratify as being consistent with and in furtherance of the MHSA, and approve for purposes of specified provisions of the California Constitution relating to debt, specified statutes related to the No Place Like Home Program and related financial provisions. The bill would also authorize the Legislature to appropriate for transfer moneys in the Mental Health Services Fund to the Supportive Housing Program Subaccount, and continuously appropriate those moneys for further transfer to the No Place Like Home Fund to be used for purposes of the No Place Like Home Program. The bill would provide that any amount appropriated and deposited in the No Place Like Home Fund pursuant to these provisions would reduce the amount of authorized but unissued bonds that the California Health Facilities Financing Authority may issue, as described above, by a corresponding amount.

Existing law contains provisions related to elections and voting, including a requirement that a measure submitted to the people by the Legislature appear on the ballot of the first statewide election occurring at least 131 days after the adoption of the proposal by the Legislature and that the Secretary of State mail state voter information guides to voters.

This bill would require the Secretary of State, notwithstanding specified provisions of existing law relating to elections and voting, to submit the No Place Like Home Act of 2018 to the voters for their approval at the November 6, 2018, statewide general election.

This bill would declare that it is to take effect immediately as an urgency statute.

~~Existing law requires the Employment Development Department to encourage and organize the involvement of private sector employers and other community leaders in creating the necessary jobs for recipients of aid under the California Work Opportunity and Responsibility to Kids Act, as specified. Existing law requires the department to conduct specific activities, including, among others, providing a forum for leaders in the faith-based communities, as well as other civic leaders, to assist the state in promoting welfare-to-work goals, as specified.~~

~~This bill would make a nonsubstantive change to this provision.~~

Vote: ~~majority~~ *2/3*. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

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

SECTION 1. The voters hereby find and declare that housing is a key factor for stabilization and recovery from mental illness and results in improved outcomes for individuals living with a mental illness. The Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, must therefore be amended to provide for the expenditure of funds from the Mental Health Services Fund to the No Place Like Home Program established pursuant to Part 3.9 (commencing with Section 5849.1) of Division 5 of the Welfare and Institutions Code, which finances the acquisition, design, construction, rehabilitation, or preservation of permanent supportive housing for individuals living with a severe mental illness who are homeless or at risk of chronic homelessness.

SEC. 2. This act shall be known, and may be cited, as the No Place Like Home Act of 2018.

SEC. 3. Section 5849.35 of the Welfare and Institutions Code is amended to read:

5849.35. (a) The authority may do all of the following:

(1) Consult with the commission and the State Department of Health Care Services concerning the implementation of the No Place Like Home Program, including the review of annual reports provided to the authority by the department pursuant to Section 5849.11.

(2) Enter into one or more *single-year or multiyear* contracts with the department for the department to provide, and the authority to pay the department for providing, services described in Sections 5849.7, 5849.8, and 5849.9, related to permanent supportive housing for the target ~~population.~~ *population and to provide for payments to the department from amounts on deposit in the Supportive Housing Program Subaccount created within the Mental Health Services Fund pursuant to subdivision (f) of Section 5890.* Before entering into any contract pursuant to this paragraph, the executive director of the authority shall transmit to the commission a copy of the contract in substantially final form. The contract shall be deemed approved by the commission unless it acts within 10 days to disapprove the contract.

(3) On or before June 15 and December 15 of each year, the authority shall certify to the Controller the amounts the authority is required to pay as provided in Section 5890 for the following six-month period to the department pursuant to any service contract entered into pursuant to paragraph (2).

(b) The department may do all of the following:

(1) Enter into one or more *single-year or multiyear* contracts with the authority to provide services described in Sections 5849.7, 5849.8, and 5849.9, related to permanent supportive housing for the target ~~population.~~ *population and to receive payments from amounts on deposit in the Supportive Housing Program Subaccount pursuant to subdivision (f) of Section 5890.* Payments received by the department under any service contract authorized by this paragraph shall be used, before any other allocation or distribution, to repay loans from the authority pursuant to Section 15463 of the Government Code.

(2) Enter into one or more loan agreements with the authority as security for the repayment of the revenue bonds issued by the authority pursuant to Section 15463 of the Government Code. The department shall deposit the proceeds of these loans, excluding any refinancing loans to redeem, refund, or retire bonds, into the fund. The department's obligations to make payments under these loan agreements shall be limited obligations payable solely from amounts received pursuant to its service contracts with the authority.

(3) The department may pledge and assign its right to receive all or a portion of the payments under the service contracts entered

into pursuant to paragraph (1) directly to the authority or its bond trustee for the payment of principal, premiums, if any, and interest under any loan agreement authorized by paragraph (2).

(c) The Legislature hereby finds and declares both of the following:

(1) The consideration to be paid by the authority to the department for the services provided pursuant to the contracts authorized by paragraph (2) of subdivision (a) and paragraph (1) of subdivision (b) is fair and reasonable and in the public interest.

(2) The service contracts and payments made by the authority to the department pursuant to a service contract authorized by paragraph (2) of subdivision (a) and paragraph (1) of subdivision (b) and the loan agreements and loan repayments made by the department to the authority pursuant to a loan agreement authorized by paragraph (2) of subdivision (b) shall not constitute a debt or liability, or a pledge of the faith and credit, of the state or any political ~~subdivision.~~ *subdivision, except as approved by the voters at the November 6, 2018, statewide general election.*

(d) The state hereby covenants with the holders from time to time of any bonds issued by the authority pursuant to Section 15463 of the Government Code that it will not alter, amend, or restrict the provisions of this section, subdivision (f) of Section 5890, or subdivision (b) of Section 5891 in any manner adverse to the interests of those bondholders so long as any of those bonds remain outstanding. The authority may include this covenant in the resolution, indenture, or other documents governing the bonds.

(e) Agreements under this section are not subject to, and need not comply with, the requirements of any other law applicable to the execution of those agreements, including, but not limited to, the California Environmental Quality Act (Division 13 (commencing with Section 21000) of the Public Resources Code).

(f) Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code shall not apply to any contract entered into between the authority and the department under this section.

SEC. 4. Section 5849.15 is added to the Welfare and Institutions Code, to read:

5849.15. The voters ratify all of the following provisions as being consistent with and in furtherance of Proposition 63, enacted by the voters at the November 2, 2004, statewide general election,

and approve all of the following provisions for purposes of Section 1 of Article XVI of the California Constitution:

(a) Chapter 43 of the Statutes of 2016, which amended Sections 5830, 5845, 5847, 5848, 5897, and 5899 and added this part.

(b) Chapter 322 of the Statutes of 2016, which added Section 15463 to the Government Code, and amended Sections 5849.1, 5849.2, 5849.3, 5849.4, 5849.5, 5849.7, 5849.8, 5849.9, 5849.11, 5849.14, 5890, and 5891 of, added Section 5849.35 to, and repealed and added Section 5849.13 of, this code.

(c) Those provisions of Chapter 561 of the Statutes of 2017 that amended any of the provisions referenced in subdivisions (a) and (b).

(d) The amendments to Section 5849.35 made by the act adding this section.

(e) The authority of the California Health Facilities Financing Authority to issue taxable or tax-exempt revenue bonds in an amount not to exceed two billion dollars ($2,000,000,000) and the process by which those bonds are issued, secured, and repaid, as set forth in the provisions referenced in subdivisions (a) to (d), inclusive.

SEC. 5. Section 5890 of the Welfare and Institutions Code is amended to read:

5890. (a) The Mental Health Services Fund is hereby created in the State Treasury. The fund shall be administered by the state. Notwithstanding Section 13340 of the Government Code, all moneys in the fund are, except as provided in subdivision (d) of Section 5892, continuously appropriated, without regard to fiscal years, for the purpose of funding the following programs and other related activities as designated by other provisions of this division:

(1) Part 3 (commencing with Section 5800), the Adult and Older Adult System of Care Act.

(2) Part 3.2 (commencing with Section 5830), Innovative Programs.

(3) Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs.

(4) Part 3.9 (commencing with Section 5849.1), No Place Like Home Program.

(5) Part 4 (commencing with Section 5850), the Children's Mental Health Services Act.

(b) The establishment of this fund and any other provisions of the act establishing it or the programs funded shall not be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health parity. This act shall not be construed to modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing these obligations of plans and insurance policies.

(c) This act shall not be construed to modify or reduce the existing authority or responsibility of the State Department of Health Care Services.

(d) The State Department of Health Care Services shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care.

(e) Share of costs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division, shall be determined in accordance with the Uniform Method of Determining Ability to Pay applicable to other publicly funded mental health services, unless this Uniform Method is replaced by another method of determining copayments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division.

(f) *(1)* The Supportive Housing Program Subaccount is hereby created in the Mental Health Services Fund. Notwithstanding Section 13340 of the Government Code, all moneys in the subaccount are reserved and continuously appropriated, without regard to fiscal years, to the California Health Facilities Financing Authority to provide funds to meet its financial obligations pursuant to any service contracts entered into pursuant to Section 5849.35. Notwithstanding any other law, including any other provision of this section, no later than the last day of each month, the Controller shall, before any transfer or expenditure from the fund for any other purpose for the following month, transfer from the Mental Health Services Fund to the Supportive Housing Program

Subaccount an amount that has been certified by the California Health Facilities Financing Authority pursuant to paragraph (3) of subdivision (a) of Section 5849.35, but not to exceed an aggregate amount of one hundred forty million dollars ($140,000,000) per year. If in any month the amounts in the Mental Health Services Fund are insufficient to fully transfer to the subaccount or the amounts in the subaccount are insufficient to fully pay the amount certified by the California Health Facilities Financing Authority, the shortfall shall be carried over to the next ~~month.~~ *month, to be transferred by the Controller with any transfer required by the preceding sentence.* Moneys in the Supportive Housing Program Subaccount shall not be loaned to the General Fund pursuant to Section 16310 or 16381 of the Government Code.

(2) The Legislature may appropriate for transfer funds in the Mental Health Services Fund to the Supportive Housing Program Subaccount in an amount up to one hundred forty million dollars ($140,000,000) per year. Any amount appropriated for transfer pursuant to this paragraph and deposited in the No Place Like Home Fund shall reduce the authorized but unissued amount of bonds that the California Health Facilities Financing Authority may issue pursuant to Section 15463 of the Government Code by a corresponding amount. Notwithstanding Section 13340 of the Government Code, all moneys in the subaccount transferred pursuant to this paragraph are reserved and continuously appropriated, without regard to fiscal years, for transfer to the No Place Like Home Fund, to be used for purposes of Part 3.9 (commencing with Section 5849.1). The Controller shall, before any transfer or expenditure from the fund for any other purpose for the following month but after any transfer from the fund for purposes of paragraph (1), transfer moneys appropriated from the Mental Health Service Fund to the subaccount pursuant to this paragraph in equal amounts over the following 12-month period, beginning no later than 90 days after the effective date of the appropriation by the Legislature. If in any month the amounts in the Mental Health Services Fund are insufficient to fully transfer to the subaccount or the amounts in the subaccount are insufficient to fully pay the amount appropriated for transfer pursuant to this paragraph, the shortfall shall be carried over to the next month.

SEC. 6. Sections 1 to 5, inclusive, of this act shall become operative upon the adoption by the voters of the No Place Like Home Act of 2018.

SEC. 7. (a) (1) Notwithstanding Sections 9040, 9043, 9044, 9061, and 9082 of the Elections Code, or any other law, Sections 1 to 5, inclusive, of this act shall be submitted by the Secretary of State to the voters as a single measure, the No Place Like Home Act of 2018, at the November 6, 2018, statewide general election.

(2) The requirement of Section 9040 of the Elections Code that a measure submitted to the people by the Legislature appear on the ballot of the first statewide election occurring at least 131 days after the adoption of the proposal by the Legislature shall not apply to the No Place Like Home Act of 2018.

(b) The Secretary of State shall include in the ballot pamphlets mailed pursuant to Section 9094 of the Elections Code the information specified in Section 9084 of the Elections Code regarding the No Place Like Home Act of 2018. If that inclusion is not possible, the Secretary of State shall publish a supplemental ballot pamphlet regarding the No Place Like Home Act of 2018 to be mailed with the ballot pamphlet. If the supplemental ballot pamphlet cannot be mailed with the ballot pamphlet, the supplemental ballot pamphlet shall be mailed separately.

(c) Notwithstanding Section 9054 of the Elections Code or any other law, the translations of the ballot title and the condensed statement of the ballot title required pursuant to Section 9054 of the Elections Code for the No Place Like Home Act of 2018 may be made available for public examination at a later date than the start of the public examination period for the ballot pamphlet.

SEC. 8. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to expeditiously provide necessary funding for the No Place Like Home Program, so as to ensure the efficient and timely development of supportive housing, it is necessary that this act take effect immediately.

~~SECTION 1. Section 17002 of the Unemployment Insurance Code is amended to read:~~

~~17002. In carrying out the provisions of this division, the department shall conduct activities including, but not limited to, the following:~~

~~(a) Establish a council of corporate executives consisting of 13 members drawn from the business community including, but not limited to, retired or former chief executive officers of major California corporations. Seven members shall be appointed by the Governor, three shall be appointed by the Senate Committee on Rules, and three shall be appointed by the Speaker of the Assembly. Appointments shall be made no later than January 31, 1998. This council shall provide ongoing advice and assistance to the department in recruiting private employers to hire recipients of aid.~~

~~(b) In consultation with the council described in subdivision (a), establish a clearinghouse for information on the Internet or other forms of toll-free communication for private sector employers to obtain information about assistance and resources for hiring CalWORKs recipients and to register their pledges to assist the state in finding the jobs necessary to meet the local welfare-to-work goals throughout the state.~~

~~(c) In consultation with the council described in subdivision (a), provide a forum for leaders in the faith-based communities, and other civic leaders, to assist the state in promoting welfare-to-work goals as part of the civic duty of their constituents.~~

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SENATE BILL No. 1458

Introduced by Senator Hueso

February 16, 2018

An act relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1458, as introduced, Hueso. County mental health plans.

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 each county mental health program to report specified information about services and expenditures.

This bill would state the intent of the Legislature to enact legislation that would require compliance from county mental health programs regarding reporting requirements established pursuant to the MHSA.

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

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

SECTION 1. It is the intent of the Legislature to enact legislation that would require compliance from county mental health programs regarding reporting requirements established pursuant to the Mental Health Services Act.

O