WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Teleconference Meeting
January 25, 2024
Presentations and Handouts

Agenda Item 6:	•Presentation:	2024-27 Strategic Plan
Agenda Item 8:	•Presentation:	Statewide Evaluation (SWE): Phase 2 Findings
Agenda Item 9:	•Presentation:	MHSSA RFA Outline
Agenda Item 10:	•Presentation:	Substance Use Disorder Contract Authorization
Agenda Item 11:	•Presentation:	The Governor's 2024-25 Proposed Budget and the Commission's 2023-2024 Mid-Year Budget Report
	•Presentation:	2024 Legislation

2024-27 Strategic Plan

- Norma Pate, Deputy Director Mental Health Services Oversight and Accountability Commission

2024-2027 Strategic Plan

Preliminary Draft MHSOAC Strategic Plan 2024-27

To develop this Strategic Plan, the Commission consulted with numerous communities and multiple partners, reflected on the progress that has been made and identified the right next steps for advancing transformational change.

2024-2027 Strategic Plan Engagement Efforts

- 40+ Interviews
- 7 Public Input Sessions
- 1 Focus Group
- 2 Surveys

Accelerating Transformational Change

Meaningful Progress

Partnered with communities, other public agencies, and the private sector to identify critical gaps in services system

A Point of Inflection

Significant opportunities advance new innovations in behavioral health treatment and delivery models

Commission's 2024-27 North Star Priority

Accelerate system-level improvements to achieve early, effective, and universally available services

2024 – 2027
Strategic Plan Goals

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Emerging Themes Challenges and Opportunities

GROWING DEMANDS FOR BEHAVIORAL HEALTH SERVICES

BEHAVIORAL HEALTH ELEVATED AS A SHARED PRIORITY

EVOLUTIONS IN TREATMENT & CARE DELIVERY

STRAIN ON PRACTITIONERS, RESOURCES, AND CONSUMERS

ACCELERATING PACE OF CHANGE

The Imperative for Transformational Change

The Mental Health Services Act was developed to improve mental health services and reduce the seven negative outcomes listed in the Act

1. **Suicide**
2. **Incarceration**
3. **School failure**
4. **Unemployment**
5. **Prolonged suffering**
6. **Homelessness**
7. **Child welfare involvement**

MHSA Vision for Transformational Change

- Evolving the fragmented and siloed services
- Empowering communities
- Resourcing state and local agencies

Strategy to Advance Transformational Change

Core Strategic Building Blocks

Commission's Vision

- Build on the strengths of communities and marginalized groups
- Create opportunities for individuals to engage in meaningful and purposeful activities

Commission Mission

- Engage diverse communities
- Employ relevant data to advance policies
- Improve positive behavioral health outcomes for every Californian

Guiding Principles

- Collaboration with diverse communities
- Outreach and engagement
- Culturally sensitive and competent services
- High-quality whole-person services and supports
- Public undestanding and partnerships across agencies and communities
- Diverse, valued and resilient workforce
- Innovation and continuous improvement

Commission's Role

BUILD UNDERSTANDING OF THE POTENTIAL TO IMPROVE WELLBEING.

ACCELERATE ADOPTION OF BEST PRACTICES.

CATALYZE INNOVATION TO DEVELOP BETTER PRACTICES.

PROVIDE ACCOUNTABILITY AND OVERSIGHT.

Capabilities

- **Driving policy:** Research, public engagement, policy development and advocacy
- **Driving practice:** Financial incentives, technical assistance and evaluation
- **Driving transformational change:** Assessment of system performance and opportunities for improvement

Decision-Making Approach

Help the Commission identify which opportunities have the greatest potential benefits and design projects with greater precision.

Need

Impact

Fit

Feasibility

2024-27 Operational Priorities

Build foundational knowledge

Close the gap between what is being done and what can be done

Close the gap between what can be done and what must be done

Goals and Objectives for 2024-27

Goal 1: Champion Vision to Action

Elevate	Objective 1: Elevate the perspective of diverse communities.
Assess and advocate	Objective 2: Assess and advocate for system improvements.
Connect	Objective 3: Connect federally and globally to learn and apply.

Goal 2: Catalyze Best Practice Networks to ensure access, improve outcomes and reduce disparities

Support	Objective 1: Support organizational capacity building
Fortify	Objective 2: Fortify professional development programs and resilient workforce strategies.
Develop	Objective 3: Develop adequate and reliable funding models.
Support	Objective 4: Support system-level analysis to ensure the tailored care and universal access required to reduce disparities.

Goal 3: Inspire Innovation and Learning

Curate	Objective 1: Curate an analytical-based narrative on the potential for innovation to improve behavioral health outcomes.
Establish	Objective 2: Establish an innovation fund to link and leverage public and private investments.
Accelerate	Objective 3: Accelerate learning and adaptation in public policies and programs.

Goal 4: Relentlessly Drive Expectations

Launch	Objective 1: Launch a public awareness strategy to reduce stigma, promote access care, and communicate the potential for recovery.
Develop	Objective 2: Develop a behavioral health index.
Promote	Objective 3: Promote understanding of the progress that is being made and the advocacy that will result in further improvements.

Plan to Action

The Commission is fortifying its internal project management, human resources, community engagement, communications protocols to effectively pursue these goals and objectives.

Summary of Themes from Community Engagement

The Commission engaged the public between May and November 2023 to inform the development of the strategic plan

Thank You

Questions

Motion

- That the Commission adopts the 2024-27 Strategic Plan.

Statewide Evaluation (SWE): Phase 2 Findings

CRDP California Reducing Disparities Project

Presentation to the MHSOAC

January 25, 2024

CDPH California Department of PublicHealth
Office of Health Equity

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The Phase 2 Statewide Evaluation answered seven questions:

Objective 1: Evaluate Overall CRDP Phase 2 Effectiveness in Identifying and Implementing Strategies to Reduce Mental Health Disparities

- To what extent were CRDP strategies and operations effective at preventing and/or reducing the severity of mental illness in California's historically unserved, underserved and/or inappropriately served communities?
- What were vulnerabilities or weaknesses in CRDP's overarching strategies and fiscal operations, and how could they have been strengthened?
- To what extent did CRDP strategies show an effective return on investment?

Objective 2: Determine Effectiveness of CDEPs

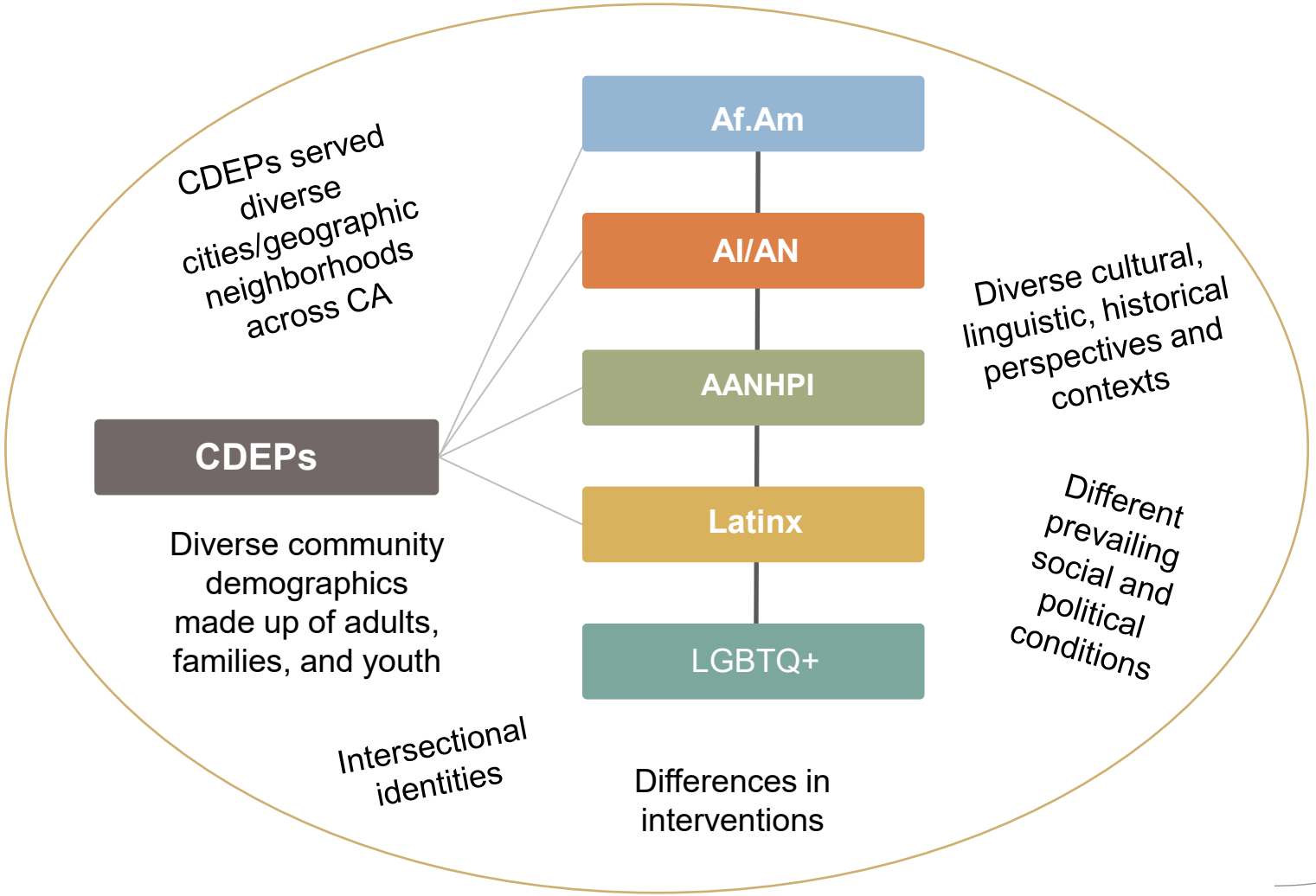
- To what extent did IPPs prevent and/or reduce the severity of prioritized mental health conditions within and across priority populations, including specific sub-populations (e.g., gender, age)?
- How cost effective were Pilot Projects? What was the business case for increasing them to a larger scale?
- To what extent did CRDP Phase 2 Implementation Pilot Projects validate their CDEPs?
- What evaluation frameworks were developed and used by the Pilot Projects?

Overview and Foci of the SWE Core Measures Key Instruments and Areas of Assessment

1 CDEP Participant Level Data aka "CDEP Participant Questionnaire"	• Pre-Test (before CDEP services) • Post-Test (typically after CDEP services)
2 Organizational Level Data	• IPP Pre- and Post-test Organizational Capacity Assessment • IPP Semi-Annual Reports (IPP-SAR) • OHE Progress Reports (submitted by TAPs, EOA, SWE)
3 Semi-Structured Interviews	• Phase 2 Partner Interviews (TAPs, EOA, SWE, OHE) • Key Informant Interviews
4 Review of Records	• Accepted grant proposals/bids; CRDP Strategic Plan; Phase 1 Priority Population Reports; approved IPP final evaluation plans; IPP final evaluation reports; IPP, TAP, EOA, and SWE invoices/budgets
5 Secondary Data (Administrative)	• Medical Expenditure Panel Survey (MEPS)

CRDP Phase 2 Findings: Data Structure and Analysis Issues

- The Statewide Evaluation (SWE) **did NOT use a randomized control trial experimental design** with assignment of CDEPs or their participants to "treatment" or "control" groups.
- **Most IPPs used non-experimental designs.**



- With such great diversity in populations served, strategies employed, and specific program designs used, a wide array of possibilities existed for IPP's quantitative (and qualitative) data collection approaches.
- **This includes variable sample sizes. Therefore, priority population comparisons of sample sizes are neither appropriate nor valid.**

The statewide evaluation data analysis plan included multiple frameworks across a spectrum, from traditional to highly innovative.

Objective 1:
Evaluate Overall CRDP Phase 2 Effectiveness in Identifying and Implementing Strategies to Reduce Mental Health Disparities.

Objective 2:
Determine Effectiveness of Community-Defined Evidence Programs.

A mixed-methods "parallel combination" approach was used for baseline participant-level data and programmatic / initiative wide data

A Bayesian analysis paradigm that also included statistical best practices to assess the extent to which CRDP Phase 2 delivered results via credible intervals on effect sizes of relevant variables.

- matched pre- and post-test participant-level data

A cost-benefit analysis for the business case to calculate the dollar value of health (and non-health) savings related to improvements in CDEP participants' mental health

- matched pre- and post-test participant-level data
- MEPS data

CRDP Findings

SWE RQ1: What was the effectiveness of CRDP and its use of CDEPs for preventing and/or reducing the severity of mental health conditions in its priority populations?

CRDP participant outcomes support CDEP effectiveness

- **CRDP made mental health services more accessible and improved mental health** in unserved, underserved, and inappropriately served communities.
- Statistical modeling of CRDP participant outcomes show that the positive mental health findings are robust and **support the overall efficacy of CDEPs as a mental health PEI strategy**.
- **Culturally grounded** technical assistance was provided to support CDEP implementation, evaluation, and organizational capacity building.

CRDP Findings

SWE RQ2: How cost-effective was the CDEP strategy and what was the return on investment for the initiative? What was the business case for CRDP Phase 2?

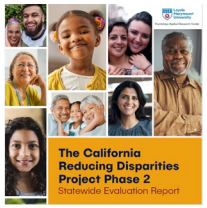
CRDP is cost effective

- The CRDP Phase 2 business case found that, **for every taxpayer $ invested in CRDP, there was an estimated return of $5.**
- The estimated net financial benefit to the state **exceeded $450 MD.**
- The business case showed that **prevention and early intervention matter.**

SWE RQ3: To what extent were CDEPs validated and what were the evaluation frameworks developed and used for CDEPs?

- IPP Local Evaluation findings highlighted culturally-informed outcomes that extend beyond standard mental health measures, **supporting CDEP effectiveness.**

ACCESS TO MENTAL HEALTH SERVICES



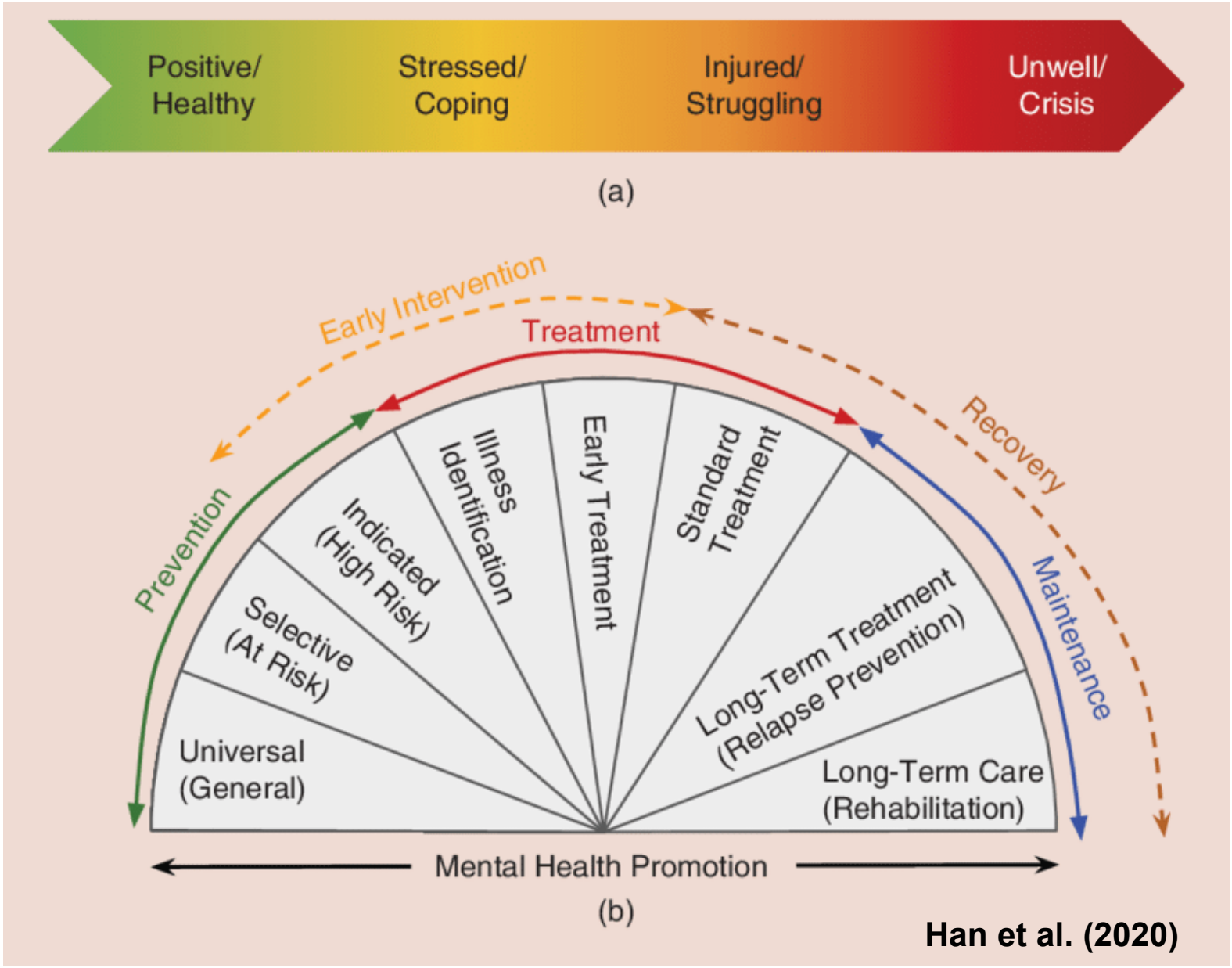
Key Findings from the CRDP Phase 2 Statewide Evaluation Report

How did CDEPs contribute to mental health access (availability, utilization, quality)?

Where do CDEPs fall in the PEI mental health spectrum?

What does the data reveal about the mental health status and needs of individuals served by the CDEP at baseline?

PEI in the Mental Health Spectrum



Han et al. (2020)

Mental Health Access Outcomes At-A-Glance

Data period: 06/2018 - 06/2021

CRDP California Reducing Disparities Project

CRDP-wide findings suggest that CDEPs served the communities they intended to serve

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ADULTS: 18+ Years (N=2,895; 22 IPPs)

SO

SEXUAL ORIENTATION

- **83%** straight or heterosexual
- **17%** LGBQ+

GI

GENDER IDENTITY

- **62%** woman/female (2% transfeminine)
- **27%** man/male (2% transmasculine)
- **6%** genderqueer/non-binary
- **2%** questioning/unsure

R

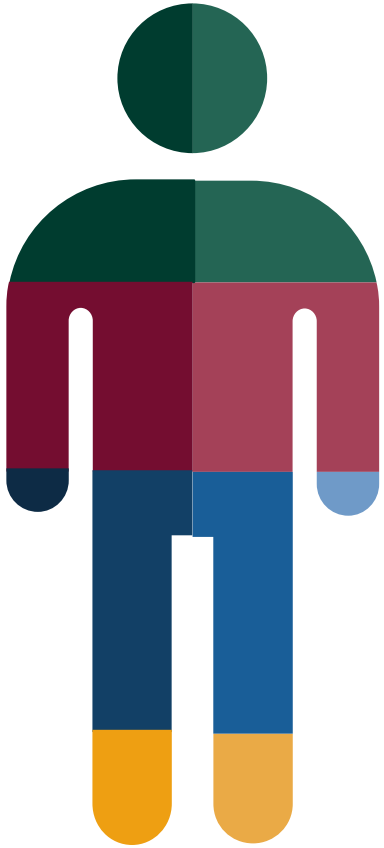
RACE

- **16%** Black (2% multi-race)
- **32%** Asian American (1% multi-race)
- **33%** Latinx (4% multi-race)
- **13%** Amer. Indian/Alaska Nat (3% multi-race)
- **2%** Nat. Hawaiian/Pac. Islander (1% multi-race)
- **10%** White (4% multi-race)

A

AGE

- **23%** were 18-29 years old
- **39%** were 30-49 years old
- **38%** were 50 plus years old



ADOLESCENTS: 12-24 Years (N=659; 16 IPPs)

SEXUAL ORIENTATION

- **71%** straight or heterosexual
- **29%** LGBQ+

GENDER IDENTITY

- **46%** woman/female (1% transfeminine)
- **38%** man/male (4% transmasculine)
- **6%** genderqueer/non-binary
- **2%** questioning/unsure

RACE

- **28%** Black (6% multi-race)
- **15%** Asian American (3% multi-race)
- **39%** Latinx (10% multi-race)
- **23%** Amer. Indian/Alaska Nat (10% multi-race)
- **1%** Nat. Hawaiian/Pac. Islander (<1% multi-race)
- **15%** White (8% multi-race)

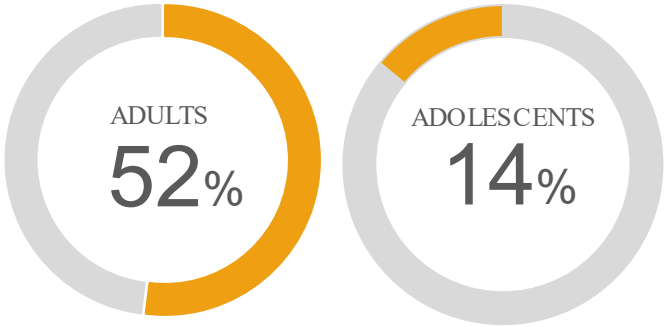
AGE

- **33%** were 12-14 years old
- **43%** were 15-16 years old
- **18%** were 17-18 years old
- **6%** were 19-24 years old

IMMIGRANT/REFUGEE STATUS

LIMITED ENGLISH PROFICIENT

"NOT AT ALL" TO "SOMEWHAT"



Source: CDEP participant questionnaire

ADULT and ADOLESCENT Mental Health Access At-A-Glance

Data period: 06/2018 - 06/2021

CRDP California Reducing Disparities Project

CRDP-wide findings suggest that the CDEPs provided services to ADULTS in the five priority populations who presented with vulnerabilities and risk factors at baseline (i.e., prior to receiving CDEP services).

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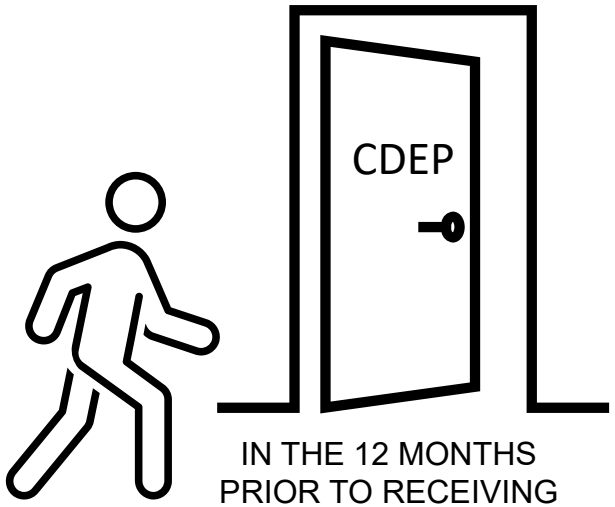


IN THE 12 MONTHS PRIOR TO RECEIVING SERVICES FROM A CDEP (BASELINE)

NEARLY
3 IN 4

ADULTS HAD A **MENTAL HEALTH NEED** AT BASELINE

NEARLY
1 IN 3
ADULTS HAD AN **UNMET MENTAL HEALTH NEED** FROM MAINSTREAM MH PROFESSIONALS

NEARLY
1 IN 2

ADOLESCENTS HAD A **MENTAL HEALTH NEED** AT BASELINE

1 IN 3
ADOLESCENTS HAD AN **UNMET MENTAL HEALTH NEED** FROM MAINSTREAM MH PROFESSIONALS

Source: CDEP participant questionnaire

The Kessler 6 Scale

SWE RQ: To what extent did IPPs prevents and/or reduce the severity of mental health conditions for their priority populations?

The Kessler-6 (K6) is a brief screening scale for non-specific psychological distress in adults (Kessler et al., 2002) and has been shown to be strongly predictive of adult serious mental illness (SMI; Kessler et al., 2003, 2010).

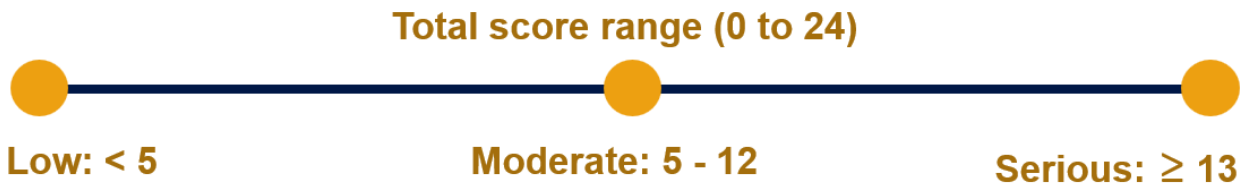
SWE CDEP Questionnaire: The next questions are about how you have been feeling during the past 30 days. *About how often during the past 30 days did you feel …*

Six items:

- Feeling *nervous*
- Feeling *hopeless*
- Feeling *restless/fidgety*
- Feeling *so depressed that nothing can cheer you up*
- Feeling *that everything was an effort*
- Feeling *worthless*

Response categories:

None of the time (0)
A little of the time (1)
Some of the time (2)
Most of the time (3)
All of the time (4)



K6 scores:

- 13-24 have probable SMI
- 0-12 probably do not have SMI (Kessler et al., 2003)

Percent of K6 scores ≥13 in general population (individuals randomly selected to take the survey):

- 3.4% to 6% in the U.S. (Kessler et al., 1996; Weissman et al., 2015)
- 8.5% in California (Grant et al., 2011)

ADULT and ADOLESCENT Mental Health Access At-A-Glance

Data period: 06/2018 - 06/2021

CRDP California Reducing Disparities Project

CRDP-wide findings suggest that the CDEPs provided services to ADULTS in the five priority populations who presented with vulnerabilities and risk factors at baseline (i.e., prior to receiving CDEP services).

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Source: CDEP participant questionnaire

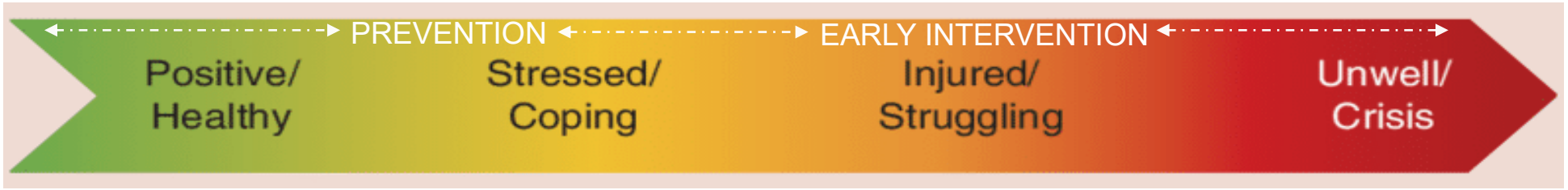
ADULTS

PAST 30 DAYS: PSYCHOLOGICAL DISTRESS

26% — OVER **1 IN 4** ADULTS WERE EXPERIENCING **LOW PSYCHOLOGICAL DISTRESS** AT SERVICE ENTRY

39% — OVER **1 IN 3** ADULTS WERE EXPERIENCING **MODERATE PSYCHOLOGICAL DISTRESS** AT SERVICE ENTRY

OVER **1 IN 3** ADULTS WERE EXPERIENCING **SERIOUS PSYCHOLOGICAL DISTRESS** AT SERVICE ENTRY — 35%



ADOLESCENTS

PAST 30 DAYS: PSYCHOLOGICAL DISTRESS

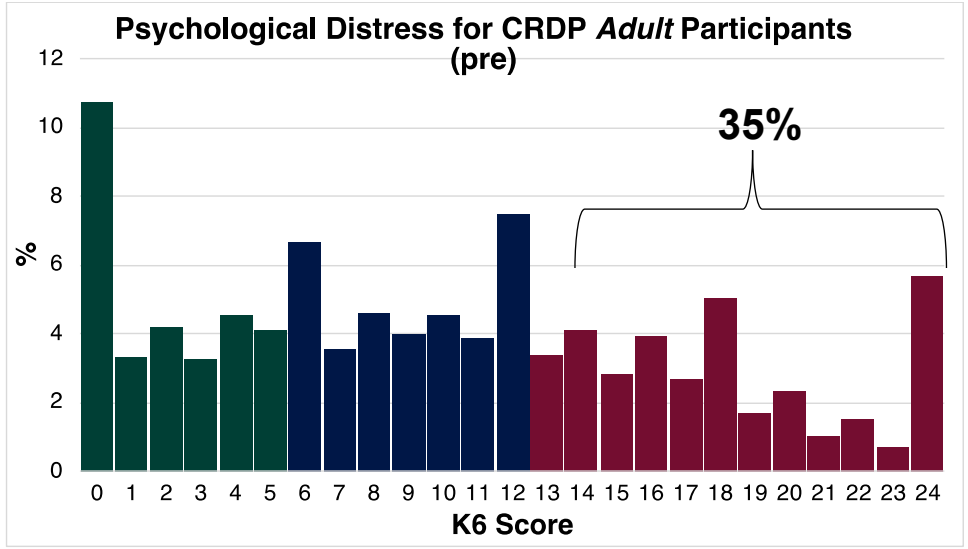
36% — **1 IN 3** ADOLESCENTS WERE EXPERIENCING **LOW PSYCHOLOGICAL DISTRESS** AT SERVICE ENTRY

38% — OVER **1 IN 3** ADOLESCENTS WERE EXPERIENCING **MODERATE PSYCHOLOGICAL DISTRESS** AT SERVICE ENTRY

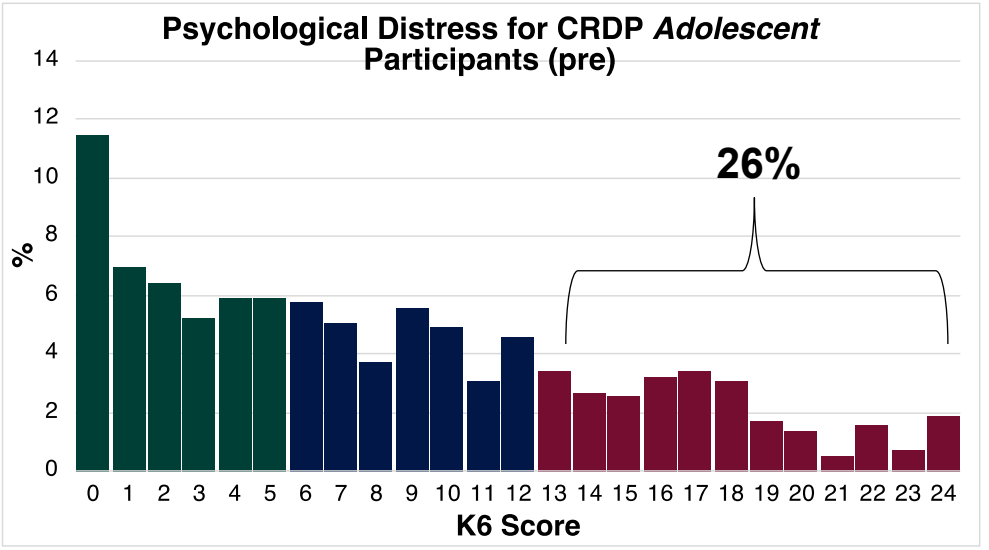
OVER **1 IN 4** ADOLESCENTS WERE EXPERIENCING **SERIOUS PSYCHOLOGICAL DISTRESS** AT SERVICE ENTRY — 26%

CRDP K6 Scores in a National Context

- According to the National Institute of Mental Health (2023) it is estimated that:
  - More than **one in five** (22.8%) U.S. adults live with a mental illness (57.8 million in 2021).[1]
    - **Nearly half** (47.2%) of these individuals received mental health services in the past year.
  - Nearly **one in two** (49.5%) of adolescents (13-18) had any mental disorder.[2]
- For those who seek and receive mental health treatment, about 1 in 2 meet criteria for a past-year mental health disorder and an additional 13% for other indicators of need (Bruffaerts et al., 2015).



While we don't have enough information to distinguish mental health problems or illness for those who have serious distress, the data suggests **CDEPs are serving individuals who are unserved and underserved**.



[1]2021 National Survey on Drug Use and Health (NSDUH)
[2] 2010 National Comorbidity Survey Adolescent Supplement (NCS-A)

Mental Health Access Outcomes At-A-Glance

Data period: 05/2017 - 04/2021

CRDP California Reducing Disparities Project

CRDP-wide findings suggest that CDEPs increased mental health service utilization for their communities' adults, adolescents, & children indirectly through their referral system or through their direct services.

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AMERICAN INDIAN / ALASKA NATIVE
7 IPPs
SERVED
6,319
INDIVIDUALS

- Range: 25 to 3,013 per IPP
- Average: 903 individuals

ASIAN AMERICAN, NATIVE HAWAIIAN, PACIFIC ISLANDER
7 IPPs
SERVED
1,693
INDIVIDUALS

- Range: 110 to 643 per IPP
- Average: 160 individuals

AFRICAN AMERICAN
7 IPPs
SERVED
1,124
INDIVIDUALS

- Range: 109 to 279 per IPP
- Average: 160 individuals

LGBTQ+
6 IPPs
SERVED
1,824
INDIVIDUALS

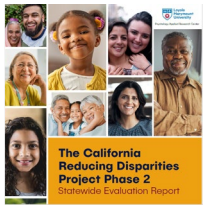
- Range: 162 to 476 per IPP
- Average: 304 individuals

LATINX
7 IPPs
SERVED
4,362
INDIVIDUALS

- Range: 141 to 2,011 per IPP
- Median*: 435 individuals

Source: IPP semi-annual reports and local evaluation plans

MENTAL HEALTH IMPROVEMENTS



Key Findings from the CRDP Phase 2 Statewide Evaluation Report

Did CDEPs prevent the development of mental illness and/or promote positive wellbeing?

Did CDEPs reduce mental health risks for people with early signs of mental illness?

Adult participants improved on ALL five core measure outcomes

- **Cultural Protective Factor 1:** Importance of Culture to Provide Strength, Good Feelings, Connection to Traditions
- **Cultural Protective Factor 2:** Balanced in Mind/Body/Spirit and Connected to Culture
- **Social Isolation/Risk Factor:** Feelings of Marginalization and Isolation

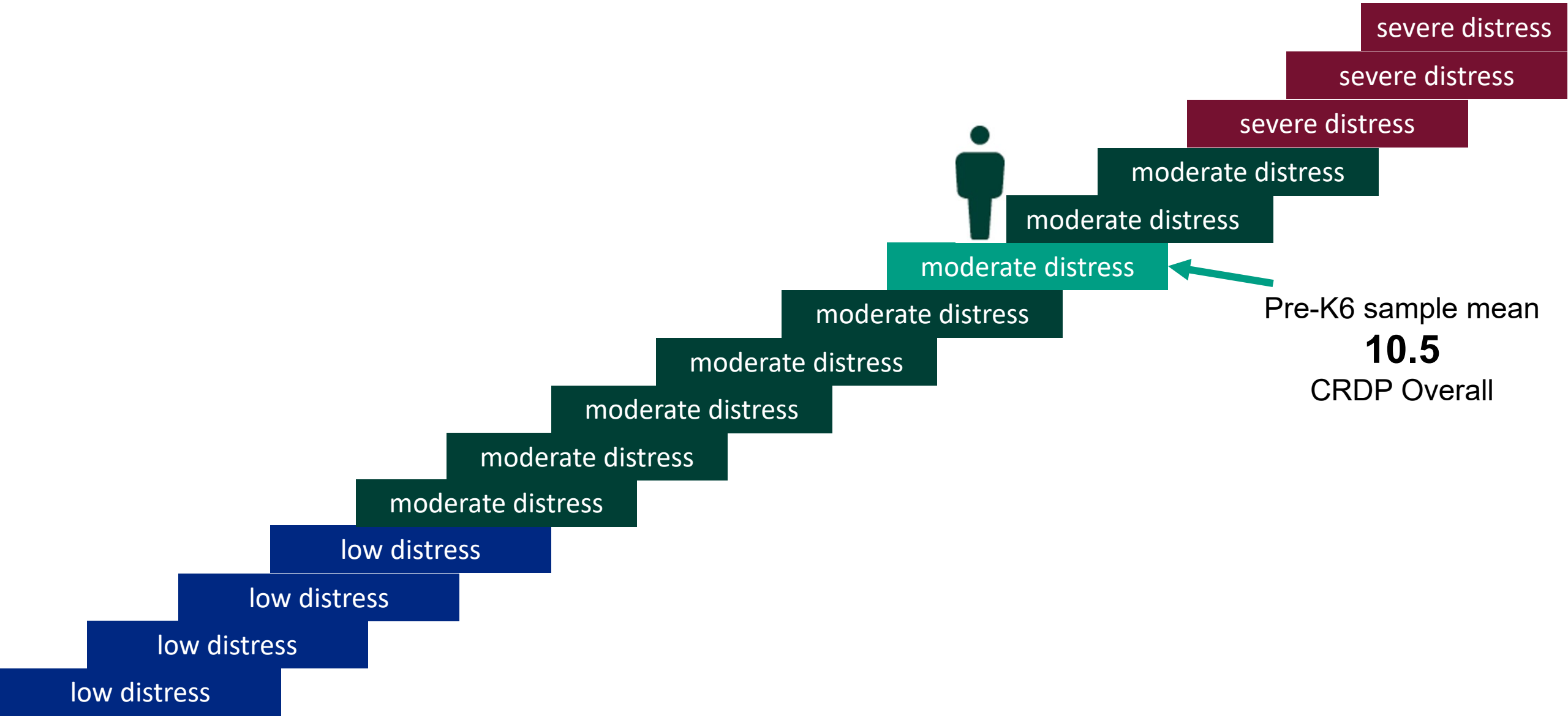
PARC-designed

- **Sheehan Disability Scale:** Psychological Functioning at Home, Work, Family, and Friends
- **Kessler 6:** Psychological Distress

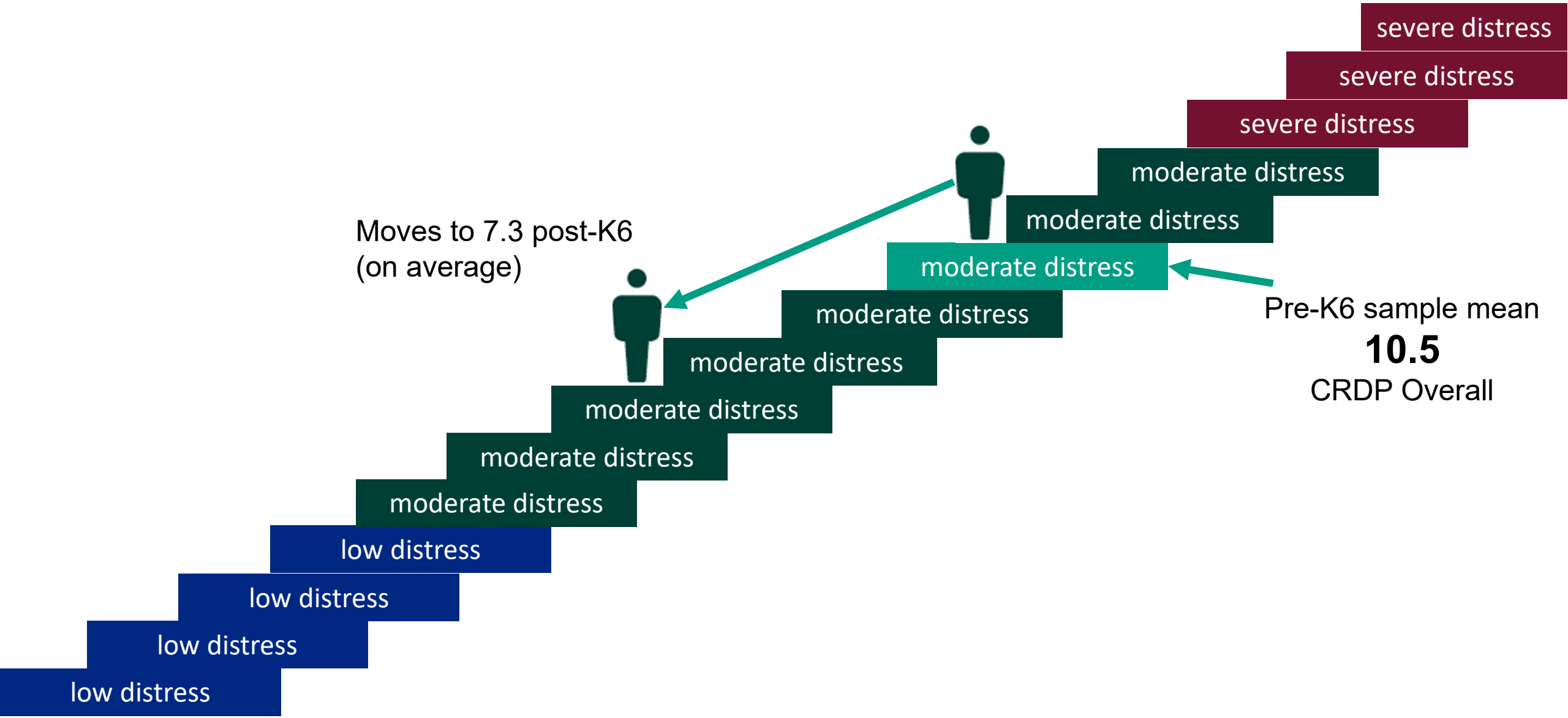
Widely-used (e.g., CHIS, NSDUH)

Source: CDEP participant questionnaire

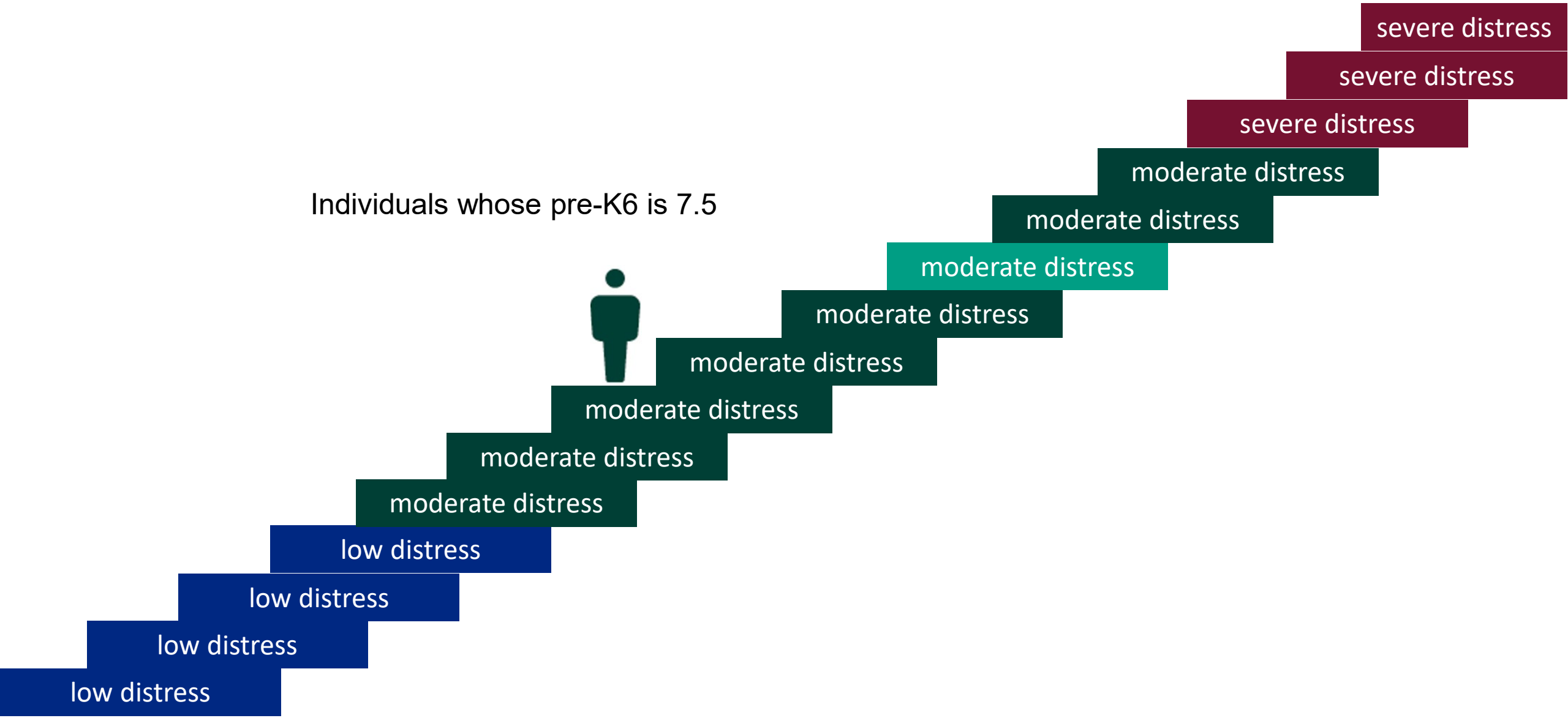
Adult psychological distress (K6) dynamics



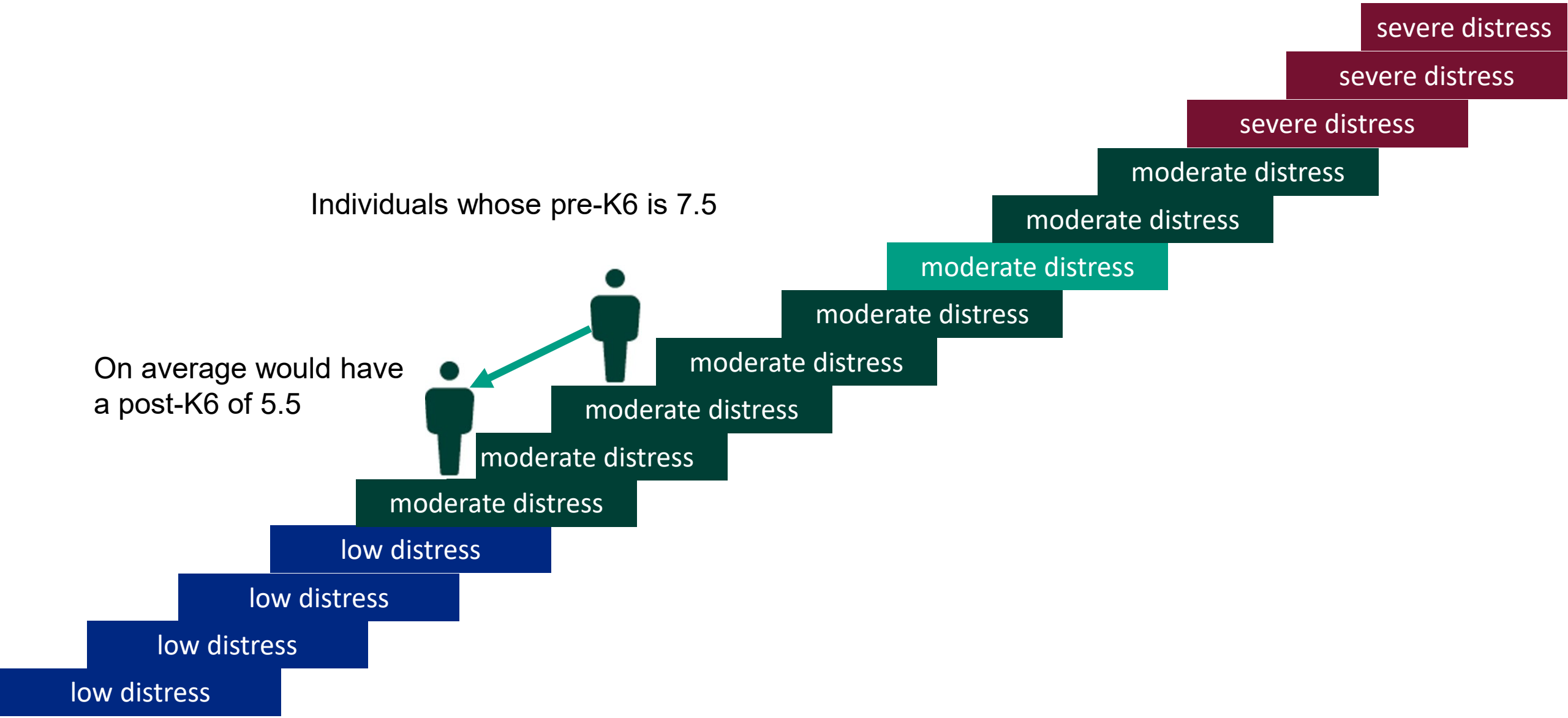
Adult psychological distress (K6) dynamics



Adult psychological distress (K6) dynamics

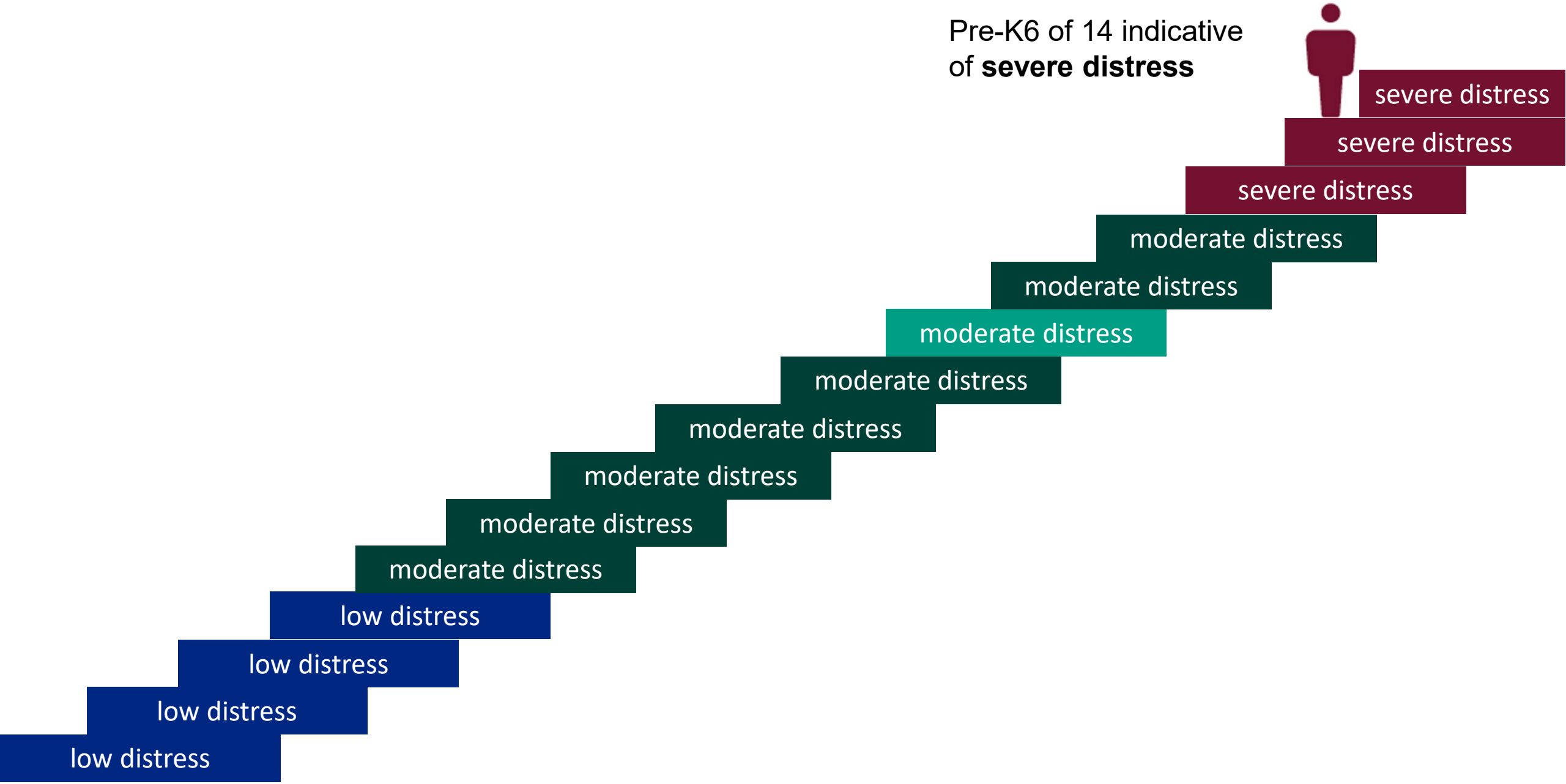


Adult psychological distress (K6) dynamics

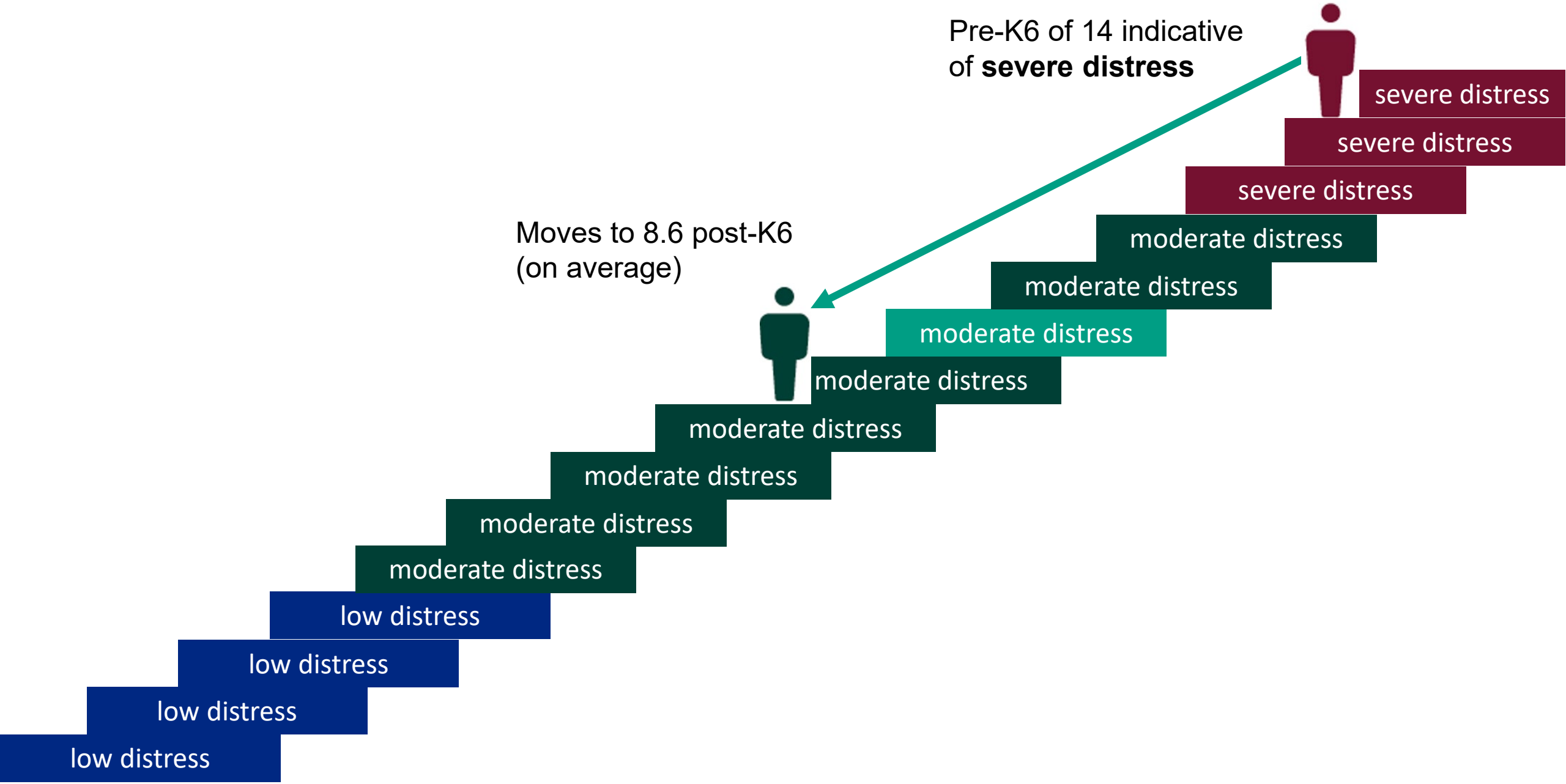


Adult psychological distress (K6) dynamics

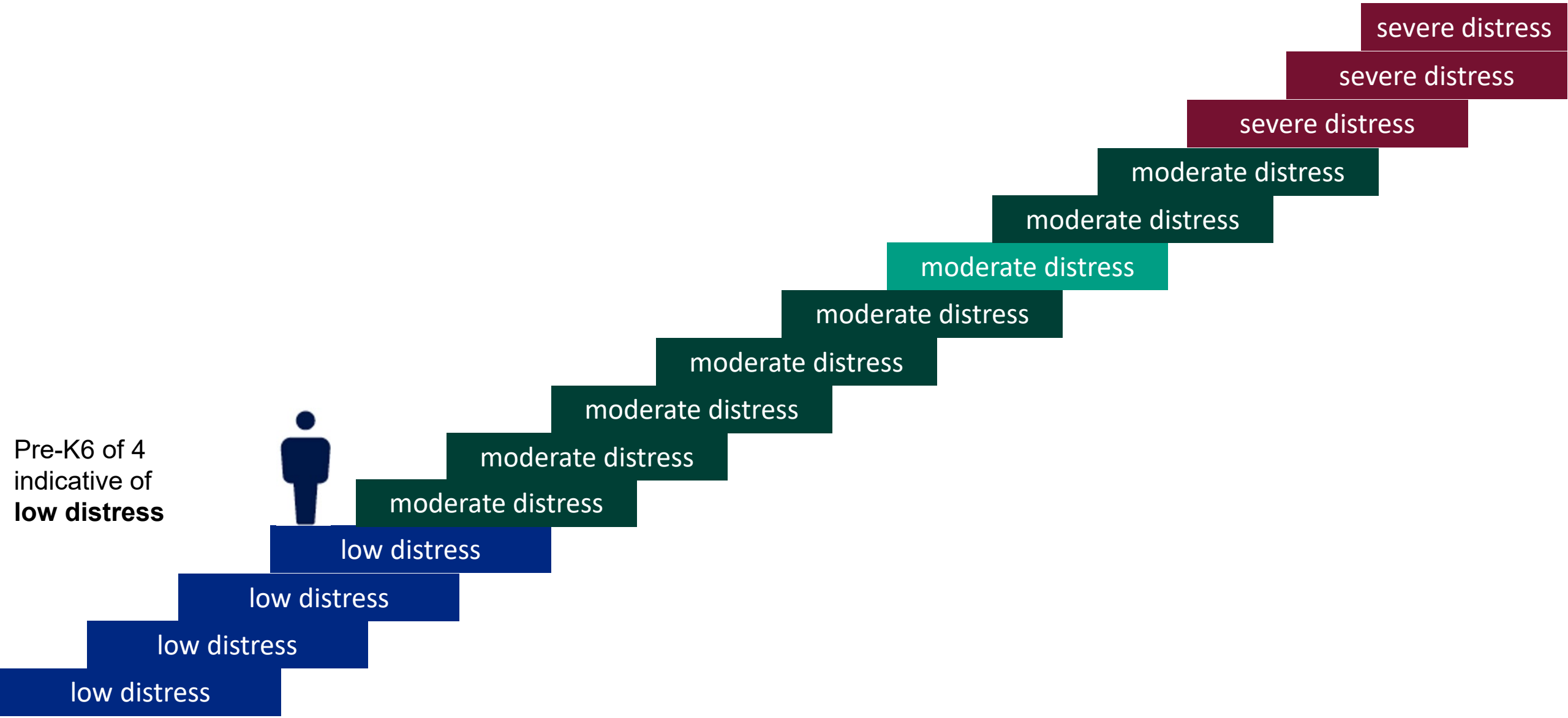
Pre-K6 of 14 indicative of **severe distress**



Adult psychological distress (K6) dynamics



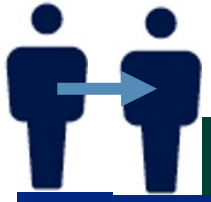
Adult psychological distress (K6) dynamics



Pre-K6 of 4 indicative of **low distress**

Adult psychological distress (K6) dynamics

Pre-K6 of 4 indicative of **low distress**



Moves to 4.6 on average, post

low distress

low distress

low distress

moderate distress

moderate distress

moderate distress

moderate distress

moderate distress

moderate distress

moderate distress

moderate distress

severe distress

severe distress

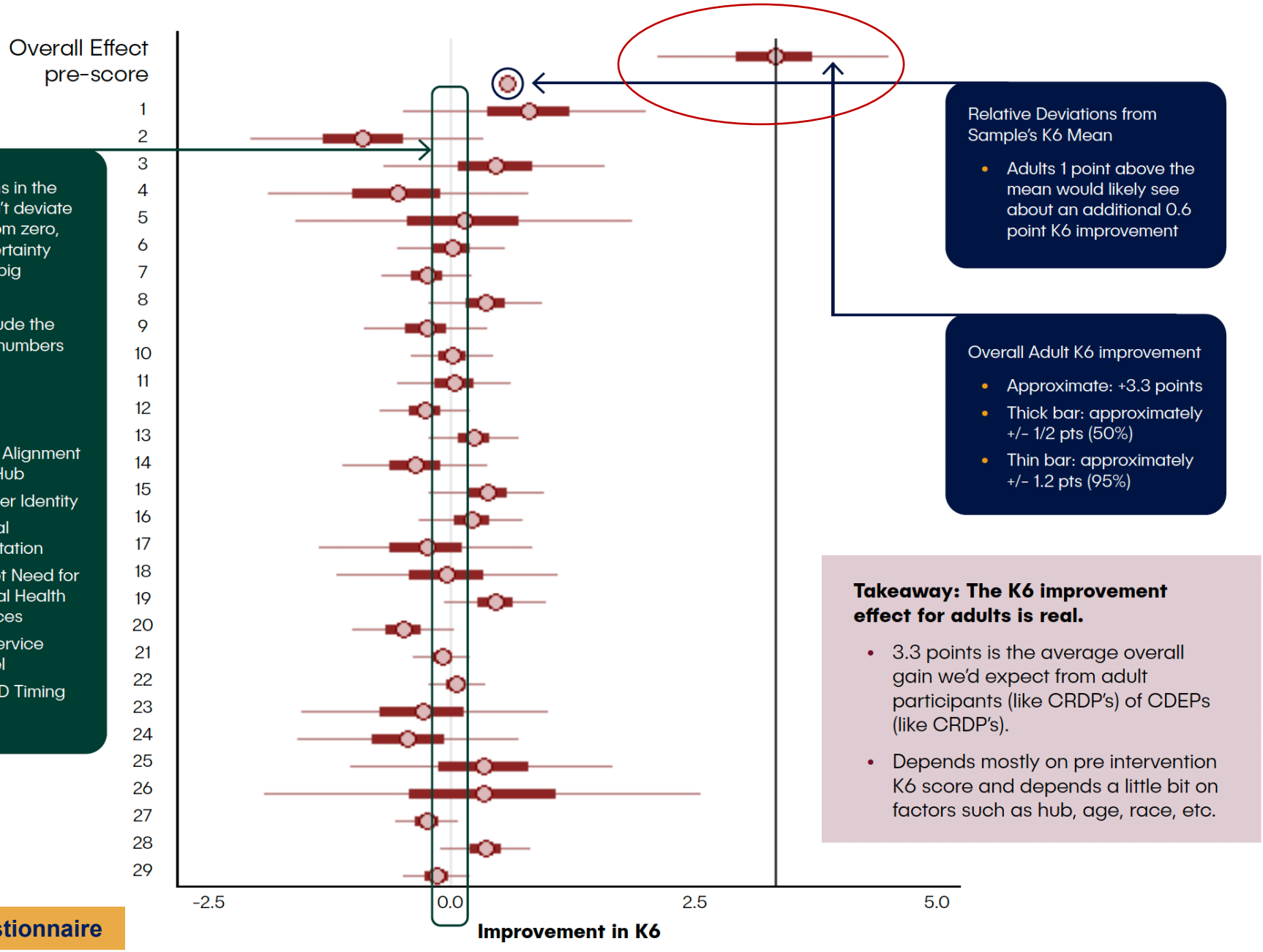
severe distress

Adult participants improved by 3 points on average, even when you take into account factors such as age, hub, gender identity, and even the timing of COVID-19.

Many terms in the model don't deviate very far from zero, while uncertainty levels are big for some.

Terms include the following (numbers 1-29):

- Hub
- Age
- Race Alignment with Hub
- Gender Identity
- Sexual Orientation
- Unmet Need for Mental Health Services
- IPP Service Model
- COVID Timing
- IPP



Relative Deviations from Sample's K6 Mean

- Adults 1 point above the mean would likely see about an additional 0.6 point K6 improvement

Overall Adult K6 improvement

- Approximate: +3.3 points
- Thick bar: approximately +/- 1/2 pts (50%)
- Thin bar: approximately +/- 1.2 pts (95%)

Takeaway: The K6 improvement effect for adults is real.

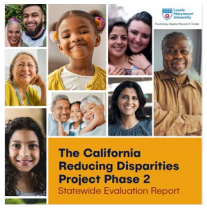
- 3.3 points is the average overall gain we'd expect from adult participants (like CRDP's) of CDEPs (like CRDP's).
- Depends mostly on pre intervention K6 score and depends a little bit on factors such as hub, age, race, etc.

Source: CDEP participant questionnaire

BUSINESS CASE: COST BENEFIT ANALYSIS OF CRDP PHASE 2

Rather than what does all of this COST…..

The question that should be asked is, how much does all of this SAVE?



Key Findings from the CRDP Phase 2 Statewide Evaluation Report

What matters most? Prevention or early intervention?

Cost Benefit Analysis (CBA) Overview

A Cost-Benefit Analysis is a systematic process for identifying, quantifying, and comparing expected benefits and costs of an action, investment, or policy (U.S. Department of Transportation, 2023)

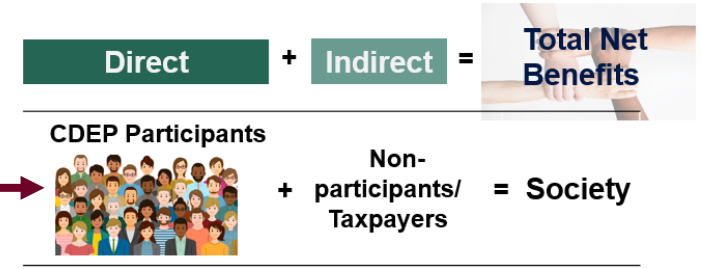
- **CRDP's CBA includes health and non-health outcomes**

Advantages of CRDP's CBA

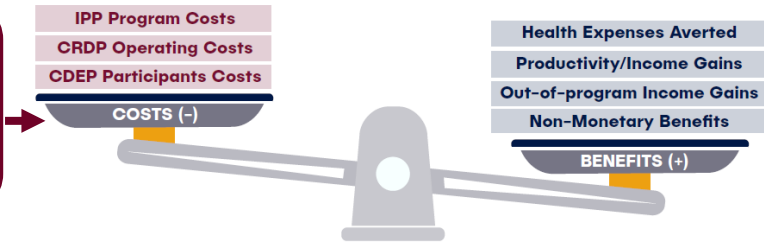
- Measures/monetizes CDEP-related social benefits
- Provides a useful benchmark from which to evaluate and compare potential PEI investments
- **Used to calculate CRDP's return on investment (ROI)**

What steps did we follow for CRDP's CBA?

1. Define framework for analysis



2. Identify costs and benefits



3. Define the time horizon

Average amount of time as a CDEP participant per hub

4. Model benefits

Long term cost-savings

5. Calculate of costs and $ benefits

Financial, economic, and health

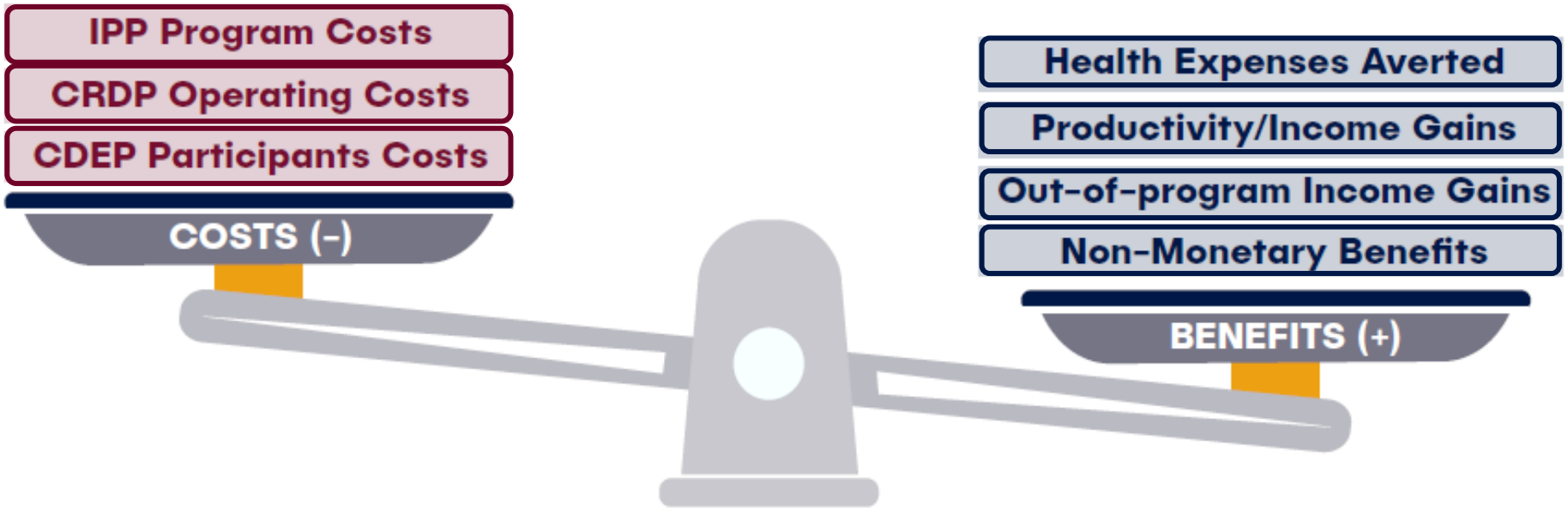
6. Tally total value and compare

Combine benefits that accrue over time

Costs and Benefits Considered for CRDP

- CDEP participants' travel costs
- CDEP participants' reduction in leisure

- Lower suicide rates
- Reduced recidivism
- Cultural connectedness
- Better job continuity



Data Sources

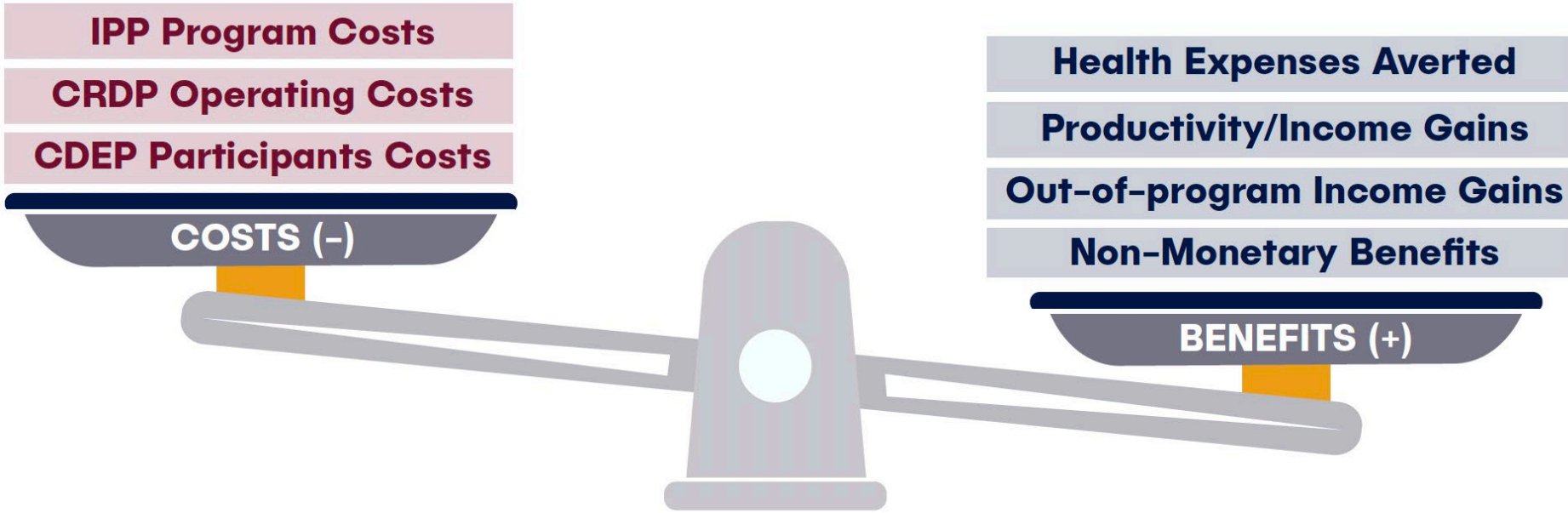
OHE budget

IPP local evaluation reports

IPP semi-annual reports

CDEP SWE participant questionnaire
(no health expenditure data)

National medical expenditure panel data
(restricted version with links to NHIS accessed through a U.S. Census Federal Research facility)



Characteristics and Limitations of MEPS Data

1. National vs. California Data

- Public use and restricted use MEPS data

2. SOGI Data

- MEPS does not include SOGI data, PARC requested a link to NHIS data that includes a few categories of sexual orientation data

3. Limited K6 sample

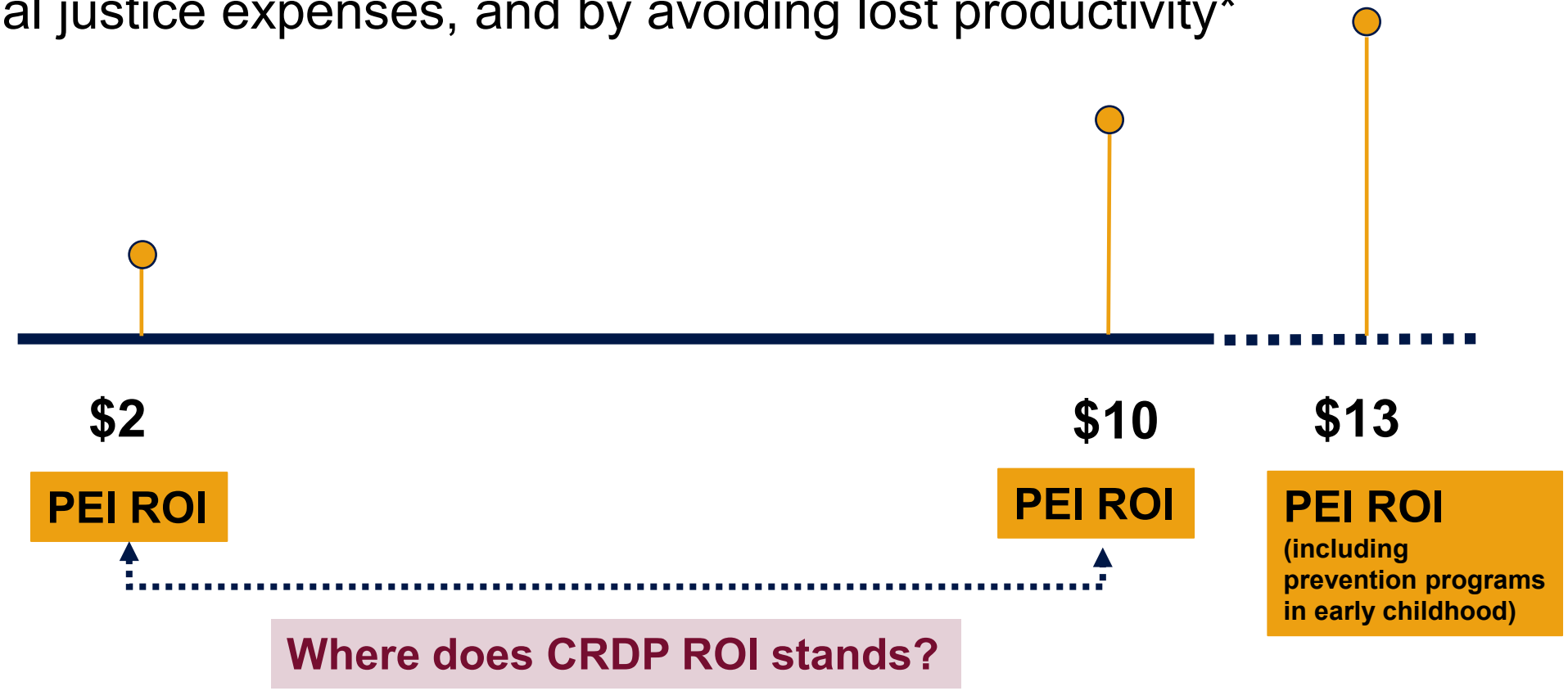
- K-6 data only available for adults, no data on anyone <18

4. AANHPI and AI/AN Sampling

- Small samples for both, mostly Asian American reflected in AANHPI pop

Context: Return on Investment (ROI) for PEI Programs

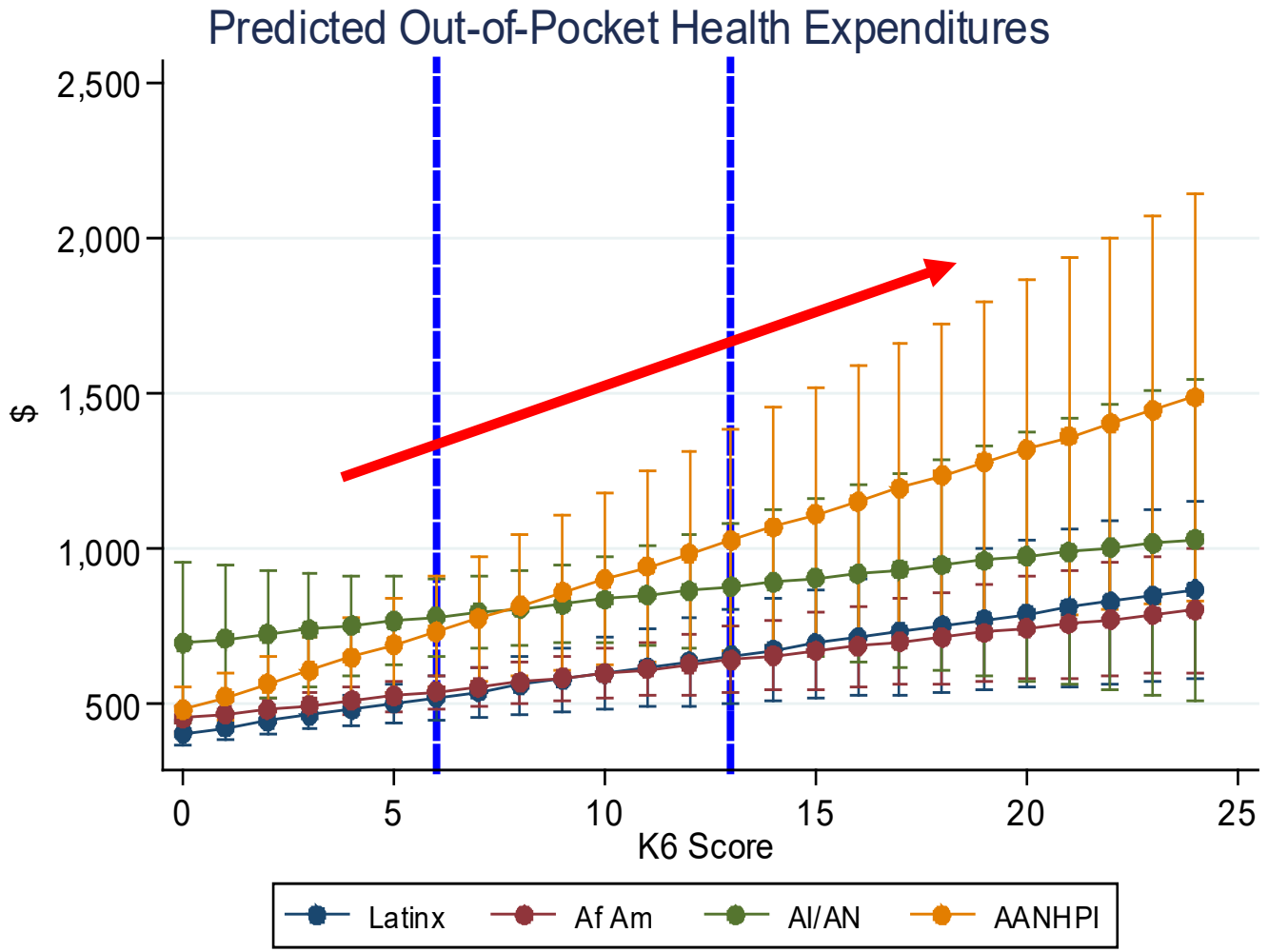
The National Academies of Sciences, Engineering, and Medicine found that for **every dollar invested in PEI, society saves $2 to $10** in health care costs, criminal justice expenses, and by avoiding lost productivity*



*Calculations from 2009 described in the MHSOAC "2022 Well and Thriving Prevention and Early Intervention in California Report"

Context: K6 MEPS and Health Expenditures

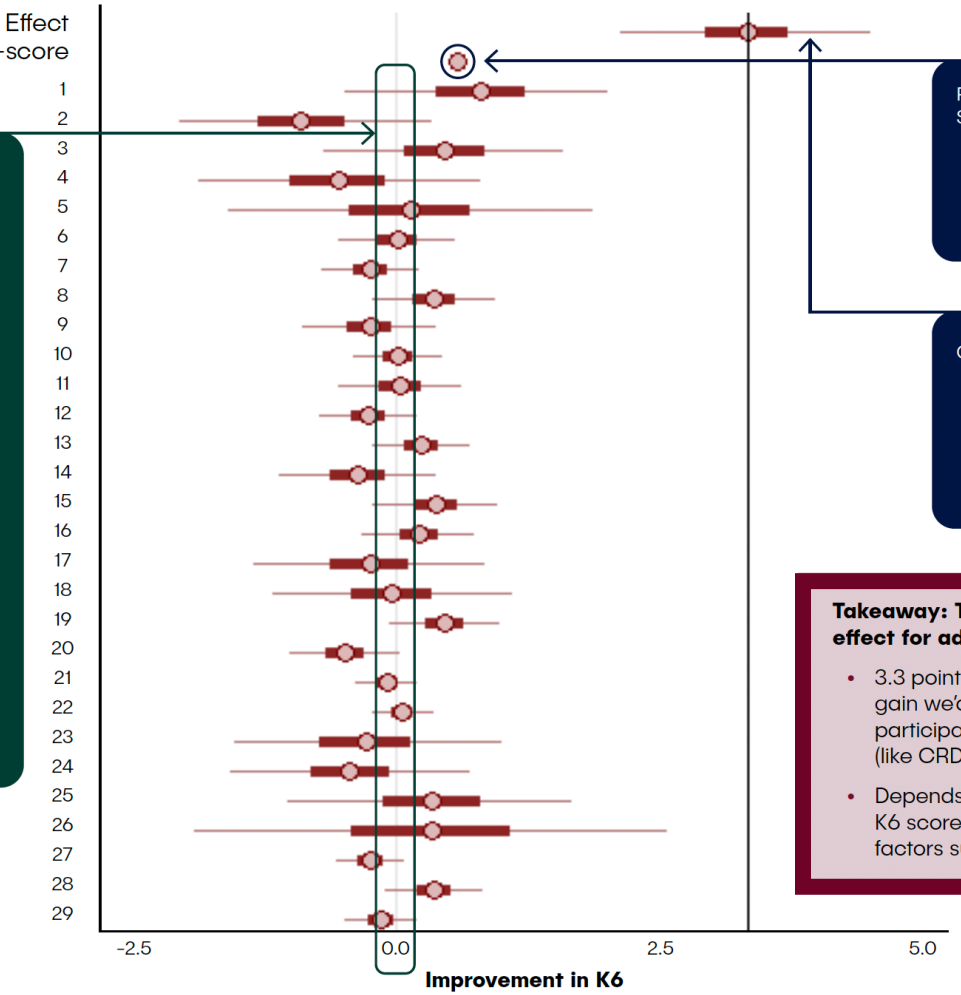
Medical Expenditure Panel Survey (MEPS) Data for 2017-2019



Positive relationship between MEPS K6 scores and out-of-pocket health expenditures

- confirms findings previously outlined in the health literature (Dismuke et al, 2011; Pirraglia et al., 2011)

Health Expenditure Values and Psych Distress



Many terms in the model don't deviate very far from zero, while uncertainty levels are big for some.

Terms include the following (numbers 1-29):

- Hub
- Age
- Race Alignment with Hub
- Gender Identity
- Sexual Orientation
- Unmet Need for Mental Health Services
- IPP Service Model
- COVID Timing
- IPP

Relative Deviations from Sample's K6 Mean

- Adults 1 point above the mean would likely see about an additional 0.6 point K6 improvement

Overall Adult K6 improvement

- Approximate: +3.3 points
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Takeaway: The K6 improvement effect for adults is real.

- 3.3 points is the average overall gain we'd expect from adult participants (like CRDP's) of CDEPs (like CRDP's).
- Depends mostly on pre intervention K6 score and depends a little bit on factors such as hub, age, race, etc.

What does a 3-point improvement in psychological distress (K6) mean in $?

Health Regression Model

$$\mathbf{Health\ Expenditures_i} = \beta_0 + \beta_1 \text{K6 score}_i + \beta_2 \text{African American}_i + \beta_3\ \text{AI/AN}_i + \beta_4\ \text{AANHPI}_i + \beta_5\ \text{Latinx}_i + \boldsymbol{\beta_6\ African\ American_i * K6_i} + \boldsymbol{\beta_7\ AI/AN_i * K6_i} + \boldsymbol{\beta_8\ AANHPI_i * K6_i} + \boldsymbol{\beta_9\ Latinx_i * K6_i} + \beta_{10} X_i + \varepsilon_i$$

- X_i includes:
  - sex at birth,
  - English language fluency,
  - U.S. born status,
  - health insurance status,
  - household income,
  - education dummies, and age dummies

- **The interactions between race/ethnicity and K6 scores (β_6 to β_9)** are the main coefficients of interest

more

Findings: Health Savings and Mental Health

K6*Race/Ethnicity	Health Expenditures	Standard Error
8#hubA	**$ 1,342.12**	**$44.4**
8#hubB	$ 551.75	$31.0
8#hubC	$ 805.04	$62.5
8#hubD	$ 779.13	$102.8
9#hubA	$ 1,385.52	$50.4
9#hubB	$ 562.87	$34.6
9#hubC	$ 817.56	$62.5
9#hubD	$ 819.38	$116.0
10#hubA	$ 1,428.92	$56.6
10#hub B	$ 573.99	$38.4
10#hubC	$ 830.08	$66.4
10#hubD	$ 859.64	$129.4
11#hubA	**$ 1,472.33**	**$62.9**
11#hubB	$ 585.11	$42.4
11#hubC	$ 842.60	$73.5
11#hubD	$ 899.90	$142.9

A 3-point drop in psychological distress for a person in hub A:

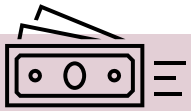
K6=11 to K6=8 *(moderate distress)*

Yearly health expenditures

$1,472 → $1,342

= $130 savings for a CDEP participant in hub A

CDEP Benefits

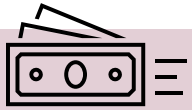
Health savings  ☑

- **Lower psychological distress *(prevention and early intervention)*** ☑
- **Lower impairment for those with severe distress *(early intervention)*** ☑

Productivity Gains ☑

- **Avoidance of productivity loss from better mental health** ☑

CRDP Long-term Benefits

Lifetime CDEP benefits 

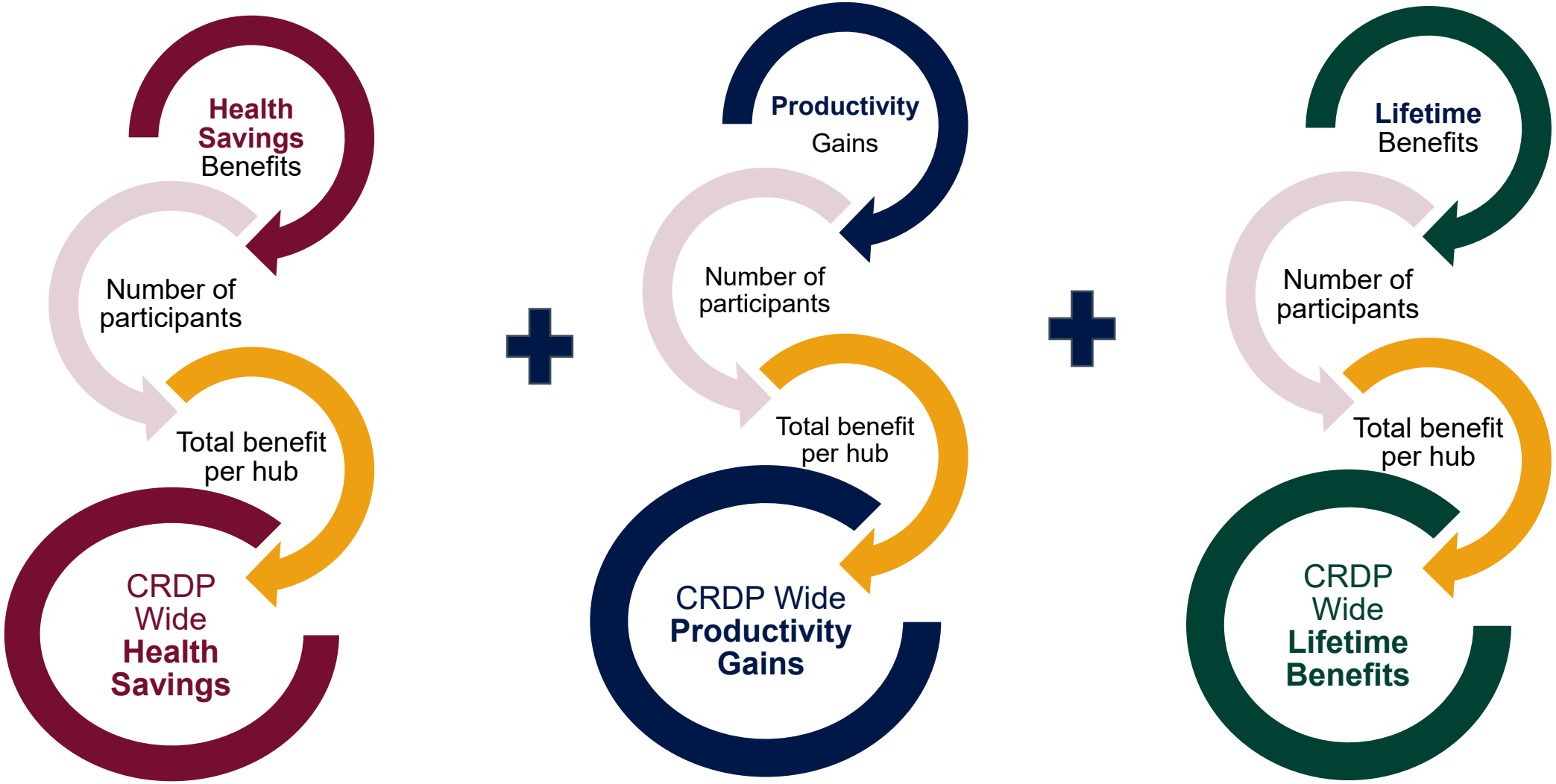
Increased earnings from sustained mental health improvements

What does this mean?
We calculated the expected value of improved life-time earnings

For example, for hub A:

- The estimated average gain in earnings (*from better mental health*) is **$1,840/year for adult participants**
  - A typical worker has an estimated retirement age of 65 years
  - The average age of participants in hub A is 37 years of age
- **We calculated long-term of annual gains for 28 years** (65-37)

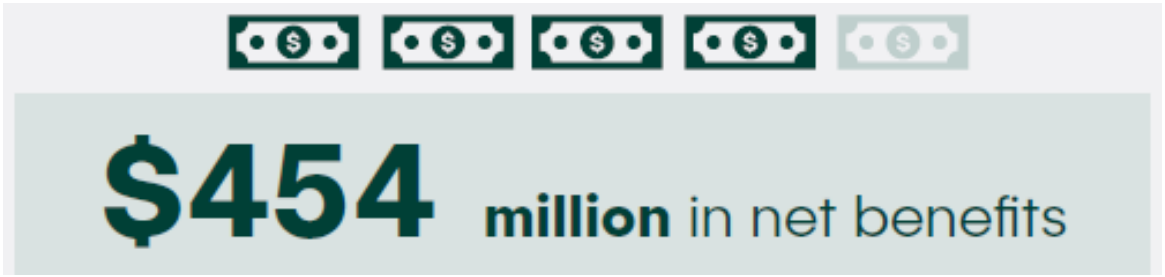
CRDP: Adding All Up



Net Estimated Long-Term Societal Benefits

Estimated benefits

Estimated direct and indirect costs



Return on Investment (ROI)

RETURN ON INVESTMENT = (Benefit-Cost) / Cost

CRDP ROI = 4.32 to 5.67

Sensitivity Analysis: including youth costs and benefits shows higher net benefits but same ROI

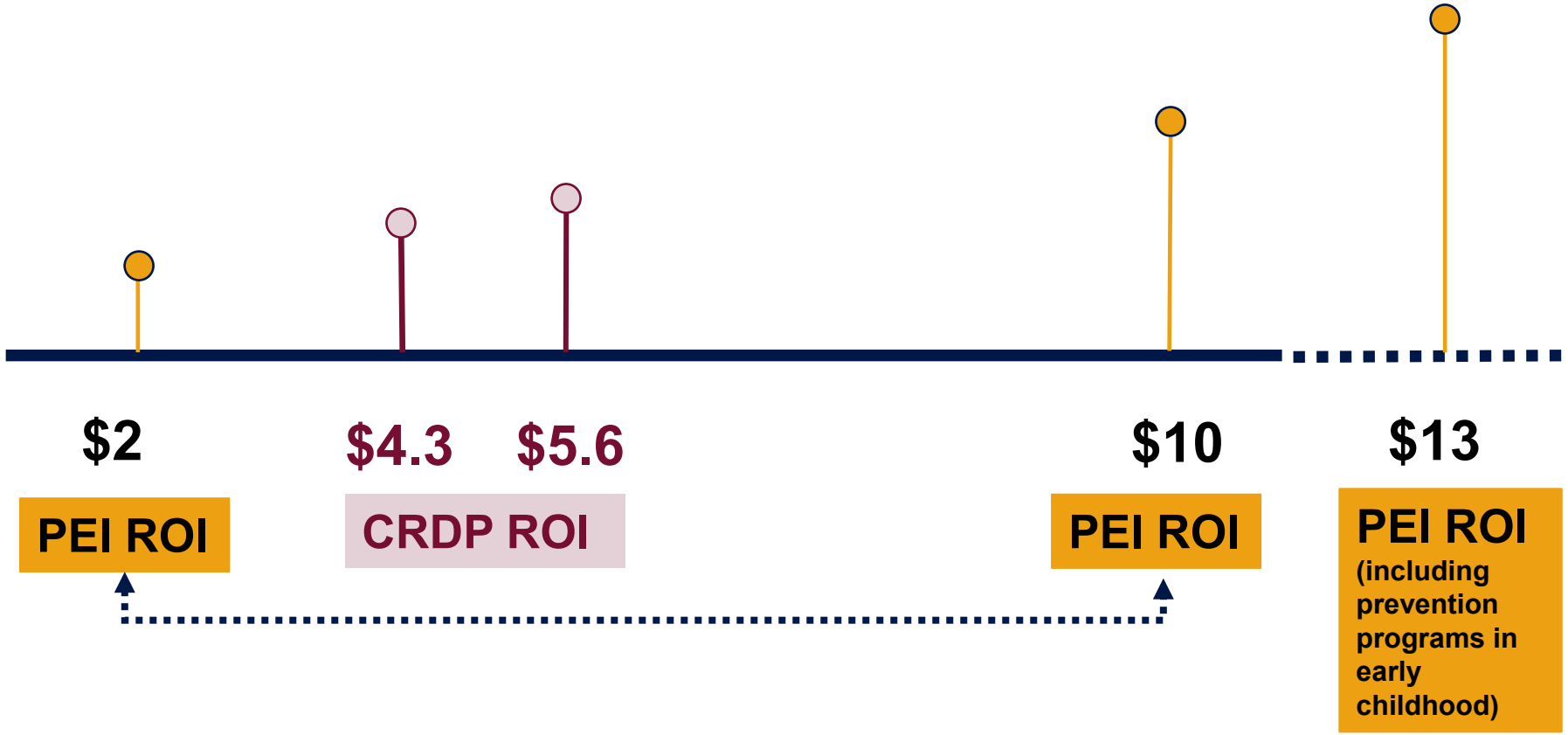
For every dollar spent, CRDP is expected to deliver **$4.3 to $5.67 in long term cost-savings**

These savings are related to:

- **Better mental health experienced by CDEP participants**
  - Fewer health-related costs (e.g., medical visits, medication, etc.)
  - Fewer days missed at work (i.e., higher productivity)
  - During **and** after CDEP participation

ROI for CRDP

For **every dollar invested in PEI, society saves $2 to $10** in health care costs, criminal justice expenses, and by avoiding lost productivity*



*Calculations from 2009 described in the MHSOAC, “2022 Well and Thriving Prevention and Early Intervention in California Report”


ONTRACK
PROGRAM RESOURCES
CALIFORNIA BLACK WOMEN'S HEALTH PROJECT
PIRE
EBAYC
EAST BAY ASIAN YOUTH CENTER
ssg
Special Service for Gro
UCDAVIS HEALTH
Center for Reducing Health Disparities
CARS
CENTER FOR APPLIED RESEARCH SOLUTIONS
Catholic Charities of the East Bay
INDIAN HEALTH CENTER OF SANTA CLARA VALLEY
THE FRESNO CENTER
FRIENDSHIP HOUSE
CAMBODIAN ASSOCIATION OF AMERICA
FOUNDED 1975
HEALTH EDUCATION COUNCIL
SAN FRANCISCO COMMUNITY HEALTH CENTER
HUMANIDAD
Therapy & Education Services
THE CENTER
For Sexuality & Gender Diversity
HEALTHY HERITAGE MOVEMENT
health RIGHT 360
A FAMILY OF PROGRAMS
INTEGRAL COMMUNITY SOLUTIONS INSTITUTE
SAFE passages
GENDER HEALTH CENTER
LGBTQ CONNECTION
Napa • Sonoma
Community Driven Action
Thank you!
NATIVE AMERICAN HEALTH CENTER
Serving the community since 1972
MAS Social Services Foundation
La Clínica
a california health center
gender spectrum
SONOMA COUNTY INDIAN HEALTH
WEST FRESNO
HEALTH CARE COALITION INC.
La Familia
COUNSELING CENTER
CULTURAL CENTER OF BUTTE COUNTY, CA
openhouse
WHOLE SYSTEMS LEARNING
UNITED AMERICAN INDIAN INVOLVEMENT, INC.
KOREAN COMMUNITY SERVICES
LATINO
Service Providers
SJPC
SAN JOAQUIN PRIDE CENTER
CRDP
California Reducing Disparities Project
TWO FEATHERS
NATIVE AMERICAN FAMILY SERVICES
REMHDCO
Racial and Ethnic Mental Health Disparities Coalition
California Pan-Ethnic
HEALTH NETWORK
parc
Loyola Marymount University

MHSSA RFA Outline

January25, 2024

Tom Orrock, Deputy Director of Operations
Riann Kopchak, Chief of Community Engagement and Grants

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Oversight & Accountability Commission

What is the MHSSA?

- 2019 Budget Bill, Senate Bill 75, included the Mental Health Student Services Act (MHSSA) to establish mental health partnerships between County Mental Health or Behavioral Health Departments and educational entities
- Commission awards grants to these partnerships to deliver school-based mental health services to young people and their families
- Supports outreach to identify early signs of unmet mental health needs, reduce stigma and discrimination, and prevent unmet mental health needs from becoming severe and disabling

Grantee Survey/Poll Results

In the Survey, over 50% of counties mentioned a need for more staff/personnel

Workforce Capacity is ranked 1st at 27% in the Poll Results

80% of counties in the Survey indicated a desire to enhance their services for marginalized and vulnerable youth

Services for marginalized and vulnerable youth ranked 2nd (18%) in Poll Results

Sustainability is an increasing concern as there are grantees who are nearing the end of their grant

Grantees are increasingly asking for an expert in sustainability, relative to future funding

Listening Session

- Sustainability and future funding to support programs
- Expand the availability of peer support programs
- Foster youth and/or kids that ‘get in trouble’ are hard to reach
- Underserved populations include ‘unnamed’ groups
- Universal screening requires adequate services
- Space and time are a constant barrier to service

MHSSA PHASE IV Funding Focus

Four Areas of Funding

Marginalized and Vulnerable Student Populations ($5 million)

- Foster youth, juvenile justice involved youth, and unnamed populations

Universal Screening ($8 million)

- Learning cohort of partners to develop an implementation plan

Sustainability ($9 million)

- Continuous quality improvement and long-term sustainability of school-county partnerships

Other Priorities ($3 million)

- Projects that address unique needs of their partnerships, such as wellness centers, mobile crisis support, SUD prevention, etc.

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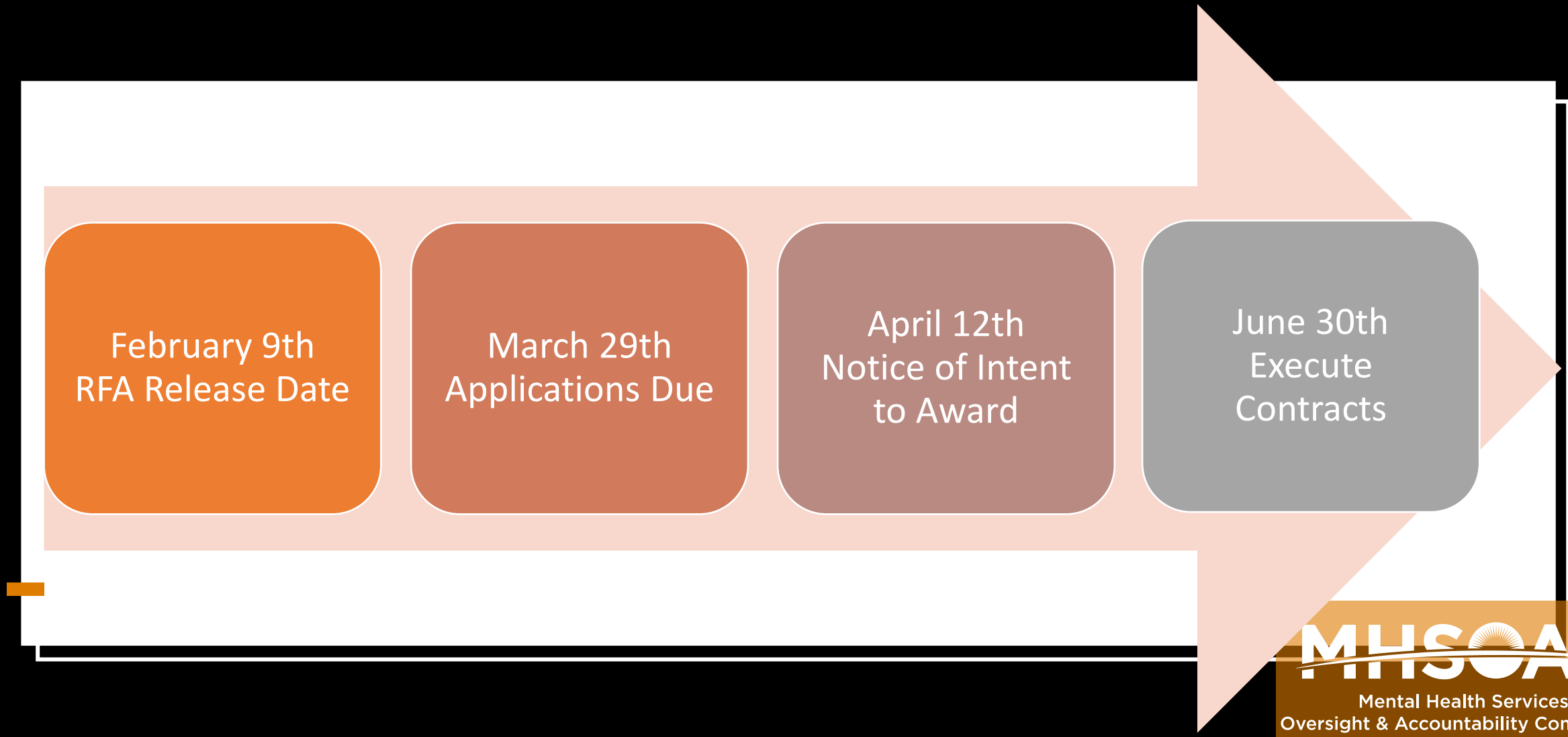
Why this approach?

Focus on key areas that will make an immediate and lasting impact on student mental health

Addresses a large section of the continuum of care for students

Includes prevention and identification of risk factors, treatment, and sustainability

RFA Timeline



Prioritize geographic diversity (size, urban/rural)

Prioritize marginalized/underserved populations

Timeframe: 3-5 years

Fiscal Year funding source to be determined

RFA Overview

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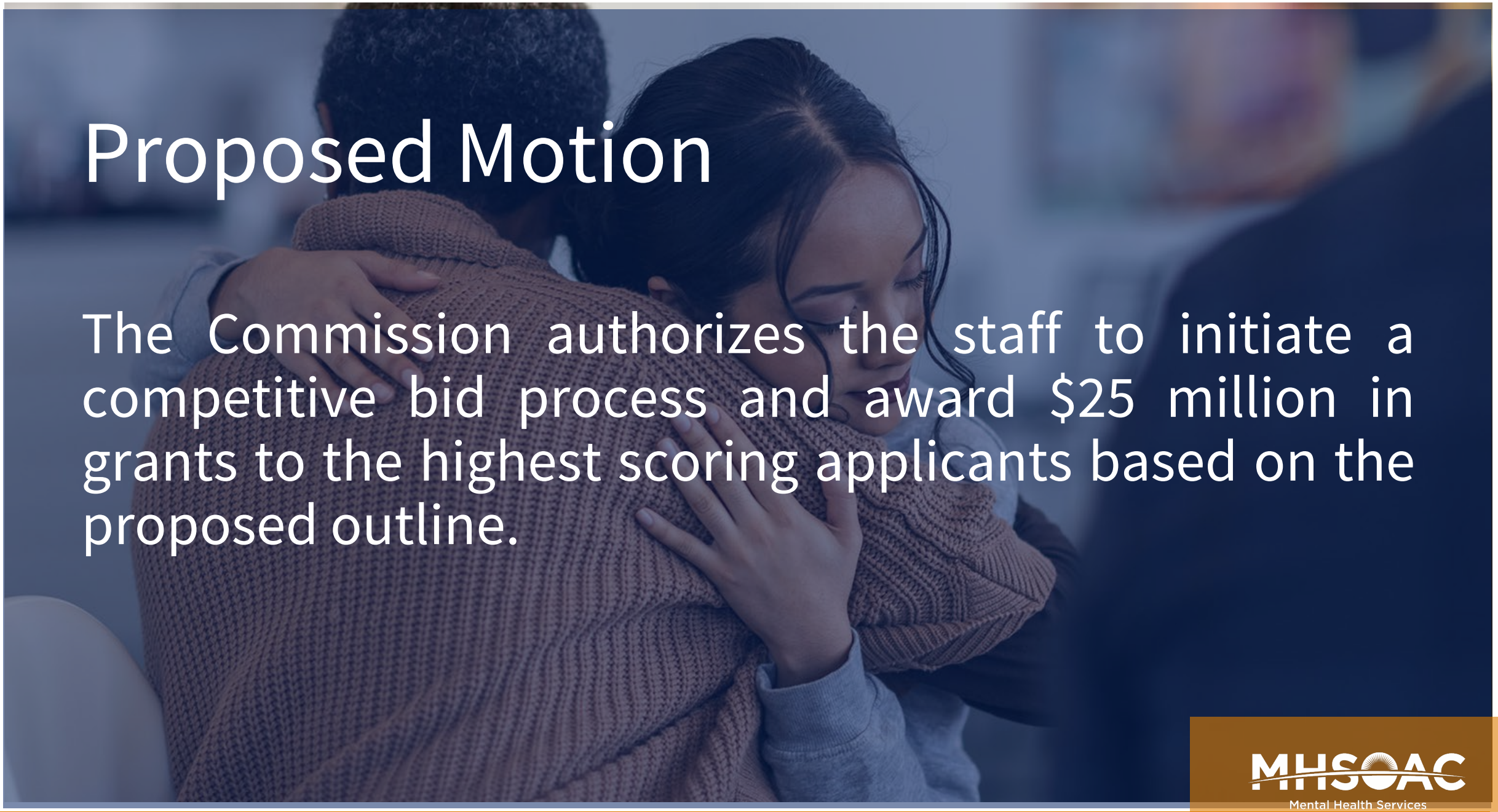
Oversight & Accountability Commission



Proposed Motion

The Commission authorizes the staff to initiate a competitive bid process and award $25 million in grants to the highest scoring applicants based on the proposed outline.

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Substance Use Disorder Contract Authorization

January 25, 2024

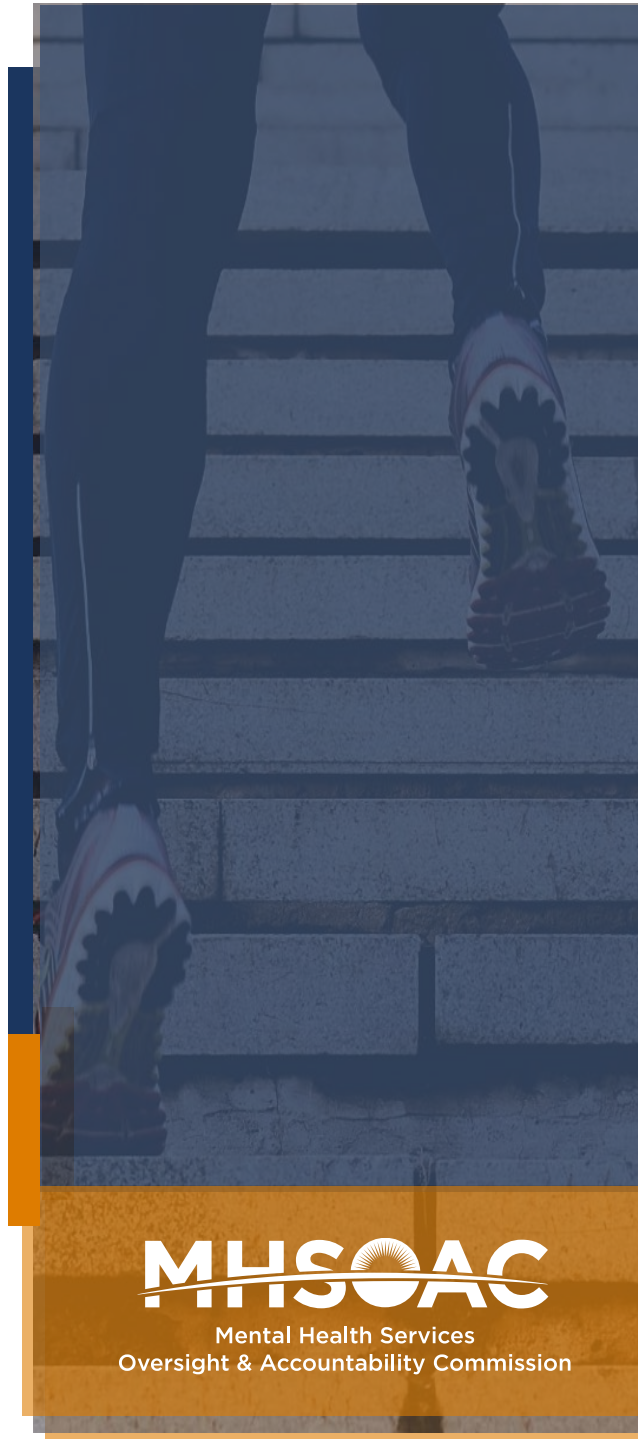
Itai Danovitch, MD.

Tom Orrock, Deputy Director of Operations

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Background

- The Commission identified SUD as a priority area for Mental Health Wellness Act funding
- In September of 2023 the Commission heard from a panel of experts on the barriers to evidence-based SUD treatment.
- In November, a proposal to expand access to integrated medical/addiction treatment was approved and the Commission asked for more details at the January 2024 meeting.



SUD Funding Strategy

Best Practice Pilot ($16 million)	MAT Prescriber cost-sharing program Medical services (IMS) in residential facilities Access to Lo-Barrier telehealth medical services
Support Contracts ($4 million)	Technical Assistance Research and Evaluation Project Coordination

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Why this approach?

- Promotes the integration of mental health care and medical care in diverse communities
- Aligns with the state's goal to bring SUD and mental health treatment together into one wholistic approach
- Improves access to evidence-based SUD services
- Promotes collaboration and shared learning

Commission Feedback

Commissioners had feedback regarding the number of organizations in the pilot program, the lack of clarity around selection criteria but approved a motion to move forward and asked for staff to provide more specifics at this January meeting.

- Allow counties and CBOs to respond to the opportunity to participate in the pilot
- Number of pilot participants was unclear and lacked specificity
- Concerns relative to sole-source and introduction of a competitive process

Selection Process

RELEASED A REQUEST FOR LETTERS OF INTEREST

MET WITH SUBJECT MATTER EXPERTS IN TA, RESEARCH AND EVALUATION, AND PROJECT COORDINATION

IDENTIFICATION OF QUESTIONS FOR RESPONDENTS

22 LETTERS OF INTEREST WERE RECEIVED

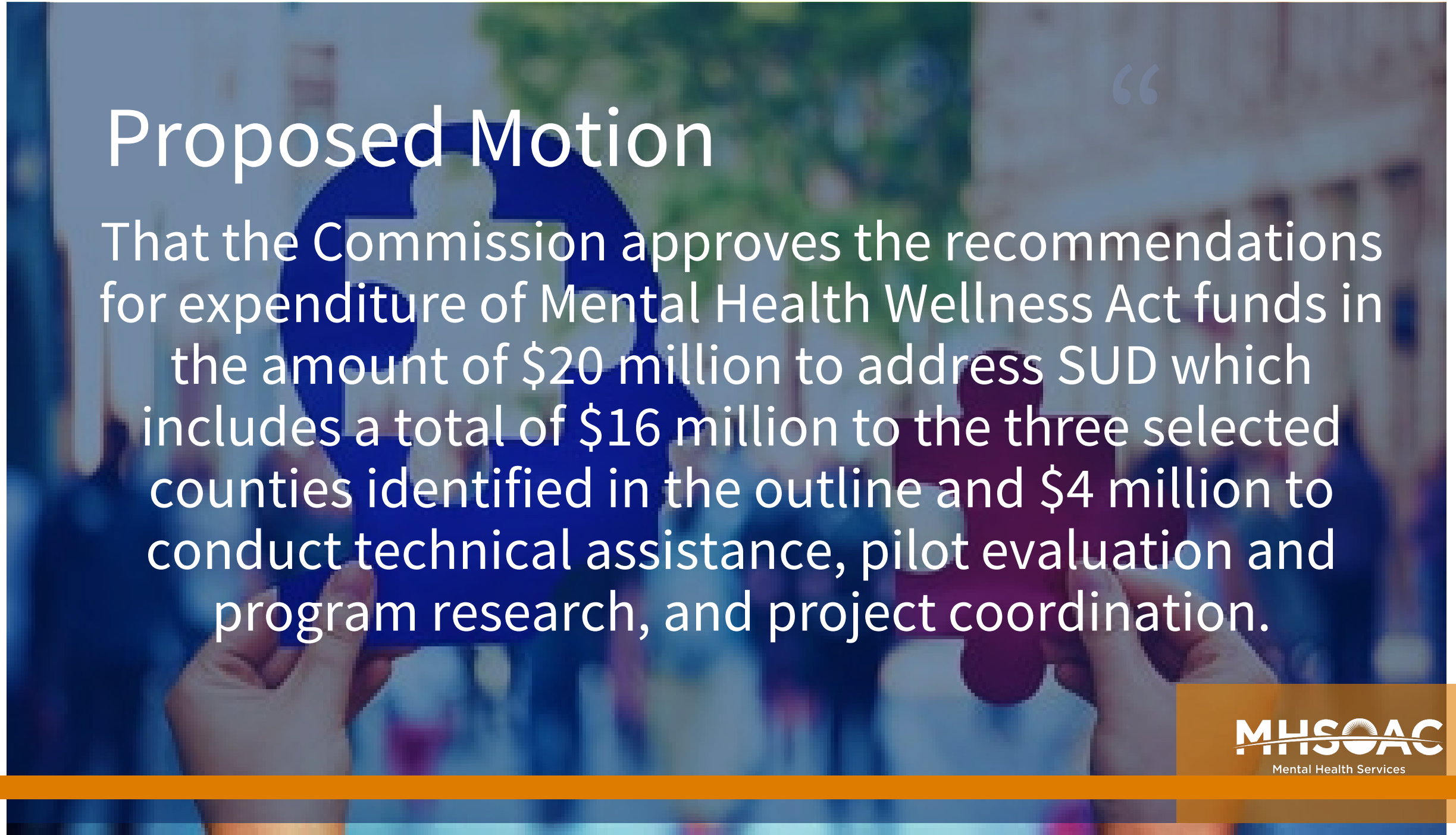
COMMISSION STAFF EVALUATED THE LETTERS USING A SCORING RUBRIC BASED ON THE FIVE QUESTIONS FROM THE REQUEST

Questions for Respondents

1	Please Indicate your level of interest in this project and ability to receive Commission funds
2	Describe the populations you intend to serve; the Commission may prioritize access to historically underserved populations
3	Discuss opportunities for cost-sharing strategies and fiscal sustainability after the short-term grant period
4	Detail the feasibility of partnering with medical prescribers
5	Describe the impact or benefit you anticipate

Recommended Pilot Participants and Contractors

- Los Angeles County Department of Public Health, Bureau of Substance Abuse and Prevention Control (Large)
- Marin County Department of Health and Human Services, Division of Behavioral Health and Recovery Services (Medium)
- Nevada County Behavioral Health (Small)
- Technical Assistance- California Institute for Behavioral Health Solutions
- Research and Evaluation- UCLA Integrated Substance Use Programs
- Project Coordination- Jett & Associates LLC.



Proposed Motion

That the Commission approves the recommendations for expenditure of Mental Health Wellness Act funds in the amount of $20 million to address SUD which includes a total of $16 million to the three selected counties identified in the outline and $4 million to conduct technical assistance, pilot evaluation and program research, and project coordination.

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The Governor's 2024-25 Proposed Budget and the Commission's 2023-2024 Mid-Year Budget Report

January 25, 2024

Governor's Proposed Budget for Fiscal Year 2024-2025

$253.4 billion for Health & Human Services programs – Increase from $230.5 billion in FY 23-24

❖ Increased Funding for Mental Health Programs

- Children and Youth Behavioral Health Initiative Wellness Coaches - Includes $9.5 million in 2024-25 increasing annually to $78 million in 2027-28 to establish the wellness coach benefit in Medi-Cal effective January 1, 2025. Wellness coaches will primarily serve children and youth and operate as part of a care team in school-linked settings.

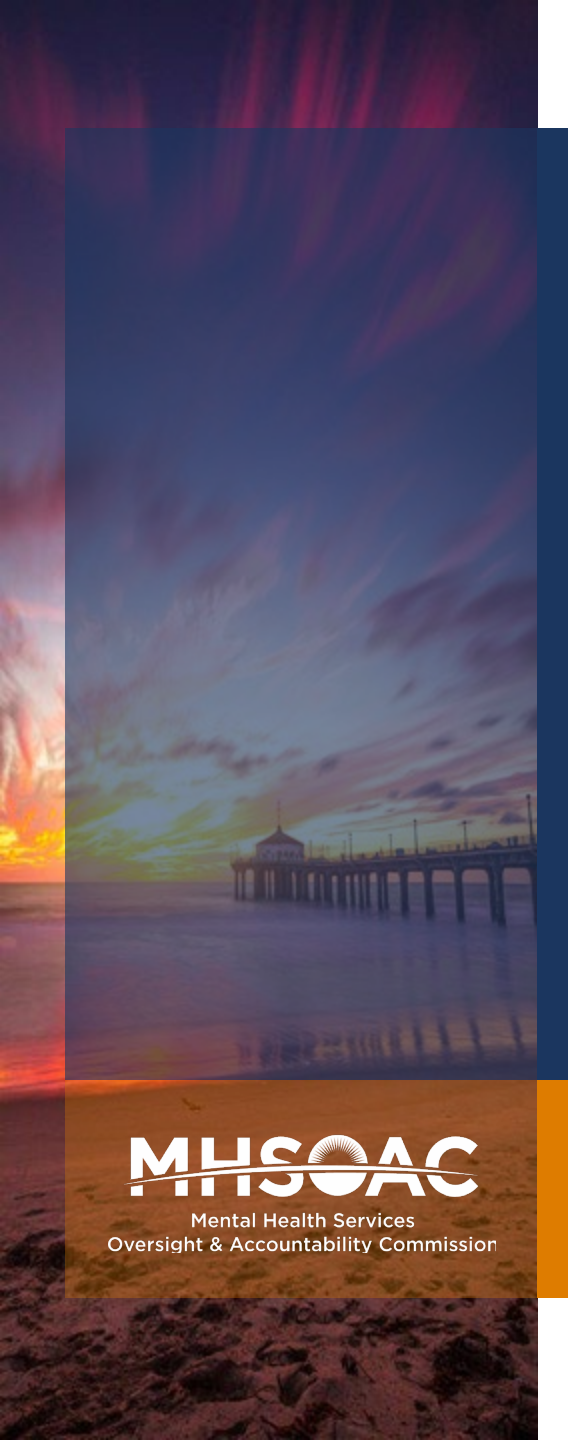
❖ Expansion of Mental Health Services

- Behavioral Health Continuum - Maintains over $8 billion total funds across various Health and Human Services departments.
- Expanding Medi-Cal to All Income-Eligible Californians - Maintains $8.5 billion to expand eligibility regardless of immigration status as of January 1, 2024.
- Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment Demonstration - Maintains $7.6 billion for DHCS and DSS to implement the BH-CONNECT Demonstration, effective January 1, 2025.
- Behavioral Health Continuum Infrastructure - Delays $140.4 million General Fund to 2025-26, for a total of $380.7 million for the final round of grants. The Budget maintains $300 million General Fund in 2023-24 and $239.6 million General Fund in 2024-25.
- Behavioral Health Bridge Housing - Shifts $265 million from Mental Health Services Fund to General Fund as appropriated in the 2023 Budget Act. Delays $235 million General Fund to 2025-26.

Governor's Proposed Budget for Fiscal Year 2024-2025

$253.4 billion for Health & Human Services programs – Increase from $230.5 billion in FY 23-24

- Focus on Early Intervention and Prevention
  - California Advancing and Innovating Medi-Cal - Maintains approximately $2.4 billion to continue transforming the health care delivery system through CalAIM.
  - Maintains $24.7 million in 2025-26 increasing to $197.9 million at full implementation to allow up to six months of rent or temporary housing to eligible individuals experiencing homelessness or at risk of homelessness.
  - Health and Human Services Innovation Accelerator Initiative - Delays $74 million General Fund until 2025-26 and 2026-27
- Healthcare Workforce Investments - In 2022 the Budget invested approximately $2.2 billion General Fund towards the state's goals of increasing the workforce in California. The Budget largely maintains those investments but proposes reductions.
  - Delays $140.1 million General Fund for the Nursing and Social Work Initiatives to 2025-26.
  - Delays $189.4 million Mental Health Services Fund to 2025-26 for various Department of Health Care Access and Information workforce investments.
  - Maintains $974.4 million (General Fund and Mental Health Services Fund) through 2025-26 for various workforce investments in the Department of Health Care Access and Information.



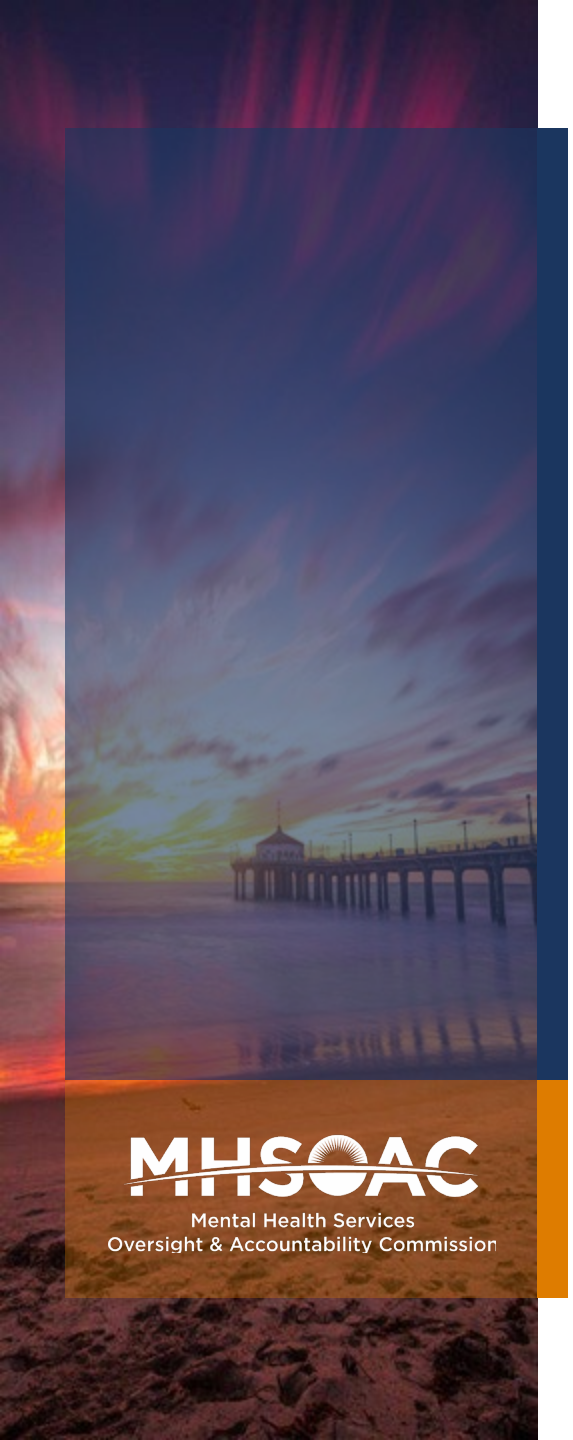
Key Opportunity

Strategic Plan for Early Psychosis Intervention

- ✓ $1.65 million for population-based coverage (Authorized in FY 2023-24 budget)
- ✓ Elements: Financing, Fiscal Impact, Technical Assistance, Research/Evaluation, Workforce, Public Narrative
- ✓ Linked to National Initiative
- ✓ Work with CHHS to identify research partner

Commission Budget 2023-24 Mid-Year Update

Expense Type	Item	Approved FY 23-24 Budget	YTD Expenses	Encumbered	Earmarked	Potentially Available
Operations	Personnel	$8,968,000	$3,492,467	$0	$4,040,858	$1,434,675
	Core Operations	$1,869,913	$664,934	$448,197	$442,977	$313,805
Commission Priorities	Communications	$599,418	$101,000	$77,400	$220,000	$201,018
	Innovation	$500,000	$0	$0	$500,000	$0
	Research	$1,075,669	$127,680	$184,380	$473,016	$290,593
Budget Directed	Universal mental health screening study	$200,000	$0	$160,000	$40,000	$0
	Evaluation of FSP Outcomes (SB 465)	$400,000	$0	$0	$400,000	$0
	EPI reappropriation	$1,675,000	$0	$0	$1,675,000	$0
	Children and Youth Behavioral Health Initiative	$15,000,000	$0	$0	$10,000,000	$5,000,000
Local Assistance	Mental Health Wellness Act	$20,000,000	$0	$0	$20,000,000	$0
	Mental Health Student Services Act	$7,606,000	$0	$0	$7,606,000	$0
	Community Advocacy	$6,700,000	$33,330	$1,976,670	$4,690,000	$0
Money Held for Reserve						-$250,000
Total		**$64,844,000**	**$4,419,412**	**$2,846,647**	**$50,087,851**	**$6,990,091**



Motion

- The Commission approves the Fiscal Year 2023-24 Mid-year expenditure plan, including the Early Psychosis strategic plan expenditure.


Thank you

2024 Legislation

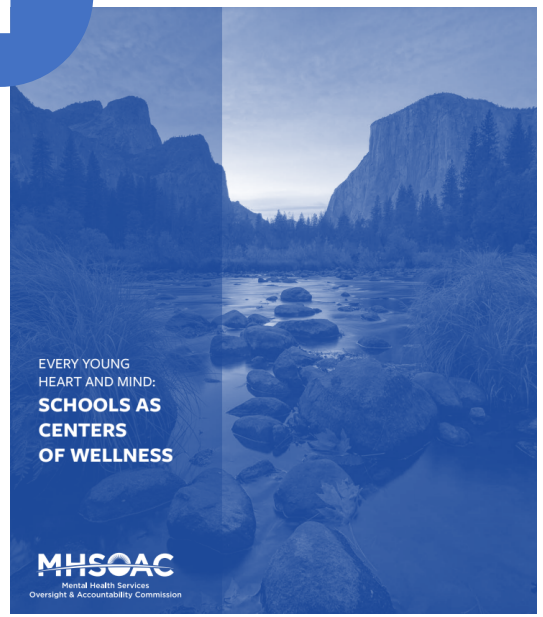
January 2024

Kendra Zoller, Deputy Director of Legislation

MHSOAC
Mental Health Services
Oversight & Accountability Commission

2024 Opportunities

1



Implement recommendation to establish an Office of School Mental Health

2

Implement recommendation to establish a workplace mental health center of excellence

3

Redo the Commission's 2021 sponsored bill to establish local youth advisory boards

Other Considerations

- Last Day to Introduce Bills: **February 16th**
- Primary Election (Prop 1): **March 5th**
- Current fiscal outlook
- TBD: 2023 carryover legislation

Questions?