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Mental Health Services
Oversight & Accountability Commission

Meeting Materials Packet

Commission Meeting
April 25, 2024
9:00 AM – 4:30 PM

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Commission Meeting Notice & Agenda

April 25, 2024

NOTICE IS HEREBY GIVEN that the Commission will conduct a meeting on April 25, 2024 at 9:00 a.m.

This meeting will be conducted via teleconference pursuant to the Bagley-Keene Open Meeting Act according to Government Code sections 11123, 11123.5, and 11133. The location(s) from which the public may participate are listed below. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

DATE	April 25, 2024
TIME	9:00 a.m.
LOCATION	1812 9th Street Sacramento, CA 95811

COMMISSION MEMBERS:
Mara Madrigal-Weiss, *Chair*
Mayra E. Alvarez, *Vice Chair*
Mark Bontrager
Bill Brown, *Sheriff*
Keyondria D Bunch, Ph.D.
Wendy Carillo, *Assemblymember*
Steve Carnevale
Rayshell Chambers
Shuonan Chen
Dave Cortese, *Senator*
Itai Danovitch, MD
Dave Gordon
Gladys Mitchell
James L. Robinson III, Psy.D., MBA
Alfred Rowlett

EXECUTIVE DIRECTOR:
Toby Ewing

ZOOM ACCESS
Zoom meeting link and dial-in number will be provided upon registration.
Free registration link:
https://mhsoac-ca-gov.zoom.us/meeting/register/tZwpdeGgrTojGtH31B6p80_xoeDAFXrE2Pm3

Public participation is critical to the success of our work and deeply valued by the Commission. Please see the detailed explanation of how to participate in public comment after the meeting agenda.

Our Commitment to Excellence

The Commission's 2024-2027 Strategic Plan articulates four strategic goals:

- Champion vision into action to increase public understanding of services that address unmet mental health needs.
- Catalyze best practice networks to ensure access, improve outcomes, and reduce disparities.
- Inspire innovation and learning to close the gap between what can be done and what must be done.
- Relentlessly drive expectations in ways that reduce stigma, build empathy, and empower the public.

Meeting Agenda

It is anticipated that all items listed as "Action" on this agenda will be acted upon, although the Commission may decline or postpone action at its discretion. In addition, the Commission reserves the right to take action on any agenda item as it deems necessary based on discussion at the meeting. Items may be considered in any order at the discretion of the Chair. Unlisted items may not be considered.

9:00 a.m. **1. Call to Order & Roll Call**

Chair Mara Madrigal-Weiss will convene the Commission meeting and a roll call of Commissioners will be taken.

9:05 a.m. **2. Announcements and Updates**

Information

Chair Mara Madrigal-Weiss, Commissioners and Staff will make announcements and updates.

9:30 a.m. **3. General Public Comment**

Information

General Public Comment is reserved for items not listed on the agenda. No discussion or action will take place.

9:50 a.m. **4. February 22, 2024 Meeting Minutes**

Action

The Commission will consider approval of the minutes from the February 22, 2024 Commission Meeting.

- Public Comment
- Vote

10:00 a.m. **5. Conflict of Interest Code**

Action

The Commission will consider approving amendments to the MHSOAC Conflict of Interest Code which will be filed with the Fair Political Practices Commission; *presented by Lauren Quintero, Chief, Administrative Services*

- Public Comment
- Vote

10:10 a.m.

6. Transformational Change in Behavioral Health: Prevention and Early Intervention

Action

The Commission will hear presentations on newly adopted requirements to strengthen prevention and early intervention strategies, the vision behind those reforms, and the challenges and opportunities under the Behavioral Health Services Act.

- Public Comment
- Vote

12:30 p.m.

7. Lunch

1:30 p.m.

8. Transformational Change in Behavioral Health: Innovation

Action

The Commission will hear presentations on newly adopted requirements on Innovation, the vision behind those reforms, and the challenges and opportunities under the Behavioral Health Services Act.

- Public Comment
- Vote

2:30 p.m.

9. 2023-2024 Spending Plan Update

Action

The Commission will hear a budget update and consider approval on expenditure plans and associated contracts for Fiscal Year 2023-2024; *presented by Norma Pate, Deputy Director, Administrative Services and Performance Management*

- Public Comment
- Vote

3:15 p.m. **10. Legislation**

Action

The Commission will consider legislative priorities for the current legislative session including:

- Assembly Bill 2352 (Irwin) relating to psychiatric advance directives, *presented by Kiran Sahota, President of Concepts Forward Consulting*
- Assembly Bill 2711 (Ramos) relating to a public health approach to suspensions and expulsions in schools, *presented by Adrienne Shilton, Senior Policy Advocate at the California Alliance of Child and Family Services; and*
- Senate Bill 1318 (Wahab) relating to youth suicide crises response in schools, *presented by Carson Knight, Legislative Aide with Senator Wahab and Amanda Dickey, Executive Director of Government Relations at the Santa Clara Office of Education*

- Public Comment
- Vote

3:45 p.m. **11. Strategic Plan**

Action

The Commission will hear an update on the 2024-2027 Strategic Plan implementation efforts being used to accomplish the Strategic Plan goals and objectives; *presented by Norma Pate, Deputy Director, Administrative Services and Performance Management*

- Public Comment
- Vote

4:30 p.m. **12. Adjournment**

Our Commitment to Transparency

In accordance with the Bagley-Keene Open Meeting Act, public meeting notices and agenda are available on the internet at www.mhsoac.ca.gov at least 10 days prior to the meeting. Further information regarding this meeting may be obtained by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov

Our Commitment to Those with Disabilities

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability need special assistance to participate in any Commission meeting or activities, may request assistance by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov. Requests should be made one (1) week in advance whenever possible.

Notes for Participation

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

The Commission is not responsible for unforeseen technical difficulties that may occur. The Commission will endeavor to provide reliable means for members of the public to participate remotely; however, in the unlikely event that the remote means fail, the meeting may continue in person. For this reason, members of the public are advised to consider attending the meeting in person to ensure their participation during the meeting.

Public participation procedures: All members of the public shall have the right to offer comment at this public meeting. The Subcommittee Chair will indicate when a portion of the meeting is to be open for public comment. Any member of the public wishing to comment during public comment periods must do the following:

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

- → If joining by computer, press the raise hand icon on the control bar. Pressing the raise hand will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute your line, announce your name, and ask if you'd like your video on. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

Under newly-signed AB 1261, by amendment to the Bagley-Keene Open Meeting Act, members of the public who use translating technology will be given additional time to speak during a Public Comment period. Upon request to the Chair, they will be given at least twice the amount of time normally allotted.

AGENDA ITEM 4

Action

April 25, 2024 Commission Meeting

February 22, 2024 Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the February 22, 2024 Commission 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.

Enclosures (2): (1) February 22, 2024 Meeting Minutes; (2) February 22, 2024 Motions Summary

Handouts: None

Proposed Motion: The Commission approves the February 22, 2024 Meeting Minutes

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date February 22, 2024

Time 9:00 a.m.

Location Embassy Suites by Hilton
1075 California Blvd.
Napa, California 94559

Members Participating:

Mara Madrigal-Weiss, Chair
Mayra Alvarez, Vice Chair
Mark Bontrager
Keyondria Bunch, Ph.D.
Steve Carnevale
Rayshell Chambers
Shuo Chen*[1]
Gladys Mitchell
Jay Robinson, Psy.D.
Alfred Rowlett

*Participated remotely
[1] a.m. only

Members Absent:

Sheriff Bill Brown
Assembly Member Carrillo
Senator Dave Cortese
Itai Danovitch, M.D.
David Gordon

MHSOAC Meeting Staff Present:

Toby Ewing, Ph.D., Executive Director
Maureen Reilly, Interim Chief Counsel
Tom Orrock, Deputy Director, Program Operations
Norma Pate, Deputy Director, Administration and Performance Management
Kendra Zoller, Deputy Director, Legislation
Riann Kopchak, Chief, Community Engagement and Grants
Melissa Martin-Mollard, Ph.D., Chief, Research and Evaluation
Lester Robancho, Health Program Specialist
Cody Scott, Meeting Logistics Technician

1: Call to Order and Roll Call

Chair Madrigal-Weiss called the Meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:07 a.m. and welcomed everyone.

Commissioner Bunch opened the meeting by honoring the importance of Black History Month.

Chair Madrigal-Weiss stated the Commission's strategic plan for 2024 through 2027 was approved at the January 25, 2024, Commission meeting. She reviewed a slide about how today's agenda supports the Commission's Strategic Plan Goals and Objectives, and noted that the meeting agenda items are connected to those goals to help explain the work of the Commission and to provide transparency for the projects underway.

Maureen Reilly, Interim Chief Counsel, called the roll and confirmed the presence of a quorum.

Lester Robancho, Commission staff, reviewed the meeting protocols.

2: Announcements and Updates

Chair Madrigal-Weiss gave the announcements as follows:

Commission Meetings

- The January 2024 Commission meeting recording is now available on the website. Most previous recordings are available upon request by emailing the general inbox at mhsoac@mhsoac.ca.gov.

Site Visit to Napa State Hospital

- Commissioners had the opportunity to participate in a tour of the Napa State Hospital yesterday and talk to staff and patients about their experiences that led to incarceration and hospitalization.
- Connected to that site visit, a panel has been put together for today's meeting to focus on strengthening early intervention to reduce criminal justice involvement and hospitalization for individuals with mental illness.

Chair Madrigal-Weiss invited Commissioners to share comments about their experiences in attending yesterday's site visit.

Commissioner Chambers acknowledged the hard work and person-centered, client-centered approach. She stated she "heard" the State Hospital's commitment to community integration and connection. Without community-based, client-focused, self-determined services, the continuum of care will get stuck in those settings. She encouraged the Commission to continue advocacy relative to building the whole system of care, including locked facilities and community settings, where it is believed that recovery is possible, that those individuals can thrive and have a full life as determined by themselves.

Commissioner Chambers stated the workforce piece was important. There are opportunities to work across the system to ensure that individuals who are eligible for community settings also have the opportunity to get viable employment opportunities in line with their potentially restricted environment in the community setting.

Commissioner Carnevale agreed and stated the most moving part was, as always, interacting with the panel of patients at the end of the day who made it clear that, if they had had support early in their lives, they would not be there. This points to the need for the system to be more focused on prevention and early intervention so places like the Napa State Hospital would not need to exist.

Commissioner Robinson agreed with the previous comments and stated he was amazed and astonished by what was seen yesterday. It is moving to hear the personal stories that get people to where they are in life. He stated he was also struck by the focus on staff safety. One of the most impactful things was comments that patients made about the time they spend in emergency departments. Efforts need to be more deliberate to create alternatives for where people can go when they are in crisis. Emergency departments are not designed for patients in mental health crisis and staff are not specifically trained for it. It needs to be acknowledged that the emergency room is not a safe place.

Commissioner Mitchell stated Napa State Hospitals are necessary but they need to sift through who really needs to be a state hospital and that is the sickest patients. Community-based services and interventions are important. She stated Commissioners were impressed with the healing part of the state hospital. She acknowledged that everything that was spoken of and demonstrated happens there, such as the robust family group and support systems.

Commissioner Mitchell stated she continues to be struck by the lack of diversity in the Napa State Hospital, where her child recently spent nine months. She stated, being a part of the family system of care, often she and her husband were the only Black parents in the group, and no Black parents were included in yesterday's advocacy panel. This is troubling.

Commissioner Rowlett asked about interventions in the community prior to a person experiencing acute distress that might result in them being hospitalized at Napa State Hospital. He suggested seeing the other part of the continuum that includes behavioral health urgent care, respite services, and crisis residentials. Many of these services include the important component of individuals and family members with lived experience. He asked staff to present on the next part of this conversation related to the community-based alternatives that are designed to ameliorate distress prior to a person going to a state hospital and that are designed more aptly to provide support versus an emergency room.

Chair Madrigal-Weiss thanked staff for putting together the site visit and for informing Commissioners on what they would see and what to look for.

<u>Committee Chair Appointments</u>

- In the past, the Commission has had standing Committees made up of 15 members to provide advice and guidance to the full Commission. The role of

Committees is to advise the Commission on specific subject areas related to its various projects and initiatives. The Strategic Plan provides an opportunity to ensure that the Committees have a well-defined role and a specific technical advisory task. The areas of focus of the Cultural and Linguistic Competency Committee (CLCC) and the Client and Family Leadership Committee (CFLC) will align with the 2024-2027 Strategic Plan goals and objectives.

- Beginning this year, the CLCC and CFLC meetings will be held on a quarterly basis. The Committees will update the Commission on the implementation of the strategic plan goals and objectives and will advise the Commission on overcoming barriers that may be faced with implementation of the plan.
- Chair Madrigal-Weiss reappointed Vice Chair Alvarez as chair of the CLCC and appointed Commissioner Chambers as chair of the CFLC. She stated Vice Chair Alvarez and Commissioner Chambers will make recommendations on Vice Chair appointments for these Committees.

Impact Map

- As noted in the Transformational Change Report released last month, the Commission is excited to announce the launch of an interactive Community Engagement Map (Map), now live on the website. At the January meeting, the Commission discussed the vital role of community engagement in its work. This tool directly ties into the strategic plan goals of championing vision into action and relentlessly driving expectation.
- The Map highlights areas throughout the state where voices are being heard, and at the same time reveals the areas where outreach efforts need to be expanded.
- The Map's filters show past and upcoming in-person and virtual events and includes everything from Commission-hosted site visits, Committee meetings, and listening sessions, to events offered by various Commission grantees representing diverse racial and ethnic communities. Phase Two enhancements to the Map to improve features and functionality are already in the works.

3: General Public Comment

June Lee, Executive Director, Korean Community Center of the East Bay, introduced herself to the Commission and provided an overview of the work of the Korean Community Center of the East Bay.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), thanked Chair Madrigal-Weiss for discussing the CFLC and the CLCC. She stated these are among the most important of the Commission's Committees. She urged, if Proposition 1 passes, utilizing these Committees to advise the Commission in the planning. Although Proposition 1 is not the same as Proposition 63, she stated the hope that the Commission will hold onto the principles of involving the community, consumers and family members, and individuals from underserved communities in Commission plans. She also urged the Commission to clarify if Committee membership will be replenished.

Patricia Sullivan, consumer and advocate, and Vice Chair, Napa County Mental Health Board, urged the use of physical emergency medicine before going to a crisis center or immediately as part of the entering process to a facility. The speaker stated they have talked to many individuals who have not gotten their proper physical medicine, such as insulin, to the point where they must be hospitalized in a physical hospital for physical medicine needs.

Richard Gallo, Peer Support Specialist, experienced technical difficulties and was unable to give their public comment.

Graciela vanWormer, family member, stated their daughter has been hospitalized in the Napa State Hospital for six months. The speaker stated they are seeking a setting in a different hospital where their daughter can obtain greater support. The speaker stated their daughter is not happy, not healthy, and not getting proper treatment. The speaker stated concern that Napa State Hospital employees do not return any calls or email messages. The speaker stated they do not want to compromise their daughter's confidentiality, but would like someone from the care team to assist their daughter. The speaker stated the hospital does not provide enough food or heat and has taken away their daughter's medication so she cannot sleep.

Chair Madrigal-Weiss stated staff will contact Graciela vanWormer offline.

Teslim Ikharo, Executive Director, Supportive Housing Community Land Alliance (SHCLA), himself to the Commission and provided an overview of the work of the SHCLA, including the SHCLA microgrant program for licensed residential care facilities in Alameda County.

4: <u>January 25, 2024, Meeting Minutes</u>

Chair Madrigal-Weiss stated the Commission will consider approval of the minutes from the January 25, 2024, Commission meeting. She stated meeting minutes and recordings are posted on the Commission's website.

Commissioner Chambers referred to her last comments before the adjournment of the January 25th meeting that the Commission has not had a discussion on Proposition 1 and staff then noted that the Commission is not allowed under the state's rules to use public dollars to advocate. Commissioner Chambers asked to put it on the record that her question was not about advocacy. She stated the need to ensure that there is opportunity for education and empowerment for better understanding both on the Commission and in the public.

Public Comment. There was no public comment.

<u>Action</u>: Chair Madrigal-Weiss asked for a motion to approve the minutes. Commissioner Robinson made a motion, seconded by Vice Chair Alvarez, that:

- *The Commission approves the January 25, 2024, Meeting Minutes, as presented.*

Motion passed 9 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Bunch, Carnevale, Chambers, Chen, Mitchell, Robinson, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioner abstained: Commissioner Bontrager.

5: Consent Calendar

Chair Madrigal-Weiss stated all matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action. She noted that the documents related to these projects and the staff analyses are included in the meeting materials.

Chair Madrigal-Weiss stated today’s Consent Calendar includes the approval of an innovation project in Riverside County and reallocation of allcove™ youth drop-in center funds. All documents related to these items were included in the meeting materials.

- Riverside Innovation Proposal: Eating Disorder Intensive Outpatient and Training Program

Chair Madrigal-Weiss stated the Riverside innovation project had a significant amount of community engagement at the local level and as part of the Commission’s process. The innovation project was shared on December 6, 2023, and January 24, 2024, with community partners. No comments were received in response to the Commission’s request for feedback for this project. The Innovation proposal included seven letters of support from community partners for this project.

- Reallocation of allcove™ youth drop-in center funds

Chair Madrigal-Weiss stated the other portion of this Consent item is related to reallocation of $2 million set-aside for allcove™. In January of 2020, the Commission approved a Request for Applications (RFA) and authorized five contracts each in the amount of $2 million to the awarded organizations. Six applications were received for the five awards; however, one of these applicants was unable to incorporate all of the allcove™ components and could notcontinue as an allcove™ grantee. The $2 million award was offered to the next highest scoring applicant as allowed in the RFA. The next highest scoring applicant turned the funds down due to staffing challenges. Staff is recommending that the remaining $2 million be reallocated to the existing four grantees to allow them to expand their programs.

Commissioner Comments & Questions

Commissioner Bunch stated one of the three focus areas for the Riverside University Health System Behavioral Health (RUHS-BH) innovation proposal is utilizing cultural competency. She asked for more detail on this focus area, particularly for the proposed target population.

Toby Ewing, Executive Director, stated discussion on Consent Calendar items needs to be tabled for discussion at a future Commission meeting; however, Commissioners can ask staff to follow up with additional details for this or any program.

Commissioner Bunch stated she will send her written comment to staff for follow-up.

Public Comment

Amy Myer, Licensed Clinical Social Worker, and Manager at Inland Empire Health Plan (IEHP), spoke in support of the RUHS-BH innovation proposal. The IEHP Disorder Team has a unique collaborative relationship with Riverside Behavioral Health.

Dakota Brown, Cultural Community Liaison, Riverside County Behavioral Health Commission, spoke in support of the RUHS-BH innovation proposal, which has brought in cultural liaisons to advise from the beginning of the process. Cultural competence must be woven in and scattered throughout all county services.

Sara Robbin, Clinician for Eating Disorders, and community advocate, spoke in support of the RUHS-BH innovation proposal. What sets this project apart is its ability to fill gaps of care in providing services for its target population.

Action: Chair Madrigal-Weiss asked for a motion to approve the Consent Calendar. Commissioner Mitchell made a motion, seconded by Commissioner Carnevale, that:

The Commission approves the Consent Calendar that includes funding for:

- *Riverside County's Eating Disorder Intensive Outpatient and Training Program Innovation Project for up to $29,139,565, and*
- *The reallocation of $2 million of allcove™ youth drop-in center funding to expand existing allcove™ programs.*

Motion passed 9 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Bunch, Carnevale, Chen, Mitchell, Robinson, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioner abstained: Commissioner Chambers.

6: Strengthening Early Intervention to Reduce Criminal Justice Involvement

Chair Madrigal-Weiss stated, consistent with the Commission's newly adopted Strategic Plan goals, and in alignment with yesterday's site visit to the Napa State Hospital, the Commission will hear a panel presentation on early interventions to reduce criminal justice involvement for individuals with mental illness. She asked staff to facilitate the discussion.

Tom Orrock, Deputy Director of Operations, stated one of the goals of the Mental Health Services Act (MHSA) is to prevent negative outcomes associated with addressed or untreated mental health needs. He stated the members of today's panel will provide insight on early intervention opportunities that can serve to divert individuals away from negative outcomes such as juvenile justice involvement, arrest, incarceration, and hospitalization. He stated the panel will speak about early warning signs of struggle in the lives of those who end up in downstream systems of care, such as the Napa State Hospital.

Deputy Director Orrock stated the state spends billions of dollars treating individuals with mental illness who have committed crimes. He provided the following statistics:

- The California Department of State Hospitals budget is $3.5 billion.
- The California Department of Corrections and Rehabilitation (CDCR) budget is $14.5 billion.
- It costs over $100,000 to treat one inmate for one year in the CDCR system.
- According to the Council on Criminal Justice and Behavioral Health (CCJBH), there are 14,000 minors detained each day in county-run juvenile detention facilities.
    - 90 percent of these youth have experienced significant trauma or toxic stress.
    - 88 percent of these youth are Black or Latinx.

Deputy Director Orrock posed the following questions to facilitate Commission discussion:

- How should the Commission use its mental health leadership and advisory role to elevate and disseminate practices, policies, and programs that are effective in strengthening early intervention practices to reduce criminal justice involvement for those with mental illness?
- What approaches could the Commission incentivize in its current and future initiatives that contribute to a safer, healthier community with reduced risk factors for criminal justice involvement for those with mental illness?
- What barriers exist in adopting and expanding solutions that are working in communities across California, and how can the Commission help to address them?
- How could the Commission support other state agencies in implementing promising approaches to early intervention?

Deputy Director Orrock stated staff had hoped to begin the discussion by hearing from a consumer and a family member but, unfortunately, LaMar Mitchell was unable to be in attendance to provide a consumer perspective; however, the Commission received a one-page description at yesterday's site visit of the experience of two Napa State Hospital residents prior to incarceration, which was included in the meeting materials.

Deputy Director Orrock introduced the members of the panel and asked them to give their presentations.

Sheila Robinson

Sheila Robinson shared her experiences from a parent perspective and advocate who has attempted to navigate the current mental health systems to gain support for her son. She highlighted her adult son's greatest qualities, discussed when his mental health challenges surfaced, and shared her experience in advocating to get her son the help he needs.

Sheila Robinson stated her lived experience is ongoing: her son, who had a sudden diagnosis in 2011 of schizoaffective disorder with bipolar highlights and psychotic disorder, is currently incarcerated in the main detention facility in Sonoma County. She noted that her son, as an ill person, deserves better care so he can live a life of dignity and hope. She likened her feeling to putting her message in a bottle and waiting for a strong outgoing tide. She noted that family members are always feeling in a state of crisis. She stated the National Alliance on Mental Health (NAMI) and Alcoholics Anonymous (Al-Anon) are good sources of support.

Sheila Robinson stated all systems seem to be impacted and everyone is trying, but California needs to go to the next step. She stated her son waits for often-delayed evaluations given by qualified individuals to evaluate while incarcerated to determine eligibility for diversion, eligibility for mandatory medication, degree of disablement, and competency to stand trial. Her son then must wait to get a bed in an incarcerated competency restoration program. So many parents are unable to process everything and are unable to deal with it, so they toss material in a box. Trying to organize the box to get an overview of the situation is difficult and emotional because so much of it is a failure and a disconnect. The system is not there yet.

Sheila Robinson thanked staff for their help and for giving her the opportunity to speak today. She stated, after 13 years, she has begun to organize the materials in some of her boxes to better see the big picture. She stated she has begun to see patterns these last few days showing the reasons why, at certain points, her son fell through the cracks. She stated it is difficult to know the right treatment for each person. She stated her son is against taking medicine because it is stigmatizing. She stated the need for follow-through long enough, in-person medication finessing, respect that individuals are not broken, people looking out for people, consistency with talk therapy, and consistent living programs. She noted that patient-centered therapy is important.

Commissioner Comments & Questions

Commissioner Mitchell thanked Shiela Robinson for her testimony. She stated it struck her that there are different phases of when individuals get sick. It is important to look at different systems or remedies because an individual at 22 years of age requires different resources and treatment than a child at the age of 13. She stated the need to look at how to make the system consistent so that, when a family comes into it, things can be done to give immediate relief as well as the feeling of security. Also, regarding Sheila Robinson having her adult child sent home after seven days in the hospital, Commissioner Mitchell pointed out that, clearly, the parent cannot provide the needed support because the adult child is still not well.

Commissioner Mitchell stated the need to look at how to come up with something that includes the housing for an adult who cannot be at home. Jail is not treatment either. She stated parents are looking for a system to stabilize their children because their diseases are not curable. Parents help their children to manage it. She asked how to create a system to provide consistent help for children and families in this fragmented system of care, considering that individuals at different ages have different needs.

Rosa Negron-Munoz, M.D.

Rosa Negron-Munoz, M.D., Distinguished Fellow of the American Psychiatric Association (DFAPA), and Distinguished Fellow of the American Academy of Child and Adolescent Psychiatry (DFAACAP), Adult, Child, and Adolescent Forensic Psychiatrist, spoke about strengthening early intervention to reduce criminal justice involvement. She provided an overview, with a slide presentation, of the lessons learned about the type of early intervention services needed to help an individual avoid incarceration, and how early intervention services for children, youth, and young adults could shift the trajectory away from negative outcomes such as homelessness, hospitalization, and incarceration and toward a life of health and wellness. She stated it is never too early for an intervention; the later the intervention, the higher the risk. She noted that everyone is different; the challenge is coming up with a system that works for everyone but at the same time can be flexible enough to take the intricacies of every family and every individual to work with them differently. She stated the need to provide appropriate services at appropriate stages.

Dr. Negron-Munoz proposed the Therapeutic Education Model (TEM) that identifies an individual who is at-risk and implements systems for the community and family, for mental health, for school, and for career planning. She quoted Michael J. Fox, who said, “If students don’t learn the way we teach them, then we need to teach them the way they learn.” She stated all children should have a counselor.

Dr. Negron-Munoz shared the background, methodology, and target areas of her study on educational factors contributing to juvenile delinquency.

Melanie Scott, Psy.D.

Melanie Scott, Psy.D., Assistant Deputy Director, Community Forensic Partnerships Division, California Department of State Hospitals, shared her perspective on individuals with serious mental illness and criminal justice involvement. She provided an overview, with a slide presentation, of the impacts the severely mentally ill population have on jails, the incompetent to stand trial treatment continuum, and observations from evaluations. She stated there is an overrepresentation of individuals who have a serious mental illness in the criminal justice system.

Dr. Scott noted that individuals with mental illness in the U.S. are 10 times more likely to be incarcerated than they are to be hospitalized. She stated this has occurred because jails have been impacted by upstream systemic failures, such as insufficient immediate availability of community mental health and substance abuse treatment for severely mentally ill populations. There tends to be a waitlist just for individuals to get the evaluation to determine if they are even eligible for the treatment services they are seeking. She stated training for mental health professionals who work in the community with severely mentally ill populations has diminished.

Carolina Klein-Moya, M.D.

Carolina Klein-Moya, M.D., Assistant Medical Director, California Department of State Hospitals, provided insight into the state-level competency program and opportunities for intervention in adulthood to reduce recidivism. She stated she oversees the operations of the five state hospitals in California and collaborates with the Community

Forensic Partnerships Division to build out and to support correctional and community programs. She stated she also has a consulting practice where she does forensic consulting in criminal and civil matters, and clinical consulting on mentally ill patients who are not institutionalized. She stated her private practice perspective is relevant.

Dr. Klein-Moya stated she has also worked in community in-patient facilities and psychiatric emergency services, and the realities that have been shared from the other panel members are so evident and devastating not just for the patient but everyone in their network. She stated the community face of care cannot be understated.

Dr. Klein-Moya stated what is seen in all the legal classifications, such as the incompetent to stand trial (IST) population, is a combination of five things:

- Severe mental illness that has often had an early onset of symptoms and has gone untreated for a long duration.
- This is usually co-morbid with medical co-morbidity, particularly hypertension and diabetes – chronic medical conditions that are treatable.
- Cognitive co-morbidity or cognitive disabilities.
- Addiction disorders or personality disorders.
- Social adversity that includes homelessness, justice involvement, and severe trauma.

Dr. Klein-Moya stated this five-angle combination makes a very severe person where each angle cannot be treated one at a time. All issues must be dealt with at the same time in the hope of undoing many years of untreated symptoms. Untreated means worse. She noted that every day that passes without treatment compounds issues.

Dr. Klein-Moya stated, to answer staff's question about early signs and symptoms and what can be done to address the needs of people with severe mental illness, terrible atrocities were committed against the mentally ill decades and centuries ago. She stated history needs to be held accountable for that and do some repair. Much of the stigma being faced is not just Hollywood's fault for portraying the mentally ill in only horror movies; we have acknowledged that we have moved on and that treatments are better, kinder, safer, and more effective. However, we assume that everyone has learned these things and do not pause to do the reparative work with community to earn their trust back. She stated she wants to believe that reparative work is done one-on-one with each patient and their families, but it has not been done as a field towards the community, or at least not enough.

Dr. Klein-Moya stated even things that were done by the community with the best intensions in mind a few decades ago have backfired. Case in point, Dr. Scott mentioned the issue of privacy laws. Although privacy laws are used to protect people's privacy, it backfired because family interventions, especially in psychosis and particularly in the first episode of psychosis, are critical in reducing rehospitalization at two years by almost 50 percent. The language adopted did not take the family intervention aspect into consideration.

Dr. Klein-Moya stated, similarly, tying accessibility to treatment to dangerousness also backfired. She stated hospitalization is not allowed for someone who is sick unless they have hurt someone. Hospitalization or psychopharmacological treatments are inherently tied to imminent dangerousness. This did two things: it promoted the stigmatization of the severely mentally ill in the belief that people who need treatment are dangerous people, and it tied the hands of the caregiver. It does a disservice to require someone to linger in and increase their illness and trauma before giving them the help they need. She stated, in an effort to protect an individual's freedom, the law deprives them of more freedom because the hospitalization ends up being longer, the incarceration ends up being longer, and the invasiveness of the treatment that is now warranted is also often higher. The association of accessibility to treatment with a dangerousness component may have had good intention but it backfired.

Dr. Klein-Moya stated there is a physician shortage, particularly a psychiatrist shortage, in California. She stated this shortage has been made more acute by the COVID-19 pandemic where there was a fleeing of the workforce. This happened at different points and in different ways. Not enough doctors are getting trained. There are not enough spots in medical schools and residencies. Residents are often not completing or they complete but do not practice medicine. Many doctors are choosing administrative or tele-psychiatrist positions. She stated there has been a fleeing of the workforce into private practice because of dealing with insurance companies, etc. Also, the recent rates of physician burnout and physician suicide are unprecedented.

Dr. Klein-Moya stated there have been suggestions to complement the psychiatrist workforce by generating many nurse practitioners to cover rural communities, but nurse practitioners mainly work in urban areas so the most underserved areas continue to be the most underserved. She noted that a resource that has been underutilized is the use of Certified Peer Specialists. Lived experience is important but it is not enough to carry out the duties of a peer specialist without the certification.

Dr. Klein-Moya stated she advocates very strongly for early interventions and community interventions. She stated that one percent of the population suffers from severe mental illness. Many of those individuals need to have a hospital level of care. By the time a person needs to be in the ICU, they need to be in the ICU. This is where the shortage of community beds is placed, which in California is more pronounced than any other state or in the state hospital. Here is where there needs to be a promotion of specialty care where it is understood that there are differences between clinical, correctional, and forensic psychiatrists, or between an addiction psychiatrist and an addiction counselor, or treating with mitigation for addiction treatment and treating only with group therapy. The science is so advanced.

Dr. Klein Moya stated, although everyone in the community is not expected to keep up, they are expected to make timely referrals, identify when ICU-level treatments are needed, know when to consult with a specialist, and know when to fight for the services that their patent needs. She stated a system of values needs to be encouraged in the community that fosters that everyone treats patients with compassion, respect, devotion, commitment, and a personal responsibility to see that person through regardless of the effort that it takes.

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

Jonathan Sherin, M.D., Ph.D., Chief Medical Officer, Healthy Brains Global Initiative, spoke about Full-Service Partnerships (FSPs) that provide support and intervention opportunities for those with mental illness. He stated FSPs are essential for community mental health but are often seen as a certain level of care only for those who have gotten to a certain point in their lives. This is a mistake. Dr. Sherin quoted former Commissioner Richard van Horn, who often said everyone with a severe and persistent mental illness ought to have an FSP.

Dr. Sharin discussed the client and family perspectives. He stated clients often have difficult times accessing care for many reasons, including insight about their conditions, and reaching out and being traumatized by the system rather than being welcomed and embraced as someone in need. He noted that families must traverse a maze to get care for their loved ones, which is infuriating. He stated another use of the acronym IST besides incompetent to stand trial is Inadequate Systems of Treatment. Inadequate Systems of Treatment are not just because there is not enough capacity but also because of their inaccessibility and difficulties getting to them.

Dr. Sherin stated, within the first month of becoming the Director of the Los Angeles County Department of Mental Health, he was called by approximately 10 different emergency room doctors who said they were glad he was there. The emergency room doctors had been calling FSPs for clients with psychotic disorders brought in by law enforcement, and the FSPs replied that they would come to get the clients but only after the emergency rooms had stabilized them. This is antithetical to the FSP.

Dr. Sherin provided an overview, with a slide presentation, of the domains of the program for mental health systems, including community services, crisis care, and re-entry initiatives. He stated the biggest problem is not the program, but the administration, the bureaucracy, and the payment – the way that the government supports the delivery of services, one of which is FSPs. He stated FSPs need to happen properly.

Dr. Sherin stated the way to do that is not to continue to focus on process, fee-for-service, and avoiding audit outcomes. He stated what needs to be focused on is how to identify outcomes that are meaningful, to get payment for those outcomes, and to liberate and empower the frontlines to seek those outcomes. It is not about mandating that, to leave the hospital, the patient must coordinate care with an outpatient provider within one week. It is about mandating that the provider must keep the person out of the hospital, off the streets, and out of the jail. That is the outcome to drive for and to get paid for. He noted that there is a massive crisis in health and human services. The only way to really get to a future where care that people need is provided is by incentivizing the work and demanding accountability for outcomes and not for process.

Dr. Sherin stated those outcomes need to be driven by grassroots efforts. The incentive structure needs to be redesigned. The Commission has an incredible opportunity to leverage existing tools and its role in the state to get counties to go after outcomes and to optimize their contracts. Contracts currently written are written for billability. He noted

that that is what is running the system, but that is not where these decisions need to be made.

Dr. Sherin stated we cannot focus simply on process. He suggested building a clubhouse and leveraging Senate Bill (SB) 803 to bring a brigade of peers to keep people engaged, to achieve the goal of keeping individuals not only out of those settings, but properly housed, educated, and hopefully employed or doing important civic work because that is ultimately the driver of recovery. If someone is on a recovery journey, they will want to take their medications and be stably housed. That is not incentivized by the current system.

Dr. Sherin stated, at the end of the day, the vehicles that we have to build to do work, which rely upon antiquated systems, fragmented funding, and endless reporting, are never going to move us to the destination that we all need to get to. He suggested that the Commission think about ways to help counties upgrade the work that they are doing with their current contracts in their communities with tools like performance management and assistance with technical assistance, and also to figure out a way to get counties to develop contracts that are based on outcomes and where outcomes are paid for, removing all the process and bureaucratic barriers that limit the hearts, minds, and dedication of clients and frontline providers.

Commissioner Comments & Questions

Commissioner Bunch stated one of Dr. Negron-Munoz's presentation slides showed that behavior in school has been associated later with delinquency. She added that there is also research that shows that teachers tend to attribute negative behaviors to Black boys for the same actions seen in white boys.

Dr. Negron-Munoz agreed and stated the same is true for Latinos and minorities in general. She stated it has to do with the socioeconomic status, how involved parents are, and how biased teachers are. A parent who is more involved is more likely to make concessions versus a parent who is not involved.

Commissioner Bunch emphasized Dr. Scott's comment about the importance of a "warm handoff". Often individuals receive treatment while incarcerated but are released with no services, housing, or medication so they end up back in the same place. Many individuals have never gotten outpatient mental health services and have only received mental health services when they are incarcerated. She stated individuals are let out of jail onto the streets in Los Angeles County with no warm handoff and no connection to services as there should be.

Commissioner Robinson agreed and added that not having a warm handoff in health care is considered a risk area of the highest magnitude. He asked what the optimal warm handoff would look like in behavioral health.

Dr. Scott agreed with Commissioners Bunch and Robinson and stated a strong warm handoff is needed for behavioral health and yet individuals who are accessing the system are oftentimes left with a packet of information to do it for themselves. Although more communication is required across systems, integrated electronic health records remain a challenge.

Commissioner Robinson noted that he was astounded at yesterday's site visit that the Napa State Hospital's health records were still paper. He stated his concern about a lack of continuity of care and questioned how the next provider can understand what is happening with the case.

Dr. Klein-Moya stated systems that have integrated health records are finding that doctors now need to read through hundreds of pages of medical records before seeing each patient. She emphasized that all medical records need to be accessible to every provider; however, she suggested a combination of a comprehensive set of documents that can be referred to as often as required or as the doctor progresses in their relationship with their patient, as well as a succinct document-to-document bottom line describing the patient's history and issues the next provider needs to know.

Dr. Klein-Moya stated the warm handoff must be very serious, strong, and warm. The next provider needs to be told what is happening, what they need to watch out for, who will be their biggest ally, the family member who tends to decompensate this person and how to integrate them, what was done that did not work, and the next step in the treatment plan that never was addressed because the patient was discharged or for other reasons. These issues will take a long time to find in a pile of records. That relationship between colleagues is critical.

Dr. Sherin stated it is easier in the Veteran's Administration (VA) because of the shared medical records and, even working in the VA, when someone is going to a contractor, they do not share the medical records. He stated, as a VA psychiatrist doing in-patient care, he would call ahead and visit the patient with the treatment team to talk it through. He stated the term he uses is "live handoff." These need to be live handoffs. This is one of the reasons an advocate, a navigator, an ombudsman, and a battle buddy in the VA (i.e., a peer) is critical. They can introduce the individual to the treatment team and share what has been learned to date. He stated the need to have a relationship that is ongoing with the client. He stated warm handoffs are not particularly warm in the current system of care. Requiring a live handoff would change this.

Dr. Scott stated living arrangements for some individuals can be fluid. Contact can be lost when trying to contact that person later. She stated family members like to be involved in their loved one's care and may have current contact information for the patient.

Commissioner Chambers agreed with the comments that repeating certain grades is an indicator for early intervention. She asked how to bridge gaps for parents who want to be involved. She stated she liked the idea in the presentations that more individuals are moving into in-patient treatment but that not everyone needs to be in in-patient treatment. Californians know that individuals are sick but sometimes lay Californians do not understand that not everyone needs to be put in locked facilities.

Commissioner Chambers stated education is key. She agreed with Dr. Klein-Moya that more education is needed on the value of ethics, devotion, and commitment to look at individuals with serious mental illness with respect. She agreed with the discussion on the warm handoff, particularly Dr. Sherin's "live handoff." She agreed with the idea of community mental health and encouraged the Commission to invest in community mental health to keep people whole.

Commissioner Chambers stated the importance of peers in helping to bridge therapeutic and provider relationships. She stated appreciation for the doctors on the panel who acknowledged the work of peers. She agreed that family is important and a trained family member is key. She agreed with integrating peers into the FSP model. She stated she is skeptical that work can be incentivized under the Medi-Cal model, although it would transform systems to do it.

Commissioner Carnevale stated appreciation for Sheila Robinson's presentation and lived experience. He stated the thing that jumped out was when she kindly stated it is no one's fault. He agreed that everyone is working hard but stated, if it is no one's fault and the system is still broken and not going anywhere, then it is everyone's fault. It is up to us to fix it.

Commissioner Carnevale applauded Dr. Sherin's presentation relative to an outcome-based system. That is the essential third piece of the Commission's strategic plan. A framework is now in place but data needs to be added that underpins the strategic plan. The Commission needs to put these outcome-based measurements in place and it must model them for the state because that is good government.

Commissioner Carnevale stated the state created a new organization called the California Institute on Law, Neuroscience, and Education, which he is a part of. The juvenile justice system is a precursor to the rest of this. He asked about the current state of the juvenile justice system – what is missing, what should be done, and what it means to the broader conversation.

Dr. Negron-Munoz stated one of her pet peeves is the system is blamed but we are the system. One of the biggest challenges in juvenile justice is the movement to a cognitive behavioral-based model that teaches aggression-replacement therapy, but all individuals are not cognitively at the same level so it gets back to how individuals learn. She stated the cognitive behavioral-based model has nice evidence-based therapies that have beautiful outcomes, but they are done with individuals who meet certain criteria and are not inclusive of everyone. The youth are set up for failure.

Dr. Negron-Munoz stated another problem is continuity of care. As soon as youth get into the juvenile justice system, she begins asking parents where the follow-up will be when their child is released and where they will get their medications. Youth are often inappropriately placed just to get them into a facility so no one is looking at the types of services the youth truly need. Some youths do quite well, but others are not cognitively intact, they do not get the program, or they may not learn it, so then they reoffend. This is part of the problem.

Dr. Negron-Munoz stated there are many children from the Department of Children and Family Services but this is not considered. It is easier when a family is intact that can be involved versus the children who already have difficulties and trauma within their families. Many different things need to be kept in mind for these children to ensure their success and decrease recidivism.

Dr. Klein-Moya stated cognitive behavioral therapy (CBT) is a convenient therapy from a billing perspective and is good for the right population, as Dr. Negron-Munoz stated, for the patient who is eligible and stands to benefit from it, but for everyone else, it has

become the de facto therapy. She stated the need to stop treating individuals de facto. Although there are common threads among individuals with the same diagnosis, the fact is that they are different people with different needs, circumstances, experiences, responses to treatment, etc. Treating everyone the same has value in a fundamental fairness type of way, but that value is diminished when the unique identity and the unique need are taken away.

Dr. Klein-Moya stated the need to favor specialization. Practitioners specialize and become experts in an area. This counts for something in this field. The field has advanced tremendously and the specialists can deal with things that non-specialists cannot. She stated mistakes are being repeated time and again. In the 1970s, everyone was deinstitutionalized without enough community supports. It happened again with the juvenile population. The hope is that they will get better. No one wants to see them deprived of freedom because they are children. The issue is that this was not paired with appropriate interventions.

Dr. Klein-Moya stated the need to be aware of the role of addiction in the juvenile population. People do not want to talk about this. Children who are heavily using drugs at 6 to 8 years old is a prevalent issue that is not being addressed directly. It is addressed as a consequence of a behavioral problem or considered as experimenting with drugs. She strongly rejected that way of thinking – these are brains in development soaked in intoxicating substances. She stated, unless addiction in juveniles is treated very aggressively and in a dedicated manner, it will be difficult to remedy.

Dr. Negron-Munoz added that it then goes to trauma. Some kids start using drugs at five years of age. She stated it is more comfortable for the clinician not to ask but they need to ask these children about it. She stated the need to look at trauma which leads to substance abuse which then goes on from there.

Dr. Sherin agreed and stated red flags need to be identified very early. Life circumstances need to be considered to get the impacts required. He stated he has been talking about people, place, and purpose as community for a long time, but if the community is the focus for individuals and there is an opportunity for them in those different domains, they will result in good outcomes. If providers are paid to ensure that an individual has them and is thriving in them, it is a new day.

Commissioner Rowlett stated he has had the unique privilege of working with individuals who have transitioned out of the Napa State Hospital before and after its being a forensic facility. He stated they describe their needs for community support in the same way in many cases that he would describe them except for being insightful about the need to mitigate the factors that caused the trauma that panel members described. He stated those factors that caused the trauma need to be addressed when they return to the community. This is not dependent upon having a psychiatric illness.

Commissioner Rowlett stated it is important that the Commission is highlighting FSPs because the perspective around community supports and FSPs is often best articulated by individuals with their own lived experience, including individuals with experience being in state hospitals who can encourage others in state hospitals that they can live successfully outside of being identified as being a consumer of mental health services,

and that they can have an identity in the United States that is not surrounded by stigma associated with being diagnosed with a psychotic disorder.

Commissioner Rowlett stated hearing that from peers is empowering; however, California has a fee-for-service system. He asked how to get to value-based care or what the Commission's role is in supporting value-based care. He stated the need to pay for what works. Currently, interventions associated with CBT that mitigate some of the negative outcomes are paid for. That is what is pursued rather than having a clubhouse that integrates people with lived experience and family members that changes the trajectory of a person's life. He stated he agreed with the clubhouse scenario but asked how to get there.

Dr. Sherin stated one of the things that is great about the county behavioral health system in California is the innovation fund, but the ability to use innovation funds to pay for outcomes to contractors is something that should be leveraged more. The innovation fund can begin to demonstrate both a humanitarian and cost return on investment. He stated, until California has the courage to push back on the fee-for-service idea and begin to push with a waiver towards outcomes as a state and change things like Medicaid's Institution for Mental Diseases (IMD) exclusion, it will never get there.

Dr. Negron-Munoz added that fee-for-service expects providers to use certain words to receive payment. This sometimes causes providers to miss the true cause of what is happening with their clients. She stated clinicians must be allowed to freely document things as they are so patients receive the right treatment. Clinician notes should not be dictated by the system.

Commissioner Mitchell thanked Commissioner Rowlett and Dr. Sherin for addressing performance management and performance outcomes. She asked how much the hundreds of thousands of dollars that are being billed improve lives. She agreed with Dr. Negron-Munoz about the need to push back. She asked why different outcomes are expected when the same things continue to be done. It does not make sense. She stated she is asking for that lay person who is receiving services weekly waiting for their life to be improved. Billing continues to be done for the same things with no improvement. She asked how to stand in the place where the most good can be done to affect lives by doing performance outcomes.

Commissioner Mitchell stated peers are important but they need to be specialized in different areas. Peers, navigators, and lead care coordinators need to help with the warm handoffs. The state must do better, but it must have an emotional connection to want to help someone's life be better.

Dr. Sherin stated Los Angeles County received a generous donation from a foundation to do incentivized outcome-based contracts for FSP 2.0. He stated the Commission got behind FSP 2.0 and helped support it in other counties, but FSP 3.0 is needed. The FSP 3.0 needs to be driven by simple outcomes. He stated he asked the Governor to let him decrease the number of people who are homeless in Los Angeles County who have a chronic psychotic disorder (which is 10 percent of the homeless population in Los Angeles County) by 10 percent per year over the next five years. He stated he will tell the Governor how much it will cost and ask to be paid, held accountable, and fired if he fails as opposed to paying for expensive audits. He asked to be judged by the fact

that this person is no longer on the street a year later: maybe they are employed and connected with their family of origin, or they have other kinship relationships.

Public Comment

Stacie Hiramoto thanked the Commission for inviting the panelists to present. They were insightful, knowledgeable, and committed. She stated she was confused by the title of this agenda item, when most of the panelists work with individuals who are already in the criminal justice system. Their points were important; however, what was missing was professionals who work with individuals in the community before criminal justice involvement and who believe that their programs prevent individuals from entering the criminal justice system. She stated those existing programs are possibly paid for by prevention and early intervention funding or are Community-based Evidence Practices (CDEPs).

Stacie Hiramoto stated she appreciated Commissioner Chambers's comments, since the consumer voice was missing from the panel. She noted that the consumer voice is important.

Stacie Hiramoto shared a different perspective about the backfiring of the requirement for someone to be dangerous before being forcibly treated. She stated much harm and trauma has been prevented from individuals being forcibly treated when not necessary and when not dangerous. Consumers would say that the tradeoff is worth it.

Stacie Hiramoto stated another thing that was missing that she was glad Commissioner Bunch brought up was the impact of race and ethnicity and other factors on whether individuals are hospitalized versus incarcerated.

Laurel Benhamida, Ph.D., Muslim American Society – Social Services Foundation (MAS-SSF), and REMHDCO Steering Committee, agreed and stated the panel did not address the issue of how individuals with limited English or non-English speakers are treated and how they navigate the system. She stated MAS-SSF is concerned about immigrants nationally and locally, particularly Afghans as well as Syrians and Iraqis. She asked the members of the panel what has improved and what still needs to be done to address racial, ethnic, and linguistic mental health disparities.

Chair Madrigal-Weiss asked Richard Gallo, who was experiencing technical difficulties, to send their comments in an email to staff.

7: Lunch

The Commission took a 45-minute lunch.

8: Universal Mental Health Screening for Children and Youth

Chair Madrigal-Weiss stated the Commission will hear a staff presentation on Phase One of the Universal Screening for Children and Youth Report, as required by the supplemental reporting language in the Budget Act of 2023-24. The goal of this report is to inform the Legislature's future budget and policy decisions related to universal mental health screening of children and youth with the goal of reducing adverse health and life

outcomes later in life stemming from unaddressed mental health issues. She asked staff to present this agenda item.

Kali Patterson, Research Scientist Supervisor, provided an overview, with a slide presentation, of the background, goals and activities, evidence to support universal mental health screening, best practices for universal mental health screening implementation, and key findings presented in the report. She stated universal mental health screening can strengthen the multi-tiered system of support (MTSS) programming and improve outcomes for all students, but no one size fits all. She stated the project aims to address gaps in knowledge and practice and offers a path forward for implementing school-based universal screening in support of California's broader youth behavioral health initiatives. This report focuses on the comprehensive literature review, including a summary of existing research.

Commissioner Comments & Questions

Commissioner Mitchell asked if the goal is to put universal screening in all schools.

Ms. Patterson stated the goal is to provide the necessary information to make an informed decision about whether it would be appropriate or if schools are ready.

Commissioner Robinson appreciated the acknowledgement about potential stigma that can be associated with screening and the sensitivity around parents' right to opt out. He highlighted that responsibility goes along with screening that finds potential issues. He asked that those conversations continue as part of the process to implementation.

Commissioner Rowlett asked how to mitigate Commissioner Robinson's points if the absence of universal mental health screening is causal to poor outcomes for Black and brown children. He asked how to get universal mental health screening more broadly accepted and established, when there are risks that local educational agencies say that they take if they identify problems and do not address them, and when there is stigma associated with Black and brown communities pursuing mental health services.

Commissioner Bontrager stated the importance of treasure hunting, not deficit hunting. He suggested, instead of searching for deficits and then doing something for youth or to youth, learning from youth about their strengths and reservoirs of resiliency.

Public Comment

Steve McNally, family member and Member, Orange County Behavioral Health Advisory Board, speaking as an individual, stated Orange County has a psychologist with 25 years of experience who puts social determinants of health into mental health screening funded by Managed Health Care that found that approximately 8 percent of students had the same suicidal ideation, regardless of whether they were from a wealthy, poor, or middle-income school. The speaker stated to let someone struggle who could have known that they could have gotten help and not to help them because of liability concerns seems wrong. The county created crisis response around schools that they were testing at the time.

Steve McNally stated physical testing is done at 5th, 7th, and 9th grades. Another trigger point would be graduating high school. The speaker suggested doing Adverse

Childhood Experiences (ACEs) Aware or other screening tools that can be tracked through on top of current physical screening.

Steve McNally stated several individuals are on boards from different cultural communities who have more denial than others or are maybe more averse to embracing mental health screenings or the concept of mental health. Addressing the stigma that exists in those communities is important to raise participation and acceptance.

Richard Gallo spoke in support of universal screening but had the following concerns:

- If a student is identified with disabilities, they would be screened through special education so they would do the screening to determine the diagnosis and eligibility for special education services.
- Special education will take advantage, allowing this to be paid for instead of using special education resources. School districts do this – it is all politics and money.

Richard Gallo stated Proposition 1 will have negative effects on programs and services that are currently being funded,but will not be funded in 2026. Peer services programs will be eliminated or reduced significantly because there will be no funding to pay for it. The mental health community needs peers to help with recovery. The speaker stated the California Department of Health and Human Services and the Department of Health Care Services have not answered any of the speaker's questions during the last year in regards to peer workers and the peer workforce with California Advancing and Innovating Medi-Cal (CalAIM), which focuses on community health workers instead of Peer Support Specialists.

Richard Gallo asked why the state is investing in 5,000 peer workers when there is no support, recognition, or respect from state agencies in including them. The speaker stated the need for the Commission to be careful with regards to Proposition 1. Counties will get less funding and programs will go away.

Dr. Benhamida stated she commented on this proposal at a committee meeting saying, with possibly over one million children in the California public school system whose home language is not English, there must be instruments that are suitable for young children that have been normed on young children from those languages of the families of origin.

Action: Chair Madrigal-Weiss asked for a motion to adopt Phase One of the Universal Screening for Children and Youth Report as presented, with the understanding that it will be delivered to the Legislature in March 2024 to be followed by Phase Two in August 2024. Commissioner Carnevale made a motion, seconded by Vice Chair Alvarez, that:

- *The Commission adopts Phase One of the Universal Screening for Children and Youth Report as presented, with the understanding that it will be delivered to the Legislature in March 2024 to be followed by Phase Two in August 2024.*

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

The following Commissioners voted “Yes”: Commissioners Bontrager, Bunch, Carnevale, Chambers, Mitchell, Robinson, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

9: Allocating Best Practice Resources

Chair Madrigal-Weiss stated the Commission will hear a proposal for the use of Mental Health Wellness Act funds to strengthen FSPs and will consider a proposal to use Mental Health Student Services Act (MHSSA) funds to advance best practices in school-based mental health. She asked staff to present this agenda item.

Executive Director Ewing stated there are two pieces to this agenda item. One is about funding to strengthen FSP work, not to approve expenditure of the funds at this time, but for clarification and guidance so staff can develop a proposal. The other piece is about possible approval for the use of available MHSSA funding.

Executive Director Ewing stated, throughout today and consistent with the conversation yesterday, the agenda has been designed to lay out an understanding of the number of Californians who are coming into contact with state hospital programs, with particular emphasis on persons who are deemed incompetent to stand trial.

Executive Director Ewing provided an overview, with a slide presentation, of the FSP logic model, the rising need for high-quality FSPs, and possible solutions. He stated individuals who are unhoused, justice involved, and hospitalized often miss many opportunities. As Dr. Sherin stated, incompetent to stand trial is an inconsistent, incompetent delivery system. FSPs, originally designed to be the last step of a safety net, were intended to prevent homelessness, incarceration, and hospitalization. Upstream from that are opportunities for better intervention, particularly around early psychosis.

Executive Director Ewing stated strengthening FSPs as an effective intervention to prevent homelessness, reduce unnecessary hospitalizations by intervening better and faster, and prevent justice involvement can and should be a priority. Staff is asking for permission and direction to develop a technical assistance and investment proposal using $20 million of Mental Health Wellness Act funding to help look at key pieces that are necessary to strengthen FSPs.

Executive Director Ewing stated the focus will be to restructure current funding models toward outcomes-based contracting, provide technical assistance to create a standardized model of FSPs, collaborate to improve data collection and standardize reporting, support innovative workforce development solutions, and foster public trust and understanding of the role of FSP.

Commissioner Comments & Questions

Vice Chair Alvarez asked how this relates to the Mental Health Wellness priorities already identified.

Executive Director Ewing stated the Commission identified a range of priorities, some of which it has already made investments in – older adults, reducing delays in hospital bed boarding, and substance use disorder. The identified priorities remaining are age 0-5 and peer respite. Strengthening FSPs will be added to the existing list of priorities.

Commissioners asked clarifying questions.

Presentation, continued

Riann Kopchak, Chief of Community Engagement and Grants, continued the slide presentation and discussed the background, goals, grantee survey/poll results, youth listening session, and areas of funding. She stated this RFA for MHSSA funding will be the fourth round of funding issued by the Commission. Key takeaways from the listening session were that taking away these services would be detrimental to the culture and devastating to the school environment, and expanding access to, funding for, and availability of peer support resources as an avenue to increasing student buy-in, adding to the workforce, bolstering services, and providing training education to students are needed.

Commissioner Comments & Questions

Commissioner Bontrager asked if the funding must flow through county behavioral health.

Executive Director Ewing stated the law requires a partnership between county behavioral health, local educational agencies, county office of education, and/or charter schools. The county does not need to be the lead but they must consent.

Commissioner Robinson asked for additional detail on how the universal mental health screening request ties in with what staff presented earlier today.

Ms. Kopchak stated the Legislature requested that strategies, tools, resources, triage, referral services, training programs, technical assistance, cost estimates, and legal consideration be identified. While the universal screening program is ongoing, this provides an opportunity for grantees to collect some of the data to help focus efforts to inform that report.

Vice Chair Alvarez stated this provides the opportunity to connect dots across initiatives and conversations that are happening, particularly in light of the Children and Youth Behavioral Health Initiative (CYBHI) and Proposition 1. Many conversations are happening separately and the Legislature is not always getting a complete picture. The MHSSA funding seems like it has been done piecemeal. She asked if there is an opportunity for a legislative briefing that helps explain the incredible work that is happening through the MHSSA to date and how it is woven into the broader strategy that is happening to reform systems.

Vice Chair Alvarez asked how this round differs from the earlier rounds.

Commissioner Robinson agreed that it feels piecemeal. He asked how to learn from what is being done.

Executive Director Ewing stated it has been done piecemeal because of how the funding was allocated and the various timeline deadlines; however, it is not as haphazard as it might feel in that there is learning going on. Today's proposal was driven by partner responses to the grantee survey and poll that asked what would be most helpful. He stated the need to recognize that the burden is on local partners to do the integration across the CYBHI fee schedule and new accountability requirements that would be imposed by Proposition 1, should it pass.

Executive Director Ewing stated at the same time the Commission has been investing in multi-county learning collaboratives in different areas around finance, data, and youth engagement, and has been in discussion with the Governor and the Legislature about putting the organizational leadership in place to move away from a broad-brush approach of a lot of funding quickly to more consistent, systematic investments in what has been proven to work. He noted that this is consistent with the Commission's strategic plan on how to promote strategies that work and how to learn what works when what works is not yet known. He stated the next agenda item will include information on the Commission's effort to establish an Office of School Mental Health to bring that kind of leadership.

Executive Director Ewing stated all parties involved recognize the need to move from just trying something new to considering what works and creating systems to support local educational agencies and behavioral health partners to be successful in supporting students. These dollars were a step in that direction, responding to what partners said would be most helpful.

Commissioner Mitchell stated students have a lot of say but adults are making decisions for them. She asked about the low student participation in the listening sessions.

Ms. Kopchak stated the listening sessions were held after school. MHSSA Grantees were asked to hold listening session parties. She stated, although 50 students were counted on the screen, there may have been more students in the room who were not on camera. The students provided great feedback and were from as far north as Tehama County down to San Diego County and included large, small, urban, and rural counties.

Ms. Kopchak stated, in addition to the listening session, the Commission has been holding a series of K-12 advocacy events. To date, staff has gone to Fresno, Sacramento, and Humboldt Counties. Approximately 50 students participated in each event. The same feedback is being received from these students as the original 50 at the MHSSA Grantee listening session parties. The final K-12 advocacy event will be held this weekend in San Bernardino.

Commissioner Mitchell asked about the demographic breakdown of the students who participated in these events.

Ms. Kopchak stated multiple ethnicities were represented, although the numbers could not be quantified.

Commissioner Mitchell asked staff to request demographic information from schools or grantees and on surveys in the future and to ensure diverse representation.

Public Comment

Stacie Hiramoto thanked Vice Chair Alvarez and Commissioner Mitchell for their comments and questions. She stated concern that students and their families do not always feel comfortable at the school. The safety net is not always there. She suggested partnering with community-based organizations that serve Black and Indigenous people of color (BIPOC) and LGBTQ communities.

Stacie Hiramoto stated she was less comfortable with the FSP piece because she has been unable to find the data on disparities in FSPs. She suggested paying attention to BIPOC and LGBTQ communities in proposals and RFPs.

Graciela vanWormer stated she emailed her comment to staff.

Chair Madrigal-Weiss stated staff will contact Graciela vanWormer offline.

Richard Gallo stated concern with the FSP piece. The speaker stated the need to include peer workers in the FSP requirements. The speaker stated the need to use a standard user tool for accurate data collection. The data collection issue has been going on for much too long. The speaker suggested reviewing how the Centers for Independent Living does their data collection to use as a model for all county grant programs.

Chair Madrigal-Weiss entertained two separate motions as follows:

Action: Chair Madrigal-Weiss asked for a motion to authorize a set-aside of $20 million of Mental Health Wellness Act funding to strengthen Full-Service Partnerships and ask staff to present a specific funding proposal at a future meeting. Commissioner Rowlett made a motion, seconded by Commissioner Carnevale, that:

- *The Commission authorizes a set-aside of $20 million of Mental Health Wellness Act funding to strengthen Full-Service Partnerships and asks staff to present a specific funding proposal at a future meeting.*

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

The following Commissioners voted “Yes”: Commissioners Bontrager, Bunch, Carnevale, Chambers, Mitchell, Robinson, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

Action: Chair Madrigal-Weiss asked for a motion to authorize staff to initiate a competitive bid process and award $25 million in grants to the highest scoring applicants to advance best practices in school-based mental health. Commissioner Carnevale made a motion, seconded by Commissioner Robinson, that:

- *The Commission authorizes staff to initiate a competitive bid process and award $25 million in grants to the highest scoring applicants to advance best practices in school-based mental health.*

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

The following Commissioners voted “Yes”: Commissioners Bontrager, Bunch, Carnevale, Chambers, Mitchell, Robinson, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

10: Legislative Priorities

Chair Madrigal-Weiss stated the Commission will consider legislative and budget priorities for the current legislative session. She asked staff to present this agenda item.

Kendra Zoller, Legislative Deputy Director, provided an update on the three proposals that the Commission asked to pursue this year as sponsored bills: establishing an Office of School Mental Health, establishing a Workplace Mental Health Center of Excellence within the University of California system, and reintroducing the Commission's 2021 sponsored bill to establish local youth advisory boards. She stated, because of the budget deficit, staff was unable to get a bill to establish an Office of School Mental Health or the Workplace Mental Health Center of Excellence within the University of California; however, those ideas in concept were met with positive feedback. Other avenues will be pursued to achieve their success.

There were no questions from Commissioners and no public comment.

11: Adjournment

Chair Madrigal-Weiss stated the next Commission meeting will take place on March 28th in Sacramento. There being no further business, the meeting was adjourned at 3:08 p.m.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
February 22, 2024

Motion #: 1

Date: February 22, 2024

Proposed Motion:

The Commission approves the January 25, 2024 Meeting Minutes

Commissioner making motion: Commissioner Robinson

Commissioner seconding motion: Vice Chair Alvarez

Motion carried 9 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	Not Voting
1. Commissioner Bontrager	☐	☐	☒	☐	☐
2. Commissioner Brown	☐	☐	☐	☒	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☒	☐	☐	☐	☐
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☐	☐	☐	☒	☐
10. Commissioner Gordon	☐	☐	☐	☒	☐
11. Commissioner Mitchell	☒	☐	☐	☐	☐
12. Commissioner Robinson	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary
Commission Meeting
February 22, 2024

Motion #: 2

Date: February 22, 2024

Proposed Motion:

That the Commission approves the Consent Calendar that includes funding for:

• Riverside County's Eating Disorder Intensive Outpatient and Training Program Innovation Project for up to $29,139,565, and

• The reallocation of $2 million of allcove™ youth drop-in center funding to expand existing allcove™ programs.

Commissioner making motion: Commissioner Mitchell

Commissioner seconding motion: Commissioner Carnevale

Motion carried 9 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	Not Voting
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Brown	☐	☐	☐	☒	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☐	☐	☒	☐	☐
7. Commissioner Chen	☒	☐	☐	☐	☐
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☐	☐	☐	☒	☐
10. Commissioner Gordon	☐	☐	☐	☒	☐
11. Commissioner Mitchell	☒	☐	☐	☐	☐
12. Commissioner Robinson	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary
Commission Meeting
February 22, 2024

Motion #: 3

Date: February 22, 2024

Proposed Motion:

That the Commission adopt Phase One of the Universal Screening for Children and Youth Report as presented, with the understanding that it will be delivered to the Legislature in March 2024 to be followed by Phase Two in August 2024.

Commissioner making motion: Commissioner Carnevale

Commissioner seconding motion: Vice Chair Alvarez

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

Name	Yes	No	Abstain	Absent	Not Voting
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Brown	☐	☐	☐	☒	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☐	☐	☐	☐	☒
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☐	☐	☐	☒	☐
10. Commissioner Gordon	☐	☐	☐	☒	☐
11. Commissioner Mitchell	☒	☐	☐	☐	☐
12. Commissioner Robinson	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary
Commission Meeting
February 22, 2024

Motion #: 4

Date: February 22, 2024

Proposed Motion:

The Commission authorizes a set aside of $20 million of Mental Health Wellness Act funding to strengthen Full-Service Partnerships and asks staff to present a specific funding proposal at a future meeting.

Commissioner making motion: Commissioner Rowlett

Commissioner seconding motion: Commissioner Carnevale

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

Name	Yes	No	Abstain	Absent	Not Voting
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Brown	☐	☐	☐	☒	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☐	☐	☐	☐	☒
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☐	☐	☐	☒	☐
10. Commissioner Gordon	☐	☐	☐	☒	☐
11. Commissioner Mitchell	☒	☐	☐	☐	☐
12. Commissioner Robinson	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

AGENDA ITEM 5

Action

April 25, 2024 Commission Meeting

MHSOAC Conflict of Interest Code Update

Summary: The Commission will consider approving amendments to the MHSOAC Conflict of Interest Code in response to new staffing classifications and organizational adjustments stemming from the passage of Proposition 1 on March 5, 2024 (SB 326, Stats. 2023, Ch.790).

As mandated by the California Fair Political Practices Commission (FPPC), all state entities, including the Commission, must conduct a biennial review of their Conflict of Interest Code to assess the necessity of amendments. These proposed amendments are needed due to statewide changes in staff position classifications, new hires, and shifts within the Commission prompted by the enactment of Proposition 1. The amendments include adjustments to the individuals obligated to report specified economic interests on the Statement of Economic Interest (Form 700) and involve slight modifications to the disclosure categories describing the economic interests to be reported.

Background: As authorized by the Political Reform Act, FPPC requires every state agency to maintain a Conflict of Interest Code, identifying officials and employees involved in governmental decision-making processes. This Code is a regulation that requires a public comment period (Rule Making Process). Each agency Code must:

- Specify positions required to disclose economic interests on Form 700.
- Assign disclosure categories outlining the types of economic interests to be disclosed on Form 700.

It is essential and legally required that an agency's Conflict of Interest Code accurately reflects its organizational structure, identifies officials obligated to file a Form 700, and defines disclosure categories pertinent to potential conflicts of interest.

Recognizing changes in positions and the Commission's structure following the passage of Proposition 1, Commission staff, in collaboration with the FPPC, has deemed an amendment to the MHSOAC Conflict of Interest Code necessary. The amendments have been developed accordingly.

Enclosures (2): (1) Amended MHSOAC Conflict of Interest Code; (2) Explanation of Changes.

Handouts: A PowerPoint presentation will be provided.

Proposed Motion: The Commission adopts the amendments to the Conflict of Interest Code as presented in Agenda Item 5 and authorizes the Executive Director to initiate the Rule Making Process prior to filing the Code with the Fair Political Practices Commission.

Mental Health Services Oversight and Accountability Commission

CONFLICT-OF-INTEREST CODE

The Political Reform Act (Government Code Section 81000, et seq.) requires state and local government agencies to adopt and promulgate conflict-of-interest codes. The Fair Political Practices Commission has adopted a regulation, 2 California Code of Regulations Section 18730 that contains the terms of a standard conflict-of-interest code, in an agency's code. After public notice and hearing, the standard code may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act. Therefore, the terms of 2 California Code of Regulations Section 18730 and any amendments to it duly adopted by the Fair Political Practices Commission are hereby incorporated by reference. This regulation and the attached Appendices designating positions and establishing disclosure categories, shall constitute the conflict-of-interest code of the **Mental Health Services Oversight and Accountability Commission (MHSOAC)**.

Commission members and the Executive Director shall file their statements of economic interests electronically with the **Fair Political Practices Commission**. All other individuals holding designated positions shall file their statements with the **MHSOAC**. All statements must be made available for public inspection and reproduction under Government Code Section 81008.

NOTE: authority cited: Sections 81008, 87300, 87306, Government Code. Reference: Section 87302, Government Code.

Mental Health Services Oversight and Accountability Commission

CONFLICT-OF-INTEREST CODE

APPENDIX A
Designated Positions

Designated Positions	Disclosure Category
Commission Member	1, 2
Executive Director	1, 2
CEA (All levels)	1, 2
Attorney (All levels)	1, 2
Consulting Psychologist	1, 2
Information Officer (All levels)	2
Research Scientist Manager	1, 2
Research Scientist Supervisor (All levels)	2
Research Scientist (All levels)	2
Staff Services Manager (All levels)	1, 2
Research Data Specialist (All levels)	2
Research Data Analyst (All levels)	2
Health Program Specialist (All levels)	2
Staff Mental Health Specialist	2
Associate Governmental Program Analyst	2
Associate Personnel Analyst	2
Fellow	2
Information Technology Manager (All levels)	3
Information Technology Specialist (All levels)	3
Consultant and/or New Positions	*

*Consultants and/or New Positions shall be included in the list of designated employees and shall disclose pursuant to the broadest disclosure category in the code subject to the following limitations:

The Executive Director may determine in writing that a particular consultant and/or a New Position, although a “designated position,” is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant’s and/or New Position’s duties and, based upon that description, a statement of the extent of disclosure requirements. This determination is a public record and shall be retained for public inspection in the same manner and location as this conflict-of-interest code.

Mental Health Services Oversight and Accountability Commission

CONFLICT-OF-INTEREST CODE

APPENDIX B
Disclosure Categories

Disclosure Category 1

A person holding a position designated in Disclosure Category 1 must report all investments, business positions in business entities, and all income (including gifts, loans, and travel payments) from sources that operate programs or provide services related to the responsibilities of the Mental Health Services Oversight and Accountability Commission. This includes but is not limited to programs offering behavioral health services and substance use disorder treatment as outlined in the Mental Health Services Act and related components of California's behavioral health system.

Disclosure Category 2

A person holding a position designated in Disclosure Category 2 must report all investments, business positions in business entities, and all income (including gifts, loans, and travel payments) from sources that provide services, equipment, materials, vehicles, and supplies, to the MHSOAC including but not limited to:

- Contracts to evaluate the outcomes and performance of the Mental Health Services Act and California's behavioral health system
- Contracts related to Commission-led meetings or sponsored events such as court reporters/transcribers, interpreters, leased facilities, A/V services, and public relations
- Contracts related to training, consulting, or community engagement by or for the Commission

Disclosure Category 3

A person holding a position designated in Disclosure Category 3 must report all investments, business positions in business entities, and all income (including gifts, loans, and travel payments) from sources that engage in information technology services utilized by the Commission. This includes but is not limited to services related to data collection, analysis, reporting, and management systems supporting the Commission's research and evaluation functions.

Conflict of Interest Code for MHSOAC

Explanation of Changes

Conflict of Interest Code, Page 1

Description of Changes
No Change.

Conflict of Interest Code, Appendix A, Page 2

Position	Description of Changes
Commission Member	No Change.
Executive Director	No Change.
CEA (All levels)	No Change.
Attorney (All levels)	ADD position. Pay Letter 12-11 Changed the Class Title from Staff Counsel to Attorney.
Staff Counsel (All levels)	DELETE position. Pay Letter 12-11 Changed the Class Title from “Staff Counsel” to “Attorney”.
Consulting Psychologist	No Change.
Information Officer (All levels)	No Change.
Research Scientist Manager (All levels)	ADD position. Reclassified position, formerly Research Scientist Supervisor II. Reclassification was necessary to reflect the expanded scope and duties of the position.
Research Scientist Supervisor (All levels)	ADD position levels. Changed level “II” to “All levels” to accommodate the inclusion of the new Research Scientist I position per approved Budget Change Proposal 4560-012-BCP-2022-GB.
Research Scientist (All levels)	No Change.
Staff Services Manager (All levels)	No Change.

Position	Description of Changes
Mental Health Program Supervisor	DELETE position. Reclassified to Health Program Manager III to better align with the scope and duties of the position.
Health Program Manager III	DELETE position. Reclassified two existing Health Program Manager III positions to Staff Services Manager III positions to better align with the scope and duties of the positions.
Research Program Specialist (All levels)	DELETE position. Abolished by CalHR's Research Data Series Consolidation Project, which was adopted by SPB on July 6, 2018 and effective August 1, 2018.
Research Data Specialist (All levels)	No Change.
Research Data Analyst (All levels)	ADD position. Reclassified two existing Associate Governmental Program Analyst positions to better align with the scope and duties of the positions.
Staff Mental Health Specialist	No Change.
Health Program Specialist (All Levels)	No Change.
Associate Governmental Program Analyst	No Change.
Associate Personnel Analyst	ADD position. New blanket position utilized in Human Resources to assist with payroll and transactions workload.
Fellow	ADD position. New position established by Assembly Bill 1134 (Gloria), Chapter 412, Statutes of 2017 which authorized the Commission to establish a Mental Health Policy Fellowship for a clinical fellow and a behavioral health consumer.
Staff Information Systems Analyst	DELETE positon. Abolished by CalHR's Information Technology Consolidation Project, which was adopted by SPB on January 11, 2018 and effective January 31, 2018.
Information Technology Manager (All levels)	ADD position. New position per approved Budget Change Proposal 4560-001-BCP-2023 GB.
Information Technology Specialist (All levels)	No Change.
Consultant and/or New Positions	No Change.

Conflict of- Interest Code, Appendix B, Page 3

Description of Changes
Disclosure Category 1 – This category has been revised to include substance use disorder treatment programs and remove obsolete language related to the Commission's direct approval of county programs.
Disclosure Category 2 – The adjustments made to this category involved refinements in technical language.
Disclosure Category 3 - Additional language has been added to this category to provide clarity and broaden the scope of examples regarding Information Technology services requiring disclosure.

AGENDA ITEM 6

Action

April 25, 2024 Commission Meeting

Transformational Change in Behavioral Health: Prevention and Early Intervention

Summary:
The Commission has invited leadership from the California Health and Human Services Agency to provide a broad overview of the Governor's Behavioral Health Reform efforts, with a focus on Proposition 1, the key changes in the law under Proposition 1, including the role of the Commission under recently enacted reforms.

Background:
Proposition 1, approved by the voters in March 2024, revises California's Mental Health Services Act, and among other changes, elevates attention on prevention, early intervention, Full Service Partnership, housing, and related strategies to improve mental health outcomes. Proposition 1 also provides bond funding to meet housing and related needs.

In addition to the newly renamed Behavioral Health Services Act with the passage of Proposition 1, the State has supported a broader array of effort to expand access to care through more expansive access to federal Medicaid-funded services, new state funding for housing and community schools, increased attention on the needs of children and youth through the Child and Youth Behavioral Health Initiative, stronger partnerships between community behavioral agencies and schools under the Mental Health Student Services Act, and other reforms and funding opportunities.

Among other changes, under the BHSA the State will take on new responsibilities for prevention, early intervention, innovation, fiscal transparency, accountability, revenue stability, and meeting workforce needs.

Issues for Consideration:
The Commission has developed significant capacity and/or guidance on community engagement, prevention, early intervention, building learning networks, accountability tools and strategies and more.

How can the Commission best support the implementation of the Behavioral Health Services Act?

Enclosure: Policy Brief: Understanding California's Recent Behavioral Health Reform Efforts

Presenter: Stephanie Welch, Deputy Secretary of Behavioral Health

Policy Brief:

Understanding California's Recent Behavioral Health Reform Efforts

INTRODUCTION

California is at a tipping point for mental health and substance use disorders, collectively known as behavioral health.

As this plan comes together, a working adult struggling with anxiety will be able to reliably depend on their employer sponsored health insurance to provide the services they need, a parent whose child is beginning to show early signs of a serious mental illness will be connected to early assessment and intensive treatment, and an unhoused neighbor struggling with co-occurring mental health and substance use disorders who has fallen through every crack in the system will have access to housing, treatment, and a path to recovery.

The truth is: We all struggle. At some point in our lives, we will all either have a challenge with mental health or substance use ourselves – or be supporting a parent, child, neighbor, friend, or coworker through their journey with behavioral health.

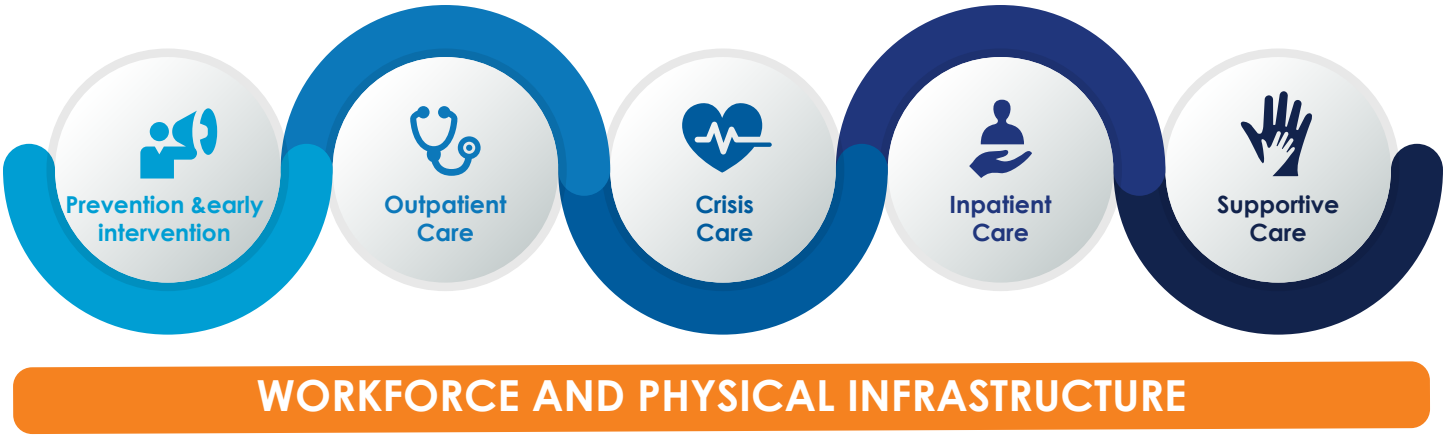
The weight of this crisis is not carried equally. Communities of color, people involved with the justice system, and those who are LGBTQ+ carry the heaviest burden.

Because these challenges cannot wait, the Newsom Administration has invested **a historic $10 billion in the full spectrum of behavioral health services**, because **all Californians are entitled to quality, culturally competent behavioral health services when, how, and where they need them.**

Together we are developing a thoughtful set of connected programs that provide tools to help anybody, anywhere, anytime with their unique behavioral health challenges.

This behavioral health plan pulls every lever the government has at its disposal, from setting a bold policy agenda, to creating and implementing new initiatives, to simplifying and streamlining programs, to enforcing laws and regulations. As we continue this journey, some changes will be immediate and visible, and others will require more patience and time.

Behavioral Health Continuum



Increasing Access by Building Workforce, Infrastructure

Undergirding all of California's behavioral health efforts are investments to build the pipeline of providers and the physical infrastructure needed for these services.

For behavioral health care to be truly accessible, services must be available when Californians need them. Providers must speak our language, look like us and come from our communities.

That's why the Administration is investing

$1.4 billion to create tens of thousands of new behavioral health professionals – offering tuition assistance and loan forgiveness and funding training programs.

We also need brick-and-mortar spaces for care, to address historic gaps and to meet growing demand for services across the lifespan. So, California has set aside **$2.2 billion** to ensure care can be provided in the least restrictive settings and within the community through a wide range of options.

Prevention and Early Intervention

It's important to recognize that for many Californians, there is still a stigma around mental health and substance use challenges. This is why it is important to both normalize the conversation around behavioral health and emphasize prevention.

In August 2022, the Administration announced a Master Plan for Kids' Mental Health, an integrated multi-year effort uniting historic investments to better serve the state's diverse children, youth, and families. At the core of the Master Plan is a historic, five-year, $4.7 billion initiative that focuses on promoting mental, emotional, and behavioral health and well-being; prevention and providing services; support and screening; and addressing inequities.

These efforts will increase access to a wide range of mental health services in schools, allowing schools to reach more students and provide more counseling and mental health supports. Schools are a critical access point for mental health and substance use services, especially for African American, Native American, Pacific Islander, and LGBTQ+ students.

Critically, in response to the exponential increase in overdoses, the state will soon launch a $40.8 million education and awareness campaign focused on opioids and fentanyl.

California is also investing more than $80 million to increase overdose reversal medication distribution to first responders, law enforcement, community-based organizations, middle and high schools, and county agencies to reverse overdoses.

To further support the success of these efforts, the state is investing $100 million in a youth-led campaign to destigmatize the conversation around youth mental health and substance use struggles.

Outpatient Care

For all Californians to be able to access behavioral health care when they need it, the state is holding commercial plans, which cover more than half of all Californians, accountable and reforming Medi-Cal, California's Medicaid program.

On the commercial side, California has some of the strongest behavioral health "parity" requirements in the country, requiring coverage of "medically necessary" services to treat mental health and substance use disorders. The treatment cannot be limited to short-term or acute treatment.

To enforce these laws, the state has dedicated $22 million over five years to conduct behavioral health-focused investigations of commercial health plans to make sure they are meeting state law – and taking enforcement action against those that are not. Californians are paying health care premiums for behavioral health care; they deserve access to it.

On the public side, Medi-Cal has vastly expanded the use of telehealth, which made behavioral health care far more accessible for some.

And California is in the process of completely reforming Medi-Cal behavioral health delivery through numerous federal waivers, including CalAIM and the proposed California Behavioral Health Community-Based Continuum Demonstration.

There will be a "no wrong door" approach to ensure beneficiaries receive mental health services regardless of where they seek care, even if the beneficiary is ultimately transferred somewhere else due to their level of impairment and mental health needs.

Medi-Cal is also reforming how county behavioral health systems are paid to reward better care and quality of life for Medi-Cal beneficiaries.

Other outpatient benefits available under Medi-Cal will include:

- Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT). ACT offers a wide range of medical and social services to people living with serious mental illness. Provided by a multidisciplinary team, the services are provided 24/7 for as long as needed and wherever they are needed. FACT builds on this model and adjusts based on criminal justice issues.

- Contingency Management, which promotes healthy behaviors through positive reinforcement (such as gift cards) for people living with stimulant use disorder who reduce or eliminate their stimulant use.

- Medication Assisted Treatment, which is the use of medication along with counseling to treat substance use disorders. This program is being expanded to increase access to treatment and reduce opioid overdose deaths with a special focus on underserved communities, including youth, rural areas and American Indian and Alaska Native tribal communities.

Crisis Care

Sometimes, of course, people have more urgent needs than can be covered by outpatient services, which is why California is building a robust system of crisis care.

During the pandemic, the state created the successful CalHOPE program, a crisis line and online platform to address stress and anxiety. It offers free outreach, individual and group crisis counseling and support. Since its inception, more than 1.3 million Californians have used CalHOPE services.

The state is also investing to build out crisis call center capacity to support the transition to 988, which is an alternative to 911 when people are experiencing a mental health crisis. It's an unprecedented opportunity to improve behavioral health crisis prevention, response, and stabilization. The easy-to-remember, three-digit number is available 24/7, 365 days per year and provides access to crisis counseling, often in several languages and via text or online chat.

In addition, Medi-Cal beneficiaries will be eligible for mobile crisis services, community-based de-escalation and relief for individuals experiencing a behavioral health crisis wherever they are, including at home, work, school, or in the community. The benefit is meant to reduce unnecessary law enforcement involvement and ER visits for people in crisis.

Inpatient Care

There are times when the best setting for someone's care is in a hospital or residential setting, so California is not only building more infrastructure to make sure those beds are available, but also improving that care.

CalAIM and CalBH-CBC will enhance care in psychiatric hospitals and residential settings by ensuring that patients' physical, mental and substance use conditions are treated and that patients are only kept in inpatient care until they can transition to community-based care.

Beneficiaries will also receive support before discharge from inpatient and residential treatment and will be supported during the transition and connected to community-based services and supports, including housing support.

Another form of inpatient care takes place at State Hospitals, which increasingly provide inpatient care for people facing felony charges and found incompetent to stand trial due to a serious mental illness, the majority of whom are also homeless. California is investing more than $600 million in new resources to ensure these individuals get access to treatment quickly and to create options to safely support community-based care and housing stability and reduce recidivism.

Supportive Care

California is also providing a range of supports to help people with the most extensive needs get the help they need to care for their mental illness and/or substance use disorder. These services include:

- The CARE Act, a compassionate civil court process that provides care to the most severely ill based on evidence that many people can stabilize, begin healing, and exit homelessness in less restrictive, community-based care that prevents more restrictive conservatorships or incarceration.
- Behavioral Health Bridge Housing, which will provide $1.5 billion to create and fund new clinically enhanced housing settings for people experiencing homelessness who have complex behavioral health conditions.
- Justice-involved initiatives under CalAIM. California is the first state in the nation to offer a targeted set of Medicaid services to youth and adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release to assist people leaving incarceration connect to the physical and behavioral health services they need prior to release.
- Enhanced care management will be available to help Medi-Cal enrollees with the highest needs. It will meet beneficiaries wherever they are – on the street, in a shelter, in their doctor's office, or at home. Beneficiaries will have a single lead care manager who will coordinate care among the physical, behavioral, dental, developmental, and social services delivery systems, making it easier for them to get the right care at the right time.
- Rent and transitional housing under CalAIM to provide up to six months of rent or temporary housing for beneficiaries who are homeless or at risk of homelessness after receiving treatment in an institutional setting.
- Community supports including housing deposits, short-term post-hospitalization housing, recuperative care, and sobering centers.
- Supported employment services to help Medi-Cal beneficiaries find and keep employment so they have income to maintain housing.

CONCLUSION

Over time, this plan will lead California to a behavioral health system that:

- Reduces misinformation, stigma and discrimination and increases knowledge, acceptance and support for care;
- Reduces the delay from the onset of symptoms to treatment and increases ongoing engagement in care;
- Reduces disparities in utilizing services among BIPOC and LGBTQ+ communities and increases access to culturally responsive care;
- Reduces the proportion of individuals with mental health and substance use disorders in prisons and jail and increases high-quality community care placements;
- Reduces the risk of homelessness and housing insecurity and increases educational and employment opportunities; and
- Reduces disappointment and frustration and increases satisfaction and trust in the quality of services received.

AGENDA ITEM 8

Action
April 25, 2024 Commission Meeting

Transformational Change in Behavioral Health: Innovation

Summary:
The Commission will hear a presentation on changes to California's approach to innovation in behavioral health with the passage of Proposition 1, and opportunities to support ongoing behavioral health innovation.

Proposition 1, approved by voters in March 2024, revises California's Mental Health Services Act, and among other changes, elevates attention on prevention, early intervention, Full Service Partnership, housing, and related strategies to improve mental health outcomes. Proposition 1 also provides bond funding to meet housing and related needs.

Presently, county behavioral health programs must use five percent of their MHSA funding for innovative programs. Counties are required to obtain approval from the Commission prior to using innovation funds. Those funds are intended to support learning and improved approaches to meeting the behavioral health needs of residents. Among other changes, Proposition 1 eliminates the requirement for counties to set aside five percent of their funding for Innovation.

In its place, the BHSA establishes two opportunities for innovation:

1. Consistent with existing law, under the BHSA counties are required to prepare Integrated Plans for Behavioral Health and Outcomes. Among other requirements, counties are directed to demonstrate "…how the county will strategically invest in early intervention and advanc(e) behavioral health innovation."

2. The BHSA allocates $20 million per year to the Commission, for five years, beginning in 2026-27 to support behavioral health innovation. The law also allows the Commission to dedicate funding from the Mental Health Wellness Act to support innovation. In using those funds, the Commission is directed to award grants to private, public, and nonprofit partners to promote development of innovative mental health and substance use disorder programs and practices with a focus on improving services, and outcomes, and meeting the needs of underserved and low-income populations.

Issues for Consideration:
Proposition 1 eliminates the innovation funding requirement but calls for ongoing innovation. How might the Commission support the ability of the counties to sustain innovations in their local programs?

What strategies should the Commission consider to support the success of its direct funding for innovation beginning in 2026-27?

Recognizing that counties continue to hold unspent MHSA innovation funding, and the Commission has a queue of innovation funding requests for consideration, should the Commission encourage the use of Innovation funds to support county transition from the MHSA to the BHSA?

Enclosure: None

Presenter:
Toby Ewing, Executive Director, Mental Health Services Oversight and Accountability Commission

AGENDA ITEM 9

Action

April 25, 2024 Commission Meeting

2023-24 Spending Plan Update

Summary

California Governor Gavin Newsom and legislative leaders have taken decisive action to address the state's budget deficit. They recently announced a $17.3 billion early action plan aimed at reducing the shortfall. Here are the key details:

1. Budget Gap: California is facing an estimated spending gap of up to $73 billion.
2. Early Action: The plan focuses on addressing part of the deficit before the regular budget process later this spring.
3. Components of the Plan:
    - Program Cuts: While some program cuts are included, the plan primarily relies on:
    - New Revenue: A nearly $4 billion expansion of a tax on health insurance plans that allows the state to draw matching federal funds.
    - Internal Borrowing: Utilizing internal borrowing and funding delays and shifts for savings.
4. Legislative Approval: The package is expected to come up for a vote in the Legislature in the next few weeks.
5. Governor's Statement: Governor Newsom expressed gratitude to legislative leaders for their partnership in addressing the shortfall. He emphasized the importance of a balanced approach that meets Californians' needs and maintains a strong fiscal foundation for the state's future.
6. Reserves and Funding Freeze: The plan includes language to freeze one-time funding from past years and an agreement to tap into half of the state's reserves in the upcoming budget.

This early action agreement represents a critical first step in shrinking the state's shortfall and ensuring an on-time balanced budget. Governor Newsom, Senate President Pro Tem Mike McGuire, and Assembly Speaker Robert Rivas are committed to addressing California's budget challenges.

Governor Newsom will present his revised budget proposal in May. California lawmakers will then have until June 15 to finalize a budget that can pass both houses of the legislature and be signed into law by Newsom. The budget must be balanced by the end of the fiscal year on June 30.

Update on the Commission's 2023-2024 Spending Plan

Each year, the Mental Health Services Oversight and Accountability Commission is presented with a budget update in July at the beginning of the new fiscal year. It is also presented in January which coincides with a presentation on the Governor's proposed budget for the following fiscal year. Staff also provide a budget presentation in May that coincides with the Governor's May Revision. These presentations aim to support fiscal transparency and ensure that Commission expenditures are in line with the Commission's priorities.

Background:

The Commission's budget is organized into three main categories: Operations, Budget Directed, and Local Assistance.

- Operations: Includes Personnel and Core Operations. These funds are provided for staff, rent, and other related expenses needed to support the work of the Commission. Funding is usually ongoing with some exceptions such as one-time funding to support Commission directed initiatives.
- Budget Directed: Funding provided in the Governor's Budget Act for technical assistance, implementation, and evaluation of grant programs with one-time and ongoing funding that is allocated over multiple fiscal years.
- Local Assistance: Includes the majority of Commission's funding that is provided to counties and other local partners. Funding is provided via grants to counties or organizations on an ongoing and/or one-time basis, spread over multiple fiscal years.

Annual funding in the Commission's budget can be authorized for a single fiscal year, or multiple fiscal years. Fluctuations in annual funding reflect the availability of one-time funding, funding authorizations that are available over multiple years and periodic on-going budget decisions that result in either growth or reductions in expenditure authority.

Staff will present and update on the Commission's 2023-24 spending plan and request consideration.

Presenter(s): Norma Pate, Deputy Director

Enclosures: None

Handouts: PowerPoint slides will be made available at the Commission Meeting

Proposed Motion: The Commission approves the revised Fiscal Year 2023-24 spending plan.

AGENDA ITEM 10

Action
April 25, 2024 Commission Meeting
Legislative Update

Summary:
The Commission has prioritized an active role in policymaking related to mental health. Commission staff meets regularly with policy staff from legislative committees and works with leadership, member staff and representatives from the Mental Health Caucus, the Republican Caucus, the Legislative Analyst's Office, and the Administration on legislation related to the Commission's work.

The Commission is routinely asked to consult or provide guidance on legislative proposals under development, proposals that would impact the Commission's operations or that would result in new duties of the Commission. Commission staff also actively promote legislative priorities consistent with the direction of the Commission, typically in the form of recommendations adopted through the Commission's policy projects.

At the April Commission meeting, Commissioners will have the opportunity to discuss and consider taking positions on legislation that will create continuous improvement and transformational change to the mental health system.

Item for Consideration:

- **Assembly Bill 2352 (Irwin)**
  - Summary: This bill seeks to build out a legal framework for Psychiatric Advance Directives (PADs) in California, which will work in tandem with a pilot project already underway in seven counties across the state to expand use of PADs and ensure access to first responders and health care professionals.
  - Sponsor: Kiran Sahota, Concepts Forward Consulting
  - Opposition: Disability Rights California; Mental Health America of California

- **Assembly Bill 2711 (Ramos)**
  - Summary: This bill would revise school suspension and expulsion policies for drug-related infractions by requiring local education agencies to create policies using a public health approach, in lieu of suspensions and expulsions.
  - Sponsor: CA Academy of Child and Adolescent Psychiatry; CA Alliance of Child and Family Services; California Youth Empowerment Network; Children Now
  - Support: Mental Health America of California
  - Opposition: None

- **Senate Bill 1318 (Wahab)**
    - Summary: This bill would require local educational agencies (LEA) to adopt a youth suicide crisis intervention protocol that prioritizes mental health professionals first and limits involvement and notification to law enforcement.
    - Sponsor: Santa Clara County Office of Education
    - Support: California Association of School Psychologists; California County Superintendents; California Federation of Teachers; California State Association of Psychiatrists; California Teachers Association; Generation Up; National Association of Pediatric Nurse Practitioners; Steinberg Institute
    - Opposition: None

Presenters:

- Kendra Zoller, Deputy Director of Legislation
- Kiran Sahota, President, Concepts Forward Consulting
- Adrienne Shilton, Senior Policy Advocate, California Alliance of Child and Family Services
- Caron Knight, Legislative Aide, Senator Wahab
- Amanda Dickey, Executive Director of Government Relations, Santa Clara Office of Education

Enclosures:

(1) AB 2352 (Irwin) Bill Analysis
(2) AB 2711 (Ramos) Bill Analysis
(3) SB 1318 (Wahab) Bill Analysis

Handouts: PowerPoint slides will be made available at the Commission Meeting

Date of Hearing: April 23, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2352 (Irwin) – As Amended April 10, 2024

SUBJECT: Behavioral health and psychiatric advance directives.

SUMMARY: Specifies the requirements for formation of a written or digital psychiatric advance directive (PAD) and specifies how a PAD may be used in numerous healthcare and legal settings. Specifically, **this bill**:

Creates PAD Requirements

1) Defines "PAD" as a legal written or digital document, executed on a voluntary basis in accordance with the requirements for advance health care directives (AHCD) by a person who has the capacity to make physical and behavioral health decisions, that allows a person with behavioral health illness to protect their autonomy and ability to direct their own care by documenting their preferences for treatment, as specified, and identifying a health care advocate, if chosen, in advance of a behavioral health crisis. Specifies a PAD does not include power of attorney for health care and allows a PAD to be a standalone document.

2) Provides that a PAD is legally sufficient if all of the following requirements are satisfied:
   a) The PAD contains the date of its execution;

   b) The PAD is signed by the individual and, if a health care advocate is chosen, signed by the health care advocate acknowledging and accepting appointment, or, if a health care advocate is not identified, signed by one additional adult in the individual's presence and at the individual's direction; and,

   c) The PAD is signed by one additional witness who is not related to the individual. Specifies the witness may be an employee or contractor of a behavioral health plan.

3) Defines "health care advocate" to mean an individual chosen by the person creating the PAD who is in agreement to uphold the person's preferences for treatment in the case of a behavioral health crisis. Prohibits the health care advocate's acceptance of appointment from allowing for power of attorney for health care decisions. The health care advocate's appointment is considered valid with a legal signature on the written or digital PAD.

4) Includes the following statutory language for a witness to a PAD to sign:

   "I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this AHCD or PAD is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this AHCD or PAD in my presence (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence (4) that I am not a person appointed as surrogate by this AHCD or PAD, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the

operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly."

5) Includes the following additional statutory language for a witness who is a non-family member to sign:

   "I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this AHCD or PAD by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law."

Adds PAD to Existing AHCD Laws

6) Clarifies that a valid and effective PAD, like an AHCD, applies to the treatment of a person who is placed in a mental health treatment facility.

7) Clarifies that a valid and effective PAD, like an AHCD, applies to the treatment of a person who is a ward or conservatee.

8) Clarifies that a written or digital PAD may include the individual's nomination of a health care advocate.

9) Clarifies that unlike an AHCD, a PAD is not required to be notarized and, like an AHCD, can be signed with a digital signature that meets specified criteria.

10) Allows an appeal to be taken with respect to a PAD, like an appeal respecting an AHCD, from either of the following:
    a) Any final order under Probate Code Section (PROB) § 4766, determining among other things, whether or not a patient has capacity to make health care decisions; or,
    b) An order dismissing the petition or denying a motion to dismiss under § PROB 4768 (which allows a court to dismiss a petition if it appears that the proceeding is not reasonably necessary for the protection of the interests of the patient).

11) Provides that a written AHCD, written or digital PAD, or similar instrument executed in another state or jurisdiction in compliance with the laws of that state or jurisdiction or of this state, is valid and enforceable in this state to the same extent as a written AHCD or PAD validly executed in this state; and in the absence of knowledge to the contrary, a physician or other health care provider may presume that a written AHCD, written or digital PAD or similar instrument, whether executed in another state or jurisdiction or in this state, is valid.

12) Provides that a health care provider, health care service plan, health care institution, disability insurer, self-insured employee welfare plan, or nonprofit hospital plan or a similar insurance plan may not require or prohibit the execution or revocation of an AHCD or PAD as a condition for providing health care, admission to a facility, or furnishing insurance.

13) Clarifies that nothing prohibits the execution of a voluntary standalone PAD.

14) Prohibits a health care provider or plan of any kind from requiring or prohibiting an AHCD or PAD as a condition for providing care.

15) Provides that a patient having capacity can revoke a PAD, just as they can revoke an agent or an AHCD.

16) Requires a provider, agent, or conservator to promptly communicate any revocation of a PAD, like an AHCD.

17) Provides that, like an AHCD, a PAD that conflicts with an earlier PAD revokes the earlier PAD to the extent of the conflict.

18) Adds PADs to the existing statutory AHCD form and explanation.

19) Requires health care providers to record the existence of a PAD, like an AHCD, and to request a copy of the PAD.

20) Provides that a PAD, like an AHCD, is exercisable free of judicial intervention and effective without judicial approval.

21) Requires the registry system for AHCDs established by the Secretary of State (SOS) to include a registry for PADs and for the SOS to establish and make available upon request, provide a registry card, and to provide privacy protections.

22) Requires the SOS to establish procedures to advise registrants that a standalone digital PAD may be accessed in a cloud-based setting or provided as a printed document.

23) Provides that failure to register with the SOS does not affect the validity of a PAD; provide superiority of a PAD, or affect the ability to revoke a PAD.

24) Clarifies that 21) through 23) above do not affect the duty of a behavioral health care provider from providing information to a patient regarding AHCDs or PADs pursuant to any provision of federal law.

25) Requires the SOS and State Department of Health Services to develop information regarding PADs with links available on internet sites.

Integrates PADs into Various Programs and Processes

26) Requires a court, in determining whether a conservatorship is the least restrictive alternative available, and whether to grant or deny a conservatorship petition, to consider the person's abilities and capacities with current and possible supports, including, but not limited to, supported decision making agreements, and PADs.

27) Requires that for purposes of the conservatorship alternatives program in court self-help centers, the centers are required to provide information relating to PADs as one of the less restrictive alternatives to conservatorship.

28) Requires at the last hearing before a minor or non-minor dependent ages out of foster care that a PAD form is provided to the minor or non-minor dependent.

29) Requires the 90-day transition plan prepared for a minor or non-minor dependent who is transitioning out of foster care to include information about creating a PAD and choosing a health care advocate, as well as a PAD written or digital form.

30) Modifies the definition of "crisis intervention" for purposes of the Lanterman-Petris-Short Act (LPS Act) to include a "health care advocate" in the list of persons who may be interviewed by qualified professionals that is designed to "alleviate personal or family situations that present a serious and imminent threat to the health or stability of the person or the family" and includes a PAD as one of the services that may be sought for the stability of the person or the family.

31) Modifies the definition of "pre-petition screening" for purposes of the LPS Act to include a PAD in the list of interventions that a person should be persuaded to receive on a voluntary basis.

32) Adds "health care advocate" to the list of persons on the statutory form who should be advised when a person is detained for a 72-hour evaluation.

33) Requires the designated facility to keep, for each patient evaluated, a record of the advisement given pursuant to 29) above which must include, among other requirements, whether the person detained has an AHCD or a PAD.

34) Requires a supporter in a Community Assistance, Recovery, and Empowerment (CARE) Act process to, among other requirements of existing law, provide information to the respondent about AHCDs and PADs.

35) Provides that a respondent in a CARE proceeding may have a supporter present in any meeting, judicial proceeding, status hearing, or communication related to interacting or communicating with the chosen health care advocate.

36) Prohibits that unless explicitly authorized by the respondent with capacity to make that authorization, a supporter in a CARE proceeding from creating a PAD.

37) Provides that a CARE plan may include a PAD.

Updates Terminology and Definitions

38) Provides that a behavioral health care provider, like a physical health care provider, who is acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for any actions in compliance with this division, including, but not limited to, any of the following conduct:

    a) Complying with a health care decision of a person that the health care provider or health care institution believes in good faith has the authority to make a health care decision for a patient, including a decision to withhold or withdraw health care;
    b) Declining to comply with a health care decision of a person based on a belief that the person then lacked authority;

c) Complying with an AHCD and assuming that the directive was valid when made and has not been revoked or terminated; and,
d) Declining to comply with an individual health care instruction or health care decision.

39) Provides that any behavioral health care provider, like a physical health care provider, who intentionally violates this part is subject to liability to the aggrieved individual for damages of two thousand five hundred dollars ($2,500) or actual damages resulting from the violation, whichever is greater, plus reasonable attorney's fees; and any person who falsifies, forges, or revokes a PAD without consent is liable for damages of ten thousand dollars ($10,000) or actual damages resulting from the action, whichever is greater, plus reasonable attorney's fees.

40) Makes the definition of PAD in 1) above applicable to all code sections in which the term "psychiatric advance directive" is used.

41) Changes "mental health" to "behavioral health" throughout the codes.

42) Makes numerous other minor, conforming, and non-substantive changes.

EXISTING LAW:

1) Provides that an AHCD is either an individual health care instruction or a power of attorney for health care. [PROB §4605]

2) Defines "health care" as any care, treatment, services, or procedure to maintain, diagnose, or otherwise affect a patient's physical or mental condition. [PROB §4615]

3) Defines "individual health care instruction" as an individual's authorized written or oral direction concerning a health care decision for the individual. [PROB §4623]

4) Defines "health care decision" as a decision made by an individual or an individual's agent, conservator, or surrogate, regarding that individual's health care, including selection and discharge of health care providers and institutions, approval or disapproval of diagnostic tests, surgical procedures, and programs of medication, and directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation. [PROB §4617 (a)]

5) Clarifies that "health care decision" does not include a decision made by a patient's agent, conservator, or surrogate to consent to treatments identified in 7), below. [PROB §4617 (b)]

6) Provides that an adult having capacity may execute a power of attorney for health care, which may authorize the agent to make health care decisions. [PROB §4671]

7) States that consent to any of the following on behalf of a patient is not authorized:

a) Commitment to or placement in a mental health treatment facility;
b) Convulsive treatment;
c) Psychosurgery;
d) Sterilization; and,
e) Abortion. [PROB § 4652]

8) States that it is the intent of the Legislature to promote the use of a PAD, subject to the requirements of this bill, by a person who wants to make sure their health care providers know their treatment preferences in the event of a future mental health crisis. [PROB §4679 (b)]

9) States legislative findings and declarations that:
   a) Research has demonstrated that the use of PADs improves collaboration, which improves outcomes, increases empowerment, and improves medication adherence;
   b) A PAD is most helpful when it includes reasons for preferring or opposing specific types of treatment; and,
   c) Mental health preferences that do not constitute health care instructions or decisions as defined in this bill may provide valuable information to improve an individual's mental health care. [PROB §4679 (c)]

10) Defines "PAD" to mean a legal document, executed on a voluntary basis by a person who has the capacity to make medical decisions that allows a person with mental illness to protect their autonomy and ability to self-direct care by documenting their preferences for treatment in advance of a mental health crisis. [PROB §4679 (a)(2) & Welfare & Institutions Code (WIC) §5971 (n)]

11) Establishes the LPS Act to end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, as well as to safeguard a person's rights, provide prompt evaluation and treatment, and provide services in the least restrictive setting appropriate to the needs of each person. Permits involuntary detention of a person deemed to be a danger to self or others, or "gravely disabled," as defined, for periods of up to 72 hours for evaluation and treatment, or for up-to 14 days and up-to 30 days for additional intensive treatment in county-designated facilities. [WIC §5000, *et seq*.]

12) Establishes the CARE Court Program which facilitates a court-ordered plan for individuals facing mental health or substance use disorders, initiated by family, county and community-based social services, behavioral health providers, or first responders [WIC §5970, *et seq*.]

13) Defines "Graduation plan" (from CARE program) to mean "a voluntary agreement entered into by the parties at the end of the CARE program that includes a strategy to support a successful transition out of court jurisdiction and that may include a PAD. A graduation plan includes the same elements as a CARE plan to support the respondent in accessing community-based services and supports." Prohibits the graduation plan from placing additional requirements on the local government entities and states that it is not enforceable by the court. [WIC §5971 (h)]

14) Provides that in CARE proceedings, when the respondent elects to be graduated from the program, the graduation plan may, at respondent's election, include a PAD, which shall have the force of law. Specifies that upon completion of the hearing, the respondent is officially graduated from the program. [WIC §5977.3 (a)(3)(A)]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, a behavioral health crisis is one of the most challenging experiences anyone can face and without a roadmap the situation can snowball for the individual in crisis, the first responders and health care professionals providing treatment, and the family and friends advocating for their loved one. The author continues that PADs are a tool meant to empower an individual with behavioral health challenges to support their decision making, communicate how to appropriately provide them care, and help de-escalate potential crisis situations. The author argues that PADs are woefully underutilized since many individuals are unaware of their existence, and most first responders and health care professionals lack access to them. The author concludes that this bill seeks to build out a legal framework for PADs in California, which will work in tandem with a pilot project already underway in seven counties across the state to expand use of PADs, and ensure access to first responders and health care professionals.

2) **BACKGROUND.**

   a) **ACHDs.** An AHCD is a document providing guidance or instructions for making health care decisions that contains either an individual health care instruction, or a power of attorney for health care, or both. The AHCD may assist in guiding inpatient treatment decisions, and is recommended for all adults, regardless of their health status. The advantage of an AHCD is that it can articulate in detail the wishes of the individual for numerous circumstances related to health care treatment, including mental health treatment, and allows the individual to designate an appointed agent to make health care decisions on that person's behalf, should that person ever become incapacitated. An AHCD is generally only applicable when the individual no longer has the capacity to make their own health care decisions**.**

      Existing law establishes the process, and provides a statutory form, for an individual to give instructions for health care decisions. The AHCD form allows an individual, with capacity to make decisions and to select an agent to make health care decisions if the individual is not able to do so. The directive also allows the individual to make end-of-life health care choices, including the choice to prolong, or not prolong, life and to seek relief from pain. Providers also have some discretion in following an AHCD. They may decline to follow an AHCD if it would violate their professional standards of care or for "reasons of conscience." Existing law also allows individuals to use AHCDs for mental health and treatment.

   b) **PADs.** Twenty-seven states, excluding California, have implemented standalone mental-health specific directives known as PADs. PADs memorialize a person's preferences for future mental health treatment and allow for a proxy in the event of a mental health crisis. Though PADs vary by state, they may contain questions prompting an individual to specify whether, in the event they are incapable of consenting to mental health treatment, they consent to the use of specific psychotropic medications; the administration of electroconvulsive treatment; admission to a facility for mental health treatment; preferences for seclusion and restraint; and, preferences for pre-emergency mental health interventions.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) 2019 report, "A practical Guide to PADS," these forms offer several advantages. For example, similar to an AHCD, a PAD may allow an individual to retain autonomy over treatment choices in psychiatric emergencies, and, in the event of a psychiatric crisis resulting in hospitalization, a PAD may facilitate a conversation with the patient about their treatment.

SAMHSA reports that people who complete a PAD tend to experience significant improvement in working alongside their clinicians, fewer coercive crisis interventions, better correspondence between preferred and prescribed medications over time, and increased perception that their personal needs for mental health services are being met. Given that people of color are hospitalized for psychiatric reasons at a higher rate than whites, PADs have the potential to help address inequities in mental health care by reducing the likelihood of unnecessary involuntary treatment and helping to ensure that any treatment provided aligns with the patient's preferences.

c) Pilot program for PAD development. Six counties (Contra Costa, Fresno, Mariposa, Monterey, Orange, Shasta), as well as the Tri-City Mental Health Authority (cities of Pomona, Claremont, and La Verne), are involved in an ongoing project, the Multi-County PADs Innovations Project, that began in July of 2021 and is scheduled to end on June 30, 2025. The project is funded by the Mental Health Service Act (MHSA) and seeks to expand and facilitate the use of PADs in California. It has received approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to "use Innovation Funds to develop the infrastructure for sustainable PADs usage in the state of California."

One key goal of the counties is to have a standardized written and digital PAD. California looks to be the first state to have a standardized template, training "toolkit," and a PADs technology platform for consumer-identified and first responder or hospital access in the event of a mental health crisis.

3) OPPOSED UNLESS AMENDED. Disability Rights California (DRC) and Mental Health America California (MHAC) are opposed unless this bill is amended. Both DRC and MHAC state that they have been working with the pilot project team, support PADS, and have proudly sponsored legislation to promote their use. However they argue that this bill goes far beyond what is needed to test a digital platform for PADs and pushes mental health policy away from the original intent of PADs. DRC and MHAC detail thorough concerns with his language, some of which are covered in the policy comments below. DRC and MHAC suggest the bill be substantially amended to focus exclusively on what they understand to be the bill's intent: create a legal framework to facilitate the testing and use of a digital platform which, in turn, will hopefully further promote the use of PADs.

4) PREVIOUS LEGISLATION.

a) AB 1029 (Pellerin), Chapter 171, Statutes of 2023, makes a number of clarifications in the law related to mental health care decisions, specifically decisions that can be made by a third party on behalf of another individual.

b) SB 326 (Eggman), Chapter 790, Statutes of 2023, recasts the MHSA as the Behavioral Health Services Act (BHSA) and modifies local and state spending priorities under the BHSA, including requiring 30% of all local BHSA funds to be spent on housing interventions, as specified; eliminating allocations for local mental health prevention-based programs and recasting other local spending categories; and, adding a state-level population-based prevention and stigma reduction program and statewide workforce program. Allows BHSA funding to be used to provide services to individuals with substance use disorder (SUD) regardless of whether they have additional mental health diagnoses or needs. Most provisions were subject to voter approval on the March 5, 2024, primary election ballot (combined with AB 531 (Irwin), Chapter 798, Statutes of 2023, the Behavioral Health Infrastructure Bond Act). SB 326 will go into effect January 1, 2025.

c) AB 2288 (Choi), Chapter 21, Statutes of 2022, adds language to advance health care AHCDs to clarify that the document may also include instructions relating to mental health treatment.

d) SB 1338 (Umberg), Chapter 319, Statutes of 2022, establishes the CARE Act, which must be implemented by Glenn, Orange, Riverside, San Diego, San Francisco, Stanislaus, and Tuolumne Counties by October 1, 2023, and the remaining counties by December 1, 2024, subject to delays based on a state or local emergency, or discretionary approval by the Department of Health Care Services (DHCS), up until December 1, 2025. Provides that the CARE Act only becomes operative upon DHCS, in consultation with county stakeholders, developing a CARE Act allocation to provide state financial assistance to counties to implement the CARE process.

5) POLICY COMMENTS.

a) Significant implications changing "mental" to "behavioral" health. While this may seem like a relatively minor update, it may have significant repercussions. Mental health and behavioral health are not interchangeable terms. Behavioral health is a broad term with varying definitions, generally referring to substance use and mental health disorders of any severity. Despite the recent passage of Proposition 1, which among other things updates the MHSA to the BHSA, swaths of state laws and programs currently apply to mental health, mental health with a co-occurring SUD, or SUD alone.

For example – this bill changes terms throughout the LPS Act which outlines mandatory treatment options for those with mental illness**.** Under the LPS Act, an individual may be involuntary committed for varying lengths of time for the purpose of treatment and evaluation, provided that certain requirements are met. This bill also replaces "mental health" with "behavioral health" throughout Laura's Law, which provides for court-ordered assisted outpatient treatment (AOT). In participating counties, the court may order a person into an AOT program if the person is found to meet existing involuntary commitment requirements under the LPS Act or meets non-involuntary commitment requirements, including that the person has refused treatment, their mental health condition is substantially deteriorating, and AOT would be the least restrictive level of care necessary to ensure the person's recovery and stability in the community. By replacing terminology throughout these code sections this bill would make significant

changes to current law, including expanding involuntary treatment laws to include those with SUD.

b) Are CARE Court proceedings an appropriate place to institute a PAD? SB 1338 (Umberg) enacted the CARE Court Program. CARE Court was intended to "provide a vital solution to ensure access to comprehensive services and supports for some of the most ill and most vulnerable Californians." SB 1338 codified the term PAD for the first time, and uses it at several points in its language. In addition to defining PAD, SB 1338:

i) Permits a PAD to be part of a "graduation plan," a voluntary agreement at the end of a CARE program to support a successful transition out of court jurisdiction;

ii) Allows a supporter to be present in any "meeting, judicial proceeding, status hearing, or communication related to . . .[e]stablishing a [PAD];"

iii) Requires DHCS to provide training and technical assistance to county behavioral health agencies regarding PADs;

iv) Requires annual CARE Act data from the trial courts to include the number, rates, and trends of PADs created for participants with active CARE plans; and,

v) Included the number of PADs in the annual metrics to determine the effectiveness of the CARE Act model.

This bill expands the presence of PADS in the CARE process including:

i) Provides that a CARE plan, which is executed once an individual is determined to be eligible for involuntary treatment and services, may include a PAD.

ii) Requires a CARE supporter to provide information to the respondent about AHCDs and PADs.

iii) Provides that unless explicitly authorized by the respondent with capacity to make that authorization, a supporter in a CARE proceeding cannot create a PAD.

Groups such as DRC and MHAC object to the use of PADs in CARE Court as they believe CARE Court is coercive. PADS are already part of the voluntary CARE graduation plan but this bill goes further by putting PADs into the mandated CARE plan. That arguably is very early in the CARE Court process and therefore could be coercive.

This bill also creates a "health care advocate" who can be chosen by the person creating the PAD. The bill as drafted further requires the health care advocate to be an individuals designated "supporter" throughout the CARE process. DRC and MHAC argue that this expansion of the health care advocate's duties into CARE Court dramatically changes the duties of the advocate and risks changing the advocate's role from neutral to coercive.

c) Should PADs be structurally different than AHCDs? This bill creates different standards and processes for PADs compared to AHCDs. For example, an AHCD contains either an individual health care instruction, or a power of attorney for health care, or both. Whereas this bill explicitly states that a PAD does not include power of attorney.

SAMSHA reports that PADs in other states contain options for power of attorney, allowing someone to appoint an individual to serve as a health care agent with decision making authority in medical or psychiatric emergencies, incapacitation, and end of life care instructions. Additionally, under existing law AHCDs and PADs have the same witness signature requirements, two witnesses or a notary public. The bill eliminates the ability to use a notary for a PAD and requires only two witnesses.

The author's office argues that the process of appointing a power of attorney or identifying a notary presents obstacles that the participants in the multi-county behavioral health innovation project believe are unnecessary for a preference document.

Under current law, granting power of attorney and executing an AHCD or PAD with a notary are options– not mandates. The opponents have a shared goal of ensuring PADs are accessible and easy to complete, but question why this bill is limiting PADs as a preference document instead of leaving individuals with the option of creating a true directive.

Going forward, the author should work with stakeholders and advocates representing peers with lived experience to ensure that the state's PADs framework meets the needs of every individual who wishes to create one.

d) Lack of statutory framework. The author's stated intent is to "build out a legal framework for PADs in California," yet this bill leaves many questions unanswered about how PADs will be created, stored, and accessed. There is a statutory form for an AHCD, but this bill does not propose a statutory form for a PAD. Should there be some sort of standard form for PADs? This bill introduces a brand new digital format for PADs, which is being built and tested by the pilot project. Will the platform built by the pilot be the standard? Or will competitors be allowed to introduce different platforms? How will hospitals, law enforcement, and other relevant parties access a digital PAD? Will they need to purchase a platform? Are there any privacy concerns?

The author's office has indicated they are working with the California Department of Justice to work through some of these questions. It is imperative that discussions on these important questions involve all relevant stakeholders with an interest in this process.

e) Ongoing pilot project. Phase one of the multi-county pilot project began in 2021 and is scheduled to end in 2025. In their most recent annual report covering fiscal years (FY) 2021-22 through 2022-23, the project notes that "moving into the FY 2023-2024, the project will train identified PADs teams, or priority population peers and professionals, in the facilitation of a PAD and continue beta testing and fine-tuning the technology platform. The Fresno pilot will sunset June 2024, and new opportunities for additional counties to identify priority populations, be trained in the technology platform and continue testing the project will become an option. In addition, FY 2023-24 will begin a collaborative effort to address the legislation needs to move PADs forward in California, both in use and, most importantly, in consent and autonomy of the individualized PAD." Phase 2, which includes the rollout of the live digital platform won't begin until July 1, 2025.

This digital PAD pilot is still ongoing, meaning there are many lessons to be learned and details to be fine-tuned. While statutory authority may be needed to allow this project to fully test digital PADs, the Legislature should ponder if this bill should include a sunset date or reporting requirements for ongoing evaluation of this new format.

6) **PROPOSED AMENDMENTS.**

a) Terminology throughout mental health and treatment laws have been carefully crafted and subject to extensive public debate. Due to the sensitivities and potential impact, these changes are usually considered in standalone bills. The Committee may wish to remove all of the changes from "mental" to "behavioral" health throughout this bill to ensure these changes are thoroughly considered to avoid unintentional consequences.

b) This bill goes beyond what is needed to build a framework for written and digital PADs, including inserting PADs and the consideration of PADs into various mental health programs and processes ranging from conservatorship, transitional hearings for foster youth, to CARE Court proceedings. The author's intention is to ensure there is adequate awareness and accessibility to PADs, which is an important goal. However, some of the language in this bill goes beyond awareness as it pertains to CARE Court. The Committee may wish to review and amend these provisions of the bill to ensure we are promoting awareness while carefully balancing protections from coercion.

c) Phase one of the multi-county pilot project began in 2021 and is scheduled to end in 2025. Phase 2, which includes the rollout of the live digital platform won't begin until July 1, 2025. The Committee may wish to require MHSOAC to assess the pilot project as it continues and report updates and recommendations to the Legislature to ensure we have sufficient oversight as this new program is implemented.

7) **DOUBLE REFERRAL**. This bill has been double referred. It passed the Assembly Judiciary Committee with a vote of 10 - 0 on April 9, 2024.

REGISTERED SUPPORT / OPPOSITION:

Support

One individual

Opposition

None on file.

Analysis Prepared by: Riana King / HEALTH / (916) 319-2097

Date of Hearing: April 24, 2024

ASSEMBLY COMMITTEE ON EDUCATION
Al Muratsuchi, Chair
AB 2711 (Ramos) – As Amended April 15, 2024

SUBJECT: Suspensions and expulsions: controlled substances: tobacco: alcohol: plans and protocols

SUMMARY: As of July 1, 2026, removes the possession of tobacco products and controlled substances on school grounds or at a school activity as bases for suspension from school, unless two documented unsuccessful interventions have been provided; authorizes the removal of a student from campus for the day who is under the influence of a controlled substance, an alcoholic beverage, or an intoxicant, provided that the student is excused due to illness; prohibits a student from being recommended for expulsion for possession, use or being under the influence of a controlled substance, alcohol, an intoxicant, or possession or use of tobacco products; prohibits disciplinary actions for students who disclose their use of tobacco, a controlled substance, or alcohol, or who are seeking help for services or supports; requires local educational agencies (LEAs) to develop a plan for students who possess or use tobacco, a controlled substance, or alcohol on school property, in collaboration with specified individuals; specifying appropriate supports and interventions for students; requires schools to refer students for supports and interventions and to review these with the student and their parents or guardians after four to six weeks to determine if further supports are required; and encourages schools to provide school-wide education and prevention activities. Specifically, **this bill**:

1) As of July 1, 2026, authorizes a student to be suspended from school on the basis of unlawful possession, use, or being under the influence of a controlled substance, an alcoholic beverage, or an intoxicant of any kind, only under the following conditions:

    a) The student is provided with two opportunities for supportive interventions, as specified in the school's adopted plan;

    b) After two documented unsuccessful interventions, the student may be suspended; and

    c) A student may be removed from campus for the day who is under the influence of a controlled substance, an alcoholic beverage, or an intoxicant of any kind, provided that the student is excused due to illness.

2) As of July 1, 2026, authorizes a student to be suspended from school on the basis of possession or use of tobacco or products containing tobacco or nicotine, only under the conditions in (1) above.

3) Prohibits a student in kindergarten through 12th grade from being recommended for expulsion for unlawful possession, use, or being under the influence of a controlled substance, an alcoholic beverage, an intoxicant of any kind, or possession or use of tobacco, or products containing tobacco or nicotine.

4) Prohibits a student enrolled in a charter school in kindergarten through 12th grade from being suspended or recommended for expulsion solely based upon the possession or use of tobacco or products containing tobacco or nicotine, or the possession, use, or being under the

influence of a controlled substance, as specified, an alcoholic beverage, or an intoxicant of any kind, as of July 1, 2026.

5) As of July 1, 2026, authorizes a student in a charter school in kindergarten through 12th grade to be suspended from school on the basis of unlawful possession, use, or being under the influence of a controlled substance, as defined, an alcoholic beverage, or an intoxicant of any kind, only under the following conditions:

   a) The student is provided with two opportunities for supportive interventions, as specified in the school's adopted plan;

   b) After two documented unsuccessful interventions, the student may be suspended; and

   c) A student may be removed from campus for the day who is under the influence of a controlled substance, an alcoholic beverage, or an intoxicant of any kind provided that the student is excused due to illness.

6) Removes the requirement that a principal or superintendent of schools recommend the expulsion of a student for unlawful possession of any controlled substance (other than first offense of one ounce of marijuana) committed at school or at a school activity off school grounds unless they determine that expulsion should not be recommended under the circumstances or that an alternative means of correction would address the conduct.

7) Removes the authority of a governing board of a school district to order a student expelled upon finding that the student, at school or at a school activity off school grounds, possessed or used tobacco, or products containing tobacco or nicotine products, including, but not limited to, cigarettes, cigars, miniature cigars, clove cigarettes, smokeless tobacco, snuff, chew packets, and betel.

8) Requires each school district, county office of education (COE), and charter school to adopt a plan by July 1, 2026, to address students who possess or use tobacco, a controlled substance, or alcohol on school property, and to include all of the following requirements:

   a) Be youth-informed;

   b) Include information on where, on campus and in the community, students can receive education, treatment, or support for substance use; and

   c) Be developed in consultation with the appropriate staff, which may include school staff, youth behavioral health staff, the COE, community-based organizations, health providers, local child welfare agencies, institutions of higher education, businesses, clinical experts, managed care plans, county behavioral health departments, or other public and private entities; and

   d) Include appropriate supports and interventions for students, including the use of prevention and intervention planning, implementation, and evaluation for students.

9) Requires the plan to include all of the following protocols after an incident involving a student using or in possession of tobacco, a controlled substance, or alcohol on school property occurs:

a) The principal, or designee, consults with the student and the student's parents or legal guardians, but the parent or guardian's unwillingness to consult must not prevent the school from attempting to provide interventions and supports for the student;

b) Prohibits disciplinary actions for students who disclose their use of tobacco, a controlled substance, or alcohol, or who are seeking help for services or supports;

c) Requires the principal, or designee, after collaboration with the student, their parents or legal guardians, and internal and external staff, to select or refer, with the student's consent, the appropriate supports and interventions, which may include prevention and intervention programs and activities to support the student, including but not limited to the following:

   i) School-based and school-linked mental health services, including early identification of drug use and referrals to counseling services or partnerships with public or private healthcare entities that have qualified mental and behavioral health professionals;

   ii) Academic intervention and mentoring within the community;

   iii) A physical health assessment;

   iv) After school programs; and

   v) Other appropriate community resources.

d) Requires the principal, or designee, in conjunction with relevant teachers and school staff, to document and record confirmation of the student's receipt of the selected prevention or intervention program and supports, including any internal or external supports or interventions, and any care coordination support.

10) Requires, after four to six weeks, the principal or designee to review the plan with the student and the parents or legal guardians, to assess the extent to which each goal has been met, and to, with the student's consent, determine whether to maintain, intensify, or phase out the interventions or supports. Requires that the student and parents or guardians be informed in writing of progress and any changes made to the intervention plans. If the student's parents or guardians did not participate in the student's initial consultation, a school may determine whether it is appropriate to include those parents or guardians in the review of the plan.

11) Requires the school, in order to best inform their policies, to maintain records of the number of times the protocols required by this measure were initiated during a school year, including the following information for each student:

a) The outcome;

b) Age;

c) Sex;

d) Race and ethnicity;

e) Foster youth status; and

f) Home language.

12) Encourages LEAs to implement all of the following:

a) Professional development and training for school staff, specialized instructional support personnel, and interested community members on drug prevention, education, early identification, intervention mentoring, recovery support services, and, where appropriate, rehabilitation referral. Requires training to include best practices that are socially and culturally relevant and trauma-informed;

b) Evidence-based drug prevention activities and programs that educate against the use of alcohol, marijuana, tobacco, cannabis, smokeless tobacco products, electronic cigarettes, vaporizer devices, and other illicit drugs;

c) Campus-wide programs and activities that provide mentoring and school counseling to all students, including those who are at risk of drug use and abuse.

13) States that this section does not affect a parent's or legal guardian's rights relating to the care, custody, and control of their minor child.

14) Defines the following terms for these purposes:

a) "Controlled substance" as a controlled substance listed in Chapter 2, Division 10, Section 11053 of the Health and Safety Code; and

b) "Local educational agency" as a school district, COE, or charter school.

15) Expresses the intent of the Legislature to do all of the following:

a) Provide teachers and school administrators with the means to foster safe and supportive learning environments for all children in California:

b) Reduce the number of suspensions and expulsions experienced by students due to illicit drug use and possession in schools;

c) Require LEAs to take a supportive approach when dealing with pupils who use or possess drugs on campus; and

d) Ensure that students who transfer between multiple classrooms, taught by multiple teachers, be allowed to attend all remaining classes for which they have not been removed for disciplinary purposes.

16) Technical and clarifying changes.

EXISTING LAW:

1) Prohibits a student from being suspended from school or recommended for expulsion, unless the superintendent of the school district or the principal of the school determines that the student has committed any of the following offenses:

a) Causing, attempting to cause, or threatening to cause physical injury to another person, or willfully using force or violence upon another person, except in self-defense;

b) Possessing, selling, or otherwise furnishing a firearm, knife, explosive, or other dangerous object, unless the student had obtained prior written permission to possess the item;

c) Unlawfully possessing, using, selling, or otherwise furnishing a controlled substance;

d) Unlawfully offering, arranging, or negotiating to sell a controlled substance, an alcoholic beverage, or an intoxicant of any kind;

e) Committing or attempting to commit robbery or extortion;

f) Causing or attempting to cause damage to school property or private property;

g) Stealing or attempting to steal school property or private property;

h) Possessing or using tobacco or products containing tobacco or nicotine products;

i) Committing an obscene act or engaging in habitual profanity or vulgarity;

j) Unlawfully possessing or unlawfully offering, arranging, or negotiating to sell drug paraphernalia;

k) Knowingly receiving stolen school property or private property;

l) Possessing an imitation firearm;

m) Committing or attempting to commit a sexual assault or sexual battery;

n) Harassing, threatening, or intimidating a student who is a complaining witness or a witness in a school disciplinary proceeding in order to prevent the student from being a witness or retaliating against that student for being a witness, or both;

o) Unlawfully offering, arranging to sell, or negotiating to sell the prescription drug Soma;

p) Engaging in or attempting to engage in hazing;

q) Engaging in the act of bullying, including bullying committed by means of an electronic act;

r) Committing sexual harassment (grades 4 through 12 only);

s) Causing or attempting to cause, threatening to cause, or participating in an act of hate violence (grades 4 through 12 only);

t) Engaging in harassment, threats, or intimidation against school district personnel or students that have the effect of disrupting classwork, creating substantial disorder, and invading the rights of either school personnel or students by creating an intimidating or hostile educational environment (grades 4 through 12 only); and,

u) Making a terroristic threat against school officials, school property, or both. (Education Code (EC) Sections 48900, 48900.2, 48900.3, 48900.4, and 48900.7)

2) Requires the principal or superintendent of schools to recommend the expulsion of a student for any of the following acts committed at school or at a school activity off school grounds, unless it is determined that the expulsion should not be recommended under the circumstances or that an alternative means of correction would address the conduct:

   a) Causing serious physical injury to another person, except in self-defense;

   b) Possession of any knife or other dangerous object of no reasonable use to the student;

   c) Unlawful possession of any controlled substance, as specified;

   d) Robbery or extortion; and

   e) Assault or battery, as defined, upon any school employee. (EC 48915)

3) Prohibits a student in kindergarten through 5th grade from being suspended for disrupting school activities or otherwise willfully defying the valid authority of school personnel, and prohibits these acts from being grounds for any student from kindergarten through 12th grade to be recommended for expulsion. (EC 48900).

4) Prohibits a student in 6th through 8th grade from being suspended for disrupting school activities or otherwise willfully defying the valid authority of school personnel until July 1, 2025. (EC 48900)

5) Requires that a suspension only be imposed when other means of correction fail to bring about proper conduct. Specifies that other means of correction may include, but are not limited to, the following:

   a) A conference between school personnel, the student's parent or guardian, and the student;

   b) Referrals to the school counselor, psychologist, social worker, child welfare attendance personnel, or other school support personnel for case management and counseling;

   c) Study teams, guidance teams, resource panel teams, or other intervention-related teams that assess the behavior, and develop and implement individualized plans to address the behavior in partnership with the student and his or her parents;

   d) Referral for a comprehensive psychosocial or psychoeducational assessment;

   e) Enrollment in a program for teaching prosocial behavior or anger management;

   f) Participation in a restorative justice program;

   g) A positive behavior support approach with tiered interventions that occur during the schoolday on campus; and

h) After school programs that address specific behavioral issues or expose students to positive activities and behaviors. (EC 48900.5)

6) Defines Chapter 2 controlled substances as including, but not limited to:

a) Opiates;

b) Opium derivatives;

c) Hallucinogenic substances;

d) Depressants; and

e) Any material, compound, mixture, or preparation that contains any quantity of the following substances having a stimulant effect on the central nervous system, including its isomers: Cocaine base, Fenethylline, including its salts, and N-Ethylamphetamine, including its salts. (Health and Safety Code (HSC) 11054)

7) Defines tobacco products as any of the following:

a) A product containing, made, or derived from tobacco or nicotine that is intended for human consumption, whether smoked, heated, chewed, absorbed, dissolved, inhaled, snorted, sniffed, or ingested by any other means, including, but not limited to, cigarettes, cigars, little cigars, chewing tobacco, pipe tobacco, or snuff;

b) An electronic device that delivers nicotine or other vaporized liquids to the person inhaling from the device, including, but not limited to, an electronic cigarette, cigar, pipe, or hookah

c) Any component, part, or accessory of a tobacco product, whether or not sold separately. (Business and Professions Code (BPC) 22950.5)

FISCAL EFFECT: Unknown

COMMENTS:

Need for the bill. According to the author, "AB 2711 is an approach that aims to address drug-related infractions by requiring that schools create a public health approach instead of relying on suspensions and expulsions. This would ensure that we arm the students with the necessary tools to address the drug use in order to reduce the likelihood of them becoming long-term drug users. Over 59% of drug-related suspensions are of boys, over 83% are of socioeconomically disadvantaged students and 83% are of youth of color. These numbers are alarming and in order to better protect our youth, we must look at addressing the health needs of students in these situations to reduce the likelihood of future substance abuse and addiction."

Drug, alcohol, and tobacco use among secondary students. The *Seventeenth Biennial State California Healthy Kids Survey* (CHKS) which was administered to a randomly selected, representative state sample of secondary students in grades seven, nine, and eleven between fall

2017 and spring 2019, includes the following findings as compared to previous iterations of the survey:

- Little improvement has occurred in most engagement measures, including school connectedness, academic motivation, and self-reported grades. In 11th grade, only 53% were classified as being connected to the school, compared to 62% in 7th grade.

- Lifetime marijuana use was reported by 6%, 17%, and 29% of students by ascending grade. Trends varied, increasing by two points in 7th grade, stable in 9th, and down almost three points in 11th after large declines in 2015-17.

- Current use of prescription drugs to get "high" declined slightly in 9th and 11th grades, by 1.5 points to 2% in both grades, continuing its decline since 2013-15. There was little change in current inhalant use in any grade, which remained below 2%.

- Current heavy drug use was reported by 2%, 6%, and 10% of 7th, 9th, and 11th graders, respectively, remaining unchanged from 2015-17. Heavy drug use has declined by between two and five percentage points since 2013-15.

- Current alcohol and other drug use on school property increased slightly in all grades (to 4%, 7%, and 8%) after declining since 2011-13. The uptick occurred primarily due to the increase in marijuana use at school.

- The percentage of high school students who were ever drunk or "high" on drugs on school property was stable in 9th grade at 8% but declined two points in 11th to 12%. The rate has steadily declined since 2011-13, by about half in all grades.

The authors of the CHKS report contend that using alcohol or other drugs at school is an indicator of both heavy substance use and disengagement from school and learning.

California suspensions and expulsions have declined, but disproportionality remains. Data from the CDE shows that while the number of suspensions and expulsions decreased over the 10-year period from 2012-13 to 2022-23, the number of African American students suspended or expelled remains significantly above their proportionate enrollment:

- Total suspensions for all offenses dropped 44%, from 609,810 to 337,507;

- African American students made up 6% of enrollment in 2012-13 and 5% in 2022-23, but received 19% of total suspensions in 2012-13 and 15% in 2022-23; and

- Total expulsions dropped by 44% over the 10-year period, from 8,564 in 2012-13 to 4,750 in 2022-23; and

- African American students accounted for 13% of total expulsions in 20212-13 and 12% in 2022-23.

CDE data from 2022-23, identifies a total of 63,270 or 19% of all suspensions and 1,043 or 22%, of all expulsions were illicit drug-related. The data does not differentiate between possession,

use, or sale of drugs. The suspensions and expulsions were disproportionately imposed on students of color, as shown in the table below:

Ethnicity	**% of total statewide enrollment**	**% of illicit drug expulsions**	**% of illicit drug suspensions**
African American	5.1%	4.2%	7.2%
Hispanic or Latino	56.1%	75.0%	67.3%
White	20.5%	13.6%	17.0%

Source: CDE DataQuest 2022-23

Research suggests that punitive approaches to drug use in schools are ineffective. A research paper, *Beyond Zero Tolerance: A Reality-Based Approach to Drug Education and School Discipline notes,"*Most American high schools do not offer effective drug education, nor do they provide interventions to assist students struggling with abuse of alcohol and other drugs. Instead, they rely primarily on deterrent punishment for students who are caught violating the rules. Proponents of the "big four" consequences – exclusion from extracurricular activities, transfer to another school, suspension, and expulsion – believe that harsh consequences for those who are caught will deter other students from committing similar offenses, and too often constitute the whole of prevention. But research has shown that these punishments are not likely to change students' behavior. Ironically, rather than serving as an effective deterrent, drug education that lacks credibility and is backed by punitive measures often fosters resentment and oppositional behavior. The few secondary schools that offer drug education often repeat messages that may have had some credence for elementary school students but lack credibility for older, more experienced teenagers." (Skager, 2013)

Impacts of exclusionary discipline policies. One study, *Educational and Criminal Justice Outcomes 12 Years After School Suspension,* notes that "school suspensions aim to obtain better behavior from the punished student and maintain school norms by removing students. Suspension removes disruptive students from schools temporarily and may improve school climate by reducing peer influences to engage in deviant behavior." The study goes on to note that a body of research has found that suspended students are more likely to:

- Engage in antisocial behavior;
- Have involvement with the criminal justice system;
- Be arrested both during the month of suspension and within a year of suspension; and
- Use marijuana and tobacco.

The study also cites various longitudinal research findings, including:

- Youth suspended in ninth grade were less likely to graduate high school, graduate on time, and enroll in postsecondary education; and

- Twelve years after suspension, suspended youth were less likely to have earned degrees or high school diplomas and were more likely to have been arrested or on probation. (Rosenbaum 2018)

Some researchers conclude that "suspensions may act more as a reinforcer than a punisher for inappropriate behavior. Others raise doubts as to whether harsh school discipline has a deterrent value. Frequent use of suspension alone has no measurable positive deterrent or academic benefit to either the students who are suspended or to non-suspended students." (Losen, 2011). The American Academy of Pediatrics states, "Without the services of trained professionals, such as pediatricians, mental health professionals, and school counselors, and without a parent at home during the day, students with out-of-school suspensions and expulsions are far more likely to commit crimes."

Researchers have pointed out that "many suspended students find school to be challenging and experience suspension from school as a reward. Suspensions may be reinforcing and even incentivizing the very behavior they are meant to correct." (Rumberger, 2017).

According to the U.S. Department of Education, "Teachers and students deserve school environments that are safe, supportive, and conducive to teaching and learning. Creating a supportive school climate—and decreasing suspensions and expulsions—requires close attention to the social, emotional, and behavioral needs of all students. Evidence does not show that discipline practices that remove students from instruction—such as suspensions and expulsions—help to improve either student behavior or school climate."

Disparities in the rate of school suspensions. The disproportionate incidence of suspensions and expulsions among certain populations of students, including African American students, has gained nationwide attention in recent years. A 2018 report by the U.S. Government Accountability Office (GAO), *K-12 Education: Discipline Disparities for Black Students, Boys, and Students with Disabilities,* found that black students, boys, and students with disabilities were disproportionately disciplined in K-12 schools, based upon an analysis of the Civil Rights Data Collection (CRDC).

CRDC data show that there was an overall 2% decline in the use of exclusionary discipline practices in public schools in the U.S. from the 2015-16 school year to the 2017-18 school year. However, there was an increase during this period of school-related arrests, expulsions with educational services, and referrals to law enforcement. The data also shows a continued disproportionality in exclusionary practices during the 2017-18 school year:

- Black students accounted for 15.1% of total student enrollment in the U.S. and received 38.8% of expulsions with educational services and 33.3% of expulsions without educational services;

- Students with disabilities represented 13.2% of enrollment and received 23.3% of expulsions with educational services and 14.8% of expulsions without educational services;

- Boys accounted for 51.4% of enrollment and received 69.5% of in-school suspensions, and 70.5% of out-of-school suspensions;

- 31.4% of Black students received one or more in-school suspensions, and 38.2% received one or more out-of-school suspensions;

- 20.5% of students with disabilities received one or more in-school suspensions, and 24.5% received one or more out-of-school suspensions;

- Black students with disabilities represent 2.3% of student enrollment, 6.2% received one or more in-school suspensions and 8.8% received one or more out-of-school suspensions; and

- Black students accounted for 28.7% of all students referred to law enforcement and 31.6% of all students arrested at school or during a school-related activity.

The GAO report review of research on the topic of disproportionate disciplinary actions suggests that "implicit bias on the part of teachers and staff may cause them to judge students' behaviors differently based on the students' race and sex. Teachers and staff sometimes have discretion to make case-by-case decisions about whether to discipline, and the form of discipline to impose in response to student behaviors, such as disobedience, defiance, and classroom disruption." (GAO, 2018)

Research on student behavior, race, and discipline has found no evidence that African American overrepresentation in school suspension is due to higher rates of misbehavior. African American students were referred more often for behaviors that seem to require more subjective judgment on the part of the person making the referral (e.g., disrespect, excessive noise, threatening behavior, and loitering). (Losen, 2011)

Holding schools accountable for suspension and expulsion rates. California's Local Control Funding Formula (LCFF) and Local Control and Accountability Plan (LCAP) requirements include school climate as one of the eight state priorities. All California school districts, COEs, and charter schools are required to report and examine student suspension and expulsion rates on their LCAP and annual updates. It has been suggested that this requirement to clearly report disciplinary actions, in the aggregate as well as by subgroup, increases the pressure on schools to employ alternatives to suspension and expulsion.

Addressing substance use disorders in school settings. According to the California School-Based Health Alliance, "School-based health centers (SBHCs) and wellness centers (WCs) are ideal places to identify youth using substances and provide evidence-based services that inform them about the health risks associated with alcohol and drug use, motivate them to change their behaviors, and support them in addressing the concerns that may be underlying their substance use. School health providers are concerned about youth substance use because it impacts a student's long-term health outcomes and their academic performance. Substance use is linked to lower grades, student absenteeism, and higher rates for high school dropout. Adolescent substance use is also highly predictive of adult substance abuse because the adolescent brain is still developing making it more susceptible to addiction. Nine out of ten people meeting the clinical criteria for a substance use disorder began using one or more addictive substances before the age of 18. Schools, school-based health programs, and school support services are ideally positioned to educate, prevent, and intervene early in youth substance use, preventing experimentation from escalating to misuse or addiction."

A review of research confirms the importance of expanding substance use services for youth in school. According to recent estimates, more than two-thirds of American adolescents reported that the pandemic had negative effects on their mental health. Co-occurring mental health and substance use problems were common among youth before the pandemic and the pandemic's negative impacts on youth psychological well-being can lead to unhealthy coping strategies such as substance use. Studies examining changes in youth substance use during the pandemic have found mixed results, including decreases in alcohol use, increases in unhealthy use of nicotine and prescription drugs, and no change in the use of marijuana or binge drinking alcohol among 12th grade students. Experimentation or self-medication with alcohol and other drugs during adolescence can have particularly detrimental effects on social and emotional well-being and brain development, and it can increase the risk of chronic mental and behavioral health conditions, including substance use disorders. (Allen, 2022)

As schools have direct contact with youth, they have been considered a prime setting for delivering health education and healthcare to students. However, schools have also struggled to effectively provide mental health and substance use services for a variety of reasons. Only 10% of U.S. public schools today have SBHCs on campus. SBHCs have traditionally focused on primary care and have not often been a source of mental health or substance abuse care.

In California, 377 SBHCs are serving more than 340,000 students, but this is a small portion of the over 10,000 schools and over 5.8 million students. 79% of the SBHCs in California provide mental health services, but data is not readily available on how many SBHCs provide substance abuse services. (California School-Based Health Alliance)

Impact of punitive discipline policies on substance use. Researchers note that punitive school discipline policies and inadequate resources can undermine efforts to provide prevention, early intervention, and treatment services to youth in need in schools. In addition, inequities may persist if youth of color continue to disproportionately face punishment, rather than treatment, for substance use, as has historically been the case. (Allen, 2022)

One author suggests that "The long-standing stigma around people who develop substance or opioid use disorders contributes to the lack of attention to and investment in comprehensive, developmentally appropriate, and culturally and linguistically effective youth substance use services. Youth are often left to figure out on their own whether they might have a substance use problem or how to solve it, with little support and understanding from adults in their lives for fears of disappointing their parents or facing negative consequences at school. Schools and communities can become more nurturing and positive spaces that promote the overall health and wellness of youth and have the knowledge and resources to respond with kindness, support, and evidence-informed and equity-focused health approaches before substance use turns into a chronic, life-altering disorder." (Allen, 2022)

Recommended Committee Amendments. Staff recommend that the bill be amended as follows:

1) Requires that a pupil who possesses, uses, or is under the influence of a controlled substance, alcohol, or an intoxicant be offered access to available supportive interventions, prior to a suspension, which may include, but are not limited to substance use prevention and treatment, mental health counseling, or other supports from the list specified in subdivision (b) of Section 48900.5.

2) Authorizes a pupil to be suspended for these acts only when other documented means of correction fail to bring about proper conduct or it is determined that the pupil's possession of a controlled substance present an imminent risk of harm to other pupils or school staff.

3) Prohibits a pupil from being recommended for expulsion for these acts, except as provided pursuant to Section 48915.

4) Authorizes the removal of a pupil from campus for the day due to being under the influence of a controlled substance, alcohol, or an intoxicant, but removes reference to this being recorded as an excused absence.

5) Prohibits a pupil who disclose their use of a controlled substance or alcohol when seeking help from being suspended solely for that disclosure.

6) Defines tobacco products as is defined in subdivision (d) of Section 22950.5 of the Business and Professions Code, which includes vaping devices.

7) Requires that a pupil who possesses or uses tobacco be offered access to available supportive interventions prior to a suspension, which may include, but are not limited to supports from the list specified in subdivision (b) of Section 48900.5.

8) Prohibits a pupil who disclose their use of tobacco when seeking help from being suspended solely for that disclosure.

9) Removes possession of drug paraphernalia from the offenses subject to suspension or expulsion.

10) Removes the provision that a pupil be provided with two opportunities for supportive interventions prior to being suspended.

11) Requires, rather than authorizes, a school to document other means of correction that are offered to a student prior to a suspension and to place the information in the pupil's records.

12) Adds "enrollment in a substance use or mental health prevention, treatment, or services program" and "enrollment in a tobacco cessation program" to the other means of correction to be employed prior to suspending a student.

13) Requires that a pupil enrolled in a charter school who possesses, uses, or is under the influence of a controlled substance, alcohol, or an intoxicant, or the possession or use of tobacco products be offered access to available school-based or community-based supportive interventions, which may include, but are not limited to substance use or mental health prevention, treatment, and services programs, and tobacco cessation programs.

14) Authorizes a charter school to suspend a pupil for these acts only if the supportive interventions offered have failed to bring about proper conduct.

15) Authorizes the removal of a pupil from a charter school campus for the day due to being under the influence of a controlled substance, alcohol, or an intoxicant, but removes reference to this being recorded as an excused absence.

16) Prohibits a pupil enrolled in a charter school who disclose their use of tobacco, a controlled substance, or alcohol when seeking help from being suspended solely for that disclosure.

17) Prohibits a pupil enrolled in a charter school from being expelled on the basis of possessing, using, or being under the influence of a controlled substance, alcohol, or an intoxicant, except if it is determined that the pupil's possession of the controlled substance presents an imminent risk of harm to other pupils or school staff.

18) Removes the requirement that LEAs adopt a plan to address pupils who possess or use tobacco, a controlled substance, or alcohol on school property.

19) Reinstates current law which requires that a principal or superintendent recommend the expulsion of a pupil for the unlawful possession of a controlled substance, (other than for the first offense of no more than one ounce of marijuana or the pupil's own medication) that presents an imminent risk of harm to pupils or staff of the school, unless the principal or superintendent determines that expulsion should not be recommended under the circumstances or that an alternative means of correction would address the conduct.

Arguments in support. Children Now, a co-sponsor of the bill, writes, "Youth alcohol, tobacco, and other drug use is a significant public health concern linked to a wide range of academic, social, and health problems. Adolescent substance use is highly predictive of adult substance abuse because the adolescent brain is still developing, making it more susceptible to addiction.

Research notes that schools can and should cultivate a positive environment in which youth feel supported, cared for, and have a safe place to rely on for help. Unfortunately, current school policies regarding drugs are largely punitive and tend reduce feelings of school connectedness, leaving students to feel less like the adults and peers in school care about their learning and health. For students who encounter drug infractions, suspension and expulsion has proven to be ineffective and can have long-lasting consequences like increasing dropout rates and accelerating delinquency in students, exacerbating the school-to-prison pipeline.

Schools, school-based health programs, and community-based support services are ideally positioned to educate, prevent, and intervene early in youth substance use, preventing experimentation from escalating to misuse or addiction. AB 2711 would limit the ability of educators to suspend or expel due to illicit drug infractions at school by instead requiring a school district, county office of education, or charter school to establish a public health framework. This public health approach would include identifying and referring youth with substance use needs to community-based services, including mechanisms for screening and referral, education on overdose risk and training for school staff, and making connections with community-based support service providers."

Arguments in opposition. The Small School Districts Association writes, "We acknowledge the importance of supporting students rather than penalizing them, and we appreciate the author's recent amendments to allow suspension after two interventions. However, we contend that the ability to suspend or expel a student does not mutually exclude the provision of support services. In fact, these disciplinary actions often act as a pivotal point for intervening and connecting affected students with necessary rehabilitation and counseling services.

We would further argue that this bill sends the wrong message to our students. Allowing students two "do-overs" before schools would have the authority to expel or suspend students for these

serious offenses might give students the wrong ideas regarding the severity of drug and alcohol use. More and more in California, we are asking schools to address the whole child in preparing them for life in our society. We feel this measure runs counter to that goal by removing consequences for these offenses.

Lastly and perhaps most importantly, the presence and use of controlled substances in schools compromise the safety of the learning environment for all students and staff. As drugs like fentanyl become more pervasive amongst recreational drugs, signaling to students that it is "okay" to possess intoxicants on campus puts the lives of all students at risk. The ability to suspend or expel serves not only as a deterrent but also as a critical measure to maintain a safe and conducive educational environment."

Related legislation. AB 599 (Ward) of the 2023-24 Session would have prohibited a pupil from being suspended or expelled from school for possessing or using tobacco or nicotine products beginning July 1, 2025. This bill would also have required the CDE to develop and make available a model policy for a public health approach to addressing student possession and use of drugs on school property by July 1, 2025. This bill was held in the Senate Appropriations Committee.

AB 1919 (Weber) of the 2023-24 Session would require a school district to document any alternative means of correction used prior to the suspension of a student and requires LEAs to adopt at least one of the best practices for restorative justice implementation developed by the CDE.

AB 2441 (Kalra) of the 2023-24 Session would eliminate criminal penalties for "willful disturbance" of a school or school meeting by students and grant a school principal discretion to report specified incidents, including drug infractions, to law enforcement if it does not include a firearm, as specified.

SB 274 (Skinner), Chapter 597, Statutes of 2023, prohibits the suspension or expulsion of a student enrolled in 6th through 12th grade in a public school on the basis of willful defiance until July 1, 2029, authorizes employees to refer students to school administrators for in-school interventions or supports, and requires that administrators document the actions taken in the student's record and inform the referring employee of those actions.

AB 2598 (Akilah Weber), Chapter 914, Statutes of 2022, requires the CDE to develop and post on its website by June 1, 2024, evidence-based best practices for restorative justice practices for LEAs to implement to improve campus culture and climate.

SB 419 (Skinner), Chapter 279, Statutes of 2019, commencing July 1, 2020, permanently extends the prohibition against suspending a student enrolled in kindergarten through grade 3 for disrupting school activities or otherwise willfully defying the valid authority of school staff to include grades 4 and 5 permanently; and to include grades 6 to 8, until July 1, 2025; and applies these prohibitions to charter schools.

AB 420 (Dickinson) Chapter 660, Statutes of 2014, eliminated the authority to suspend a student enrolled in kindergarten through 3rd grade, and the authority to recommend for expulsion a student enrolled in grades kindergarten through 12th grade for disrupting school activities or otherwise willfully defying the valid authority of school personnel engaged in the performance of their duties. The bill sunset on July 1, 2018.

REGISTERED SUPPORT / OPPOSITION:

Support

ACLU California Action
Aldea Children & Family Services
Alliance for Children's Rights
Association of Community Human Service Agencies
California Academy of Child and Adolescent Psychiatry
California Alliance of Caregivers
California Community Foundation
California Consortium for Urban Indian Health
California Public Defenders Association
California School-based Health Alliance
California Youth Empowerment Network
Children Now
Children's Institute
Communities United for Restorative Youth Justice
Community Solutions for Children, Families and Individuals
Didi Hirsch Mental Health Services
Helpline Youth Counseling
Hillsides Pasadena
Lincoln Families
Mental Health America of California
National Center for Youth Law
Oakland Unified School District
Progress Ranch Treatment Services
Psychiatric Physicians Alliance of California
Redwood Community Services
Seneca Family of Agencies
St Anne's Family Services
Stanford Sierra Youth and Families
Steinberg Institute
Sycamores
The Children's Partnership
The Los Angeles Trust for Children's Health
Trinity Youth Services
Westcoast Children's Clinic
Youth Leadership Institute
2 individuals

Opposition

Kern County Superintendent of Schools Office
Small School Districts Association

Analysis Prepared by: Debbie Look / ED. / (916) 319-2087

SENATE COMMITTEE ON EDUCATION
Senator Josh Newman, Chair
2023 - 2024 Regular

Bill No:	SB 1318	**Hearing Date:**	April 3, 2024
Author:	Wahab		
Version:	March 19, 2024		
Urgency:	No	**Fiscal:**	Yes
Consultant:	Kordell Hampton		

Subject: Pupil health: suicide prevention policies: pupil mental health crisis.

SUMMARY

This bill would require, on or before July 1, 2026, a local educational agencies (LEA) to adopt a mental health crisis intervention protocol in the event of a pupil having a mental health crisis, as defined, including the process by which staff and external agencies are deployed to address a pupil mental health crisis, as specified.

BACKGROUND

Existing Law:

Education Code (EC)

1) Requires the governing board of an LEA that serves pupils in grades 7 to 12 to adopt, before the 2017-18 school year, procedures relating to suicide prevention, intervention, and postvention in consultation with school and community stakeholders, school-employed mental health professionals, and suicide prevention experts. (EC § 215(a))

2) Requires the governing board of an LEA that serve pupils in Kindergarten and grades 1 to 6 to adopt, before the 2020-21 school year, a policy on pupil suicide prevention in kindergarten in consultation with school and community stakeholders, school-employed mental health professionals, and suicide prevention experts. (EC § 215 (a)(2)(A))

3) Requires, beginning July 1, 2019, a public school, including a charter school, or a private school, that issue identification cards to pupils grades 7 to 12 to include information to the National Suicide Prevention Lifeline, Crisis Text Line, and local suicide prevention hotline. (EC § 215.5)

4) Require the California Department of Education (CDE) to identify one or more evidence-based online training programs that a LEA can use to train school staff and pupils as part of the LEAs policy on pupil suicide prevention. (EC § 216)

ANALYSIS

This bill:

1) Requires a LEAs, on or before July 1, 2026, to adopt a policy that establishes a crisis intervention protocol in the event a pupil experiences a mental health crisis that includes all of the following while prioritizing the use of school mental health professionals when addressing a pupil mental health crisis:

    a) A process by which staff and external agencies are deployed to address a pupil's mental health crisis and prioritizes the use of school mental health professionals when addressing a pupil's mental health crisis.

        i) Specifies if a school mental health professional is not available, the protocol may identify a school employee who has completed training related to youth behavioral health to provide interim care and a warm handoff to a mental health professional.

        ii) Specifies that if a trained school employee is not available to address the pupil's mental health crisis, the protocol shall identify one or more community-based organizations, mobile crisis units, 988 services, or other qualified mental health professionals who shall be contacted in the event of a pupil mental health crisis.

    b) Limits involvement and notification of law enforcement, including peace officers and school resource officers, to situations in which a pupil's life is in imminent danger and their needs cannot be addressed by a mental health professional.

    c) A process to inform the parent or guardian of the pupil experiencing the mental health crisis, including the process for assessing whether the pupil is endangered by parental notification and requires that notification to the pupil if the parent or guardian of the pupil is informed.

2) Requires the governing board or body of a LEA, when the governing board or body reviews its policy on pupil suicide prevention, to discuss whether funding should be redirected to hiring a school mental health professional if the LEA does not have a school mental health professional or contract with a mental health professional.

3) Defines "Local educational agency" means a county office of education, school district, state special school, or charter school.

4) Defines "Mental health professional" means an individual with a behavioral health license, and may include an intern, community health worker, peer counselor, or wellness coach.

5) Defines "Pupil mental health crisis" means any of the following:

    a) A pupil who is exhibiting suicidal thoughts or behaviors.

    b) A pupil who has completed a suicide risk assessment and is determined to be at risk of suicide.

    c) A pupil who is attempting to physically harm themselves or others.

6) Defines “School mental health professional” means a school employee with a clear or preliminary pupil personnel services credential, or school nurse services credential, or a licensed or associate therapist, social worker, or psychologist.

STAFF COMMENTS

1) ***Need for the bill.*** According to the author, “The rising suicide rate among California’s children is unprecedented, and it is time to take action. In the first year of the pandemic, intentional self-harm among children aged 13-18 increased by 91%, and without making substantial changes to our youth suicide prevention policies, this statistic will not improve. SB 1318 is a strong step to provide children with the professional mental health support they need in times of crisis. The bill clarifies that the involvement of law enforcement officers, including resource officers, should be the final step to protect a child’s life, and that connection with mental health professionals should be the first. SB 1318 is a lifeline for our most vulnerable youth.”

2) ***Mental Health Crisis Among Students.*** Mental health problems can significantly impact various aspects of a student's life. They can reduce the quality of life, academic achievement, and physical health. Additionally, these issues can negatively affect relationships with friends and family members. Furthermore, students may face long-term consequences, including a negative impact on their future employment, earning potential, and overall health.

   In a study produced by the Center for Disease Control, ***“***Forty-two percent of high school students in 2021 reported feeling so sad or hopeless for at least two consecutive weeks in the previous year that they stopped engaging in their usual activities, up from 26 percent in 2009.” Moreover, Thoughts of suicide, suicide attempts, and actual suicides among young people have also risen in that period, with Black children nearly two times more likely than their white peers to die by suicide, according to the U.S. Centers for Disease Control and Prevention’s biennial Youth Risk Behavior Survey.

   Strong mental health is one of the most critical factors contributing to a student's academic success. When students have a positive mental state, they tend to learn better, retain information more effectively, and realize their full potential more effectively. Their mental health also plays a crucial role in their well-being and social development. Students with good mental health can build stronger relationships, make better decisions, and work collaboratively with their peers. Moreover, students with positive mental health are also more likely to become responsible and productive members of their communities as they transition into adulthood. They have a better sense of self-awareness and are more equipped to navigate the challenges of the transition to adulthood. Therefore, it is essential to prioritize mental health education and promote a positive mental state among students.

3) ***CDE Youth Behavioral Health Programs.*** Pursuant to SB 14 (Portantino, Chapter 672, Statutes of 2021) the CDE was required to recommend, by January 1, 2023, best practices and identify evidence-based and evidence-informed training programs for schools to address youth behavioral health, including, but not necessarily limited to, staff and pupil training.

On the CDE's *website*, the department has identified the Youth Mental Health First Aid (YMHFA) a research-based curriculum created upon the medical first aid model. It is designed to provide parents, family members, caregivers, teachers, school staff, neighbors, and other caring adults with skills to help a school-age child or youth who may be experiencing emotional distress, the onset of a mental illness, addiction challenge or who may be in crisis. YMHFA participants learn to recognize signs and symptoms of children and youth in emotional distress, initiate and offer help, and connect the youth to professional care through a five-step action plan.

YMHFA also clarifies "that its training is **not** intended for staff with a mental health background such as school psychologists, social workers, clinicians, etc., due to its basic nature. The ideal audience includes teachers, administrators, nurses, counselors, and any other credentialed staff, classified staff (school secretaries, registrars, yard supervisors, campus monitors, bus drivers, lunch staff, janitors, aides, after school staff, etc.), parents, youth employers, and other community partners that have contact with students."

4) ***Pupil Personal Service (PPS) Credential.*** PPS credential holders may work with individual students, groups of students, or families to provide the services authorized by their credentials to address the needs of all students by providing a comprehensive PPS program. PPS credential covers services for individuals who serve as counselors, school psychologists, school social workers, and school child welfare and attendance regulators. Holders of these credentials perform, including, but not limited to, the following duties:

   School Counseling: Develop, plan, implement, and evaluate a school counseling and guidance program that includes academic, career, personal, and social development; advocate for the high academic achievement and social development of all students; provide schoolwide prevention and intervention strategies and counseling services; and provide consultation, training, and staff development to teachers and parents regarding students' needs.

   School Social Work: Assess home, school, personal, and community factors that may affect a student's learning; identify and provide intervention strategies for children and their families, including counseling, case management, and crisis intervention; consult with teachers, administrators, and other school staff regarding social and emotional needs of students; and coordinate family, school, and community resources on behalf of students.

   School Psychology: Provide services that enhance academic performance; design strategies and programs to address problems of adjustment; consult with other educators and parents on issues of social development and behavioral and academic difficulties; conduct psycho-educational assessment for purposes of identifying special needs; provide psychological counseling for individuals, groups, and families; and coordinate intervention strategies for management of individuals and schoolwide crises.

   Child Welfare and Attendance: Access appropriate services from both public and private providers, including law enforcement and social services; provide staff development to school personnel regarding state and federal laws pertaining to

due process and child welfare and attendance laws, address school policies and procedures that inhibit academic success, implement strategies to improve student attendance; participate in schoolwide reform efforts; and promote understanding and appreciation of those factors that affect the attendance of culturally-diverse student populations.

This bill would prioritize school employees, who hold a PPS credential, to interact with youth experiencing a mental health crisis before engaging community based organizations and law enforcement, in that order, as specified.

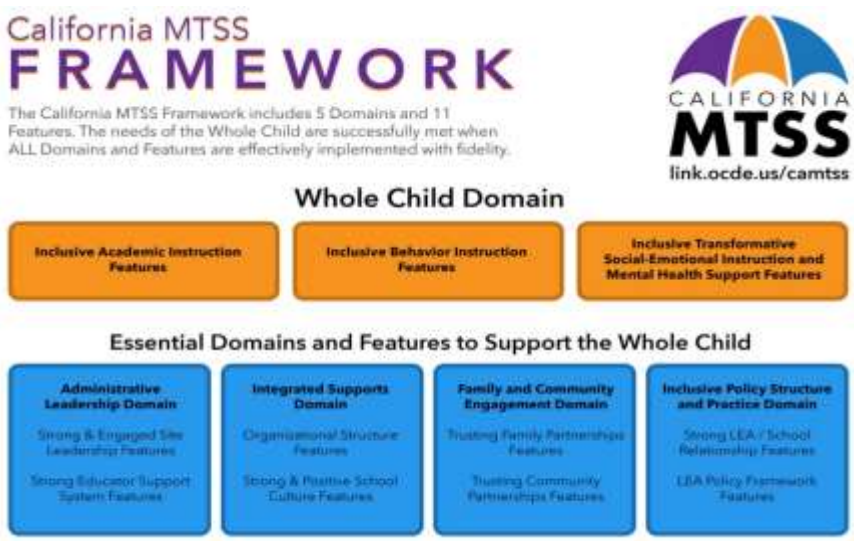
5) ***California Investment In Youth Mental Health Services.*** Since 2019, California has taken action to address youth mental health. California has enacted grant programs and established initiatives to provide schools proper support to assist students and families.

California Community Schools Partnership Program (CSSP).
A community school is a public school that serves students from pre-kindergarten through grade twelve, and it has partnerships with the local community to support improved academic outcomes, whole-child engagement, and family development.

In response to longstanding inequities exacerbated by the COVID-19 pandemic, California supported CCSPP investments in 2020, 2021, and 2022. In 2020, the California Legislature allocated $45 million in Federal Elementary and Secondary School Emergency Relief (ESSER) to support existing community schools throughout the state. Then, in 2021, the California legislature passed the California Community Schools Partnership Act and in 2022, the Legislature expanded the program by adding funds and extending the program to 2031. Between 2021 and 2022, the Legislature allocated a historic $4.1 billion in state dollars to support new and existing community schools, particularly those serving high concentrations of high-need students.

The partnership strategies of community schools include integrated support services, extended learning time, and collaborative leadership and practices for educators and administrators. Community schools use a community-driven shared decision-making approach to improve access to nurses, counselors, and social workers. This creates community hub campuses where students and families have easy access to the services needed to close opportunity gaps.

Mulitured Systems of Support (MTSS).
MTSS is a comprehensive framework that aligns academic, behavioral, social, and emotional learning and mental health supports in a fully integrated system of support for the benefit of all students. CA MTSS offers the potential to create needed systematic change through intentional design and redesign of services and supports to identify and match all students' needs quickly. The MTSS framework provides opportunities for LEAs to strengthen school, family, and community partnerships while developing the whole child in the most inclusive, equitable learning environment, thus closing the equity gaps for all students.



In 2015, Assembly Bill 104 (Committee on Budget, Chapter 13, Statutes of 2015), appropriated $10,000,000 for developing, aligning, and improving academic and behavioral support systems. The CDE conducted a competitive grant process and awarded the funds to the Orange County Department of Education (OCDE) for their Scaling Up MTSS Statewide (SUMS) proposal, which included the Butte County Office of Education (Butte COE) as a rural partner. In 2016, an additional $20,000,000, appropriated by SB 828 (Committee on Budget, Chapter 29, Statutes 2016), augmented the original grant award. The Budget Act of 2018 authorized an additional $15,000,000, appropriated by AB 1808 (Committee on Budget, Chapter 32, Statutes of 2018), and SB 840 (Budget Act of 2018, Chapter 29, Statutes of 2018). This phase of the grant focuses on improving the school climate statewide. The total $95,000,000 awarded to date is to encourage LEAs to establish and align schoolwide, data-driven academic and behavioral support systems to more effectively meet the needs of California's diverse learners in the most inclusive environment.

Comprehensive school mental health programs offer three tiers of support within an MTSS approach:

- Tier 1: Universal mental health promotion activities for all students;
- Tier 2: Selective prevention services for students identified as at risk for mental health problems; and
- Tier 3: Indicated services for students who already show signs of a mental health problem.

Children and Youth Behavioral Health Initiative (CYBHI).
Established as part of the Budget Act of 2021, the CYBHI is a multiyear, multi-department package of investments that seeks to reimagine the systems, regardless of payer, that support behavioral health for all California's children, youth, and their families. Efforts will focus on promoting social and emotional well-being, preventing behavioral health challenges, and providing equitable, appropriate, timely, and accessible services for emerging and existing behavioral health (mental health and

substance use) needs for children and youth ages 0-25. CYBHI is grounded in focusing on equity; centering efforts around children and youth voices, strengths, needs, priorities, and experiences; driving transformative systems change; and using ongoing learning as the basis for change and improvement in outcomes for children and youth.

In January 2024, the California Department of Health Care Services (DHCS), in partnership with Kooth and Brightline, is launching two behavioral health virtual services platforms for children, youth, and families. Launching as a part of the state's CalHOPE program, with funding from the CYBHI a $4.6 billion investment in youth behavioral health, the web- and app-based platforms will offer all California residents, regardless of insurance coverage, free one on one support with a live coach, a library of multimedia resources, wellness exercises, and peer communities moderated by trained behavioral health professionals to ensure the appropriateness of content and the safety of all users. These new CalHOPE platforms will complement existing services offered by health plans, counties, and schools by providing additional care options and resources for parents and caregivers, children, youth, and young adults in California.

This bill stipulates that the governing board or body of a LEA, when the governing board or body reviews its policy on pupil suicide prevention, is required to discuss whether funding should be redirected to hiring a school mental health professional if the LEA does not have a school mental health professional or contract with a mental health professional.

6) ***Committee Amendments.*** *Committee staff recommends, and the author has agreed to accept, the following amendments:*

   a) Redefine "Mental health professional" to mean any individual licensed by the California Board of Behavioral Sciences or the California Board of Psychology and any intern or associate working towards licensure, and may include a peer counselor, certified wellness coach, and community health workers trained in behavioral health conditions.

   b) Replace "youth mental health crisis" with "youth suicide crisis", to match the intent of the bill.

   c) Clarify "school mental health professional" to mean a school employee with a clear or prelimniary pupil personnel services credential with a specialization in

school counseling, school social work, or school psychology or a credentialed school nurse or a licensed or associate therapist, social worker, or psychologist under the supervision of a school employee with a pupil personnel services or administrative services credential.

d) Makes technical changes.

7) **Related Legislation.**

AB 309 (Gabriel, Chapter 662, Statutes of 2021) requires the CDE to develop model pupil mental health referral protocols, in consultation with relevant stakeholders, subject to the availability of funding for this purpose.

AB 2639 (Berman, Chapter 437, Statutes of 2018) requires the CDE to identify and make available an online training program in suicide prevention that an LEA can use to train school staff and pupils, consistent with the LEA's policy on suicide prevention.

AB 2246 (O'Donnell, Chapter 642, Statutes of 2016) requires LEAs to adopt policies for the prevention of student suicides, and requires the CDE to develop and maintain a model suicide prevention policy.

SB 224 (Portantino, Chapter 675, Statutes of 2021) requires LEAs and charter schools that offer courses in health education to students in middle school or high school to include in those courses instruction in mental health that meets specified requirements, and requires the CDE, by January 1, 2024, to develop a plan to increase mental health instruction in California public schools.

SB 14 (Portantino, Chapter 672, Statutes of 2021) requires a student's absence related to pupil mental or behavioral health to count as an excused absence for school attendance reporting and, subject to appropriation, requires the CDE, by January 1, 2023, to recommend best practices and identify evidence-based and evidence-informed training programs for schools to address youth behavioral health, including staff and student training.

SUPPORT

Santa Clara County Office of Education (sponsor)
California Association of School Psychologists
California County Superintendents
California Federation of Teachers
California State Association of Psychiatrists
California Teachers Association
Generation Up
National Association of Pediatric Nurse Practitioners
Steinberg Institute

OPPOSITION

None received

-- END --

AGENDA ITEM 11

Information

April 25, 2024 Commission Meeting

2024-27 Strategic Plan

Summary

The Mental Health Services Oversight and Accountability Commission's 2024-2027 Strategic Plan guides the Commission's efforts over the next four years. As directed by the Commission, staff have developed a process for implementing tracking progress of the Strategic Plan goals and objectives.

Strategic Plan Goals

The Commission's vision is that all Californians experience wellbeing through a coordinated system that prioritizes prevention, early intervention, and recovery-oriented services; builds on the strengths of communities and marginalized groups; and creates opportunities for individuals to engage in meaningful and purposeful activities and helps them to thrive. Toward this vision, the Commission has identified four key strategic goals to guide its work.

1. Champion vision into action – so policymakers and the public understand and support the development of effective services and supports to reduce personal suffering and the heartbreaking consequences of unmet mental health needs.

2. Catalyze best practice networks – to ensure access, improve outcomes, and reduce disparities – to close the gap between what can be done and what is being done.

3. Inspire innovation and learning – to close the gap between what can be done and what must be done.

4. Relentlessly drive expectations – in ways that reduce stigma, build empathy, and empower the public to drive accountability for outcomes.

Implementation Appendix

To support the Commission's deliberations, staff have developed a strategic implementation plan with metrics for tracking and reporting progress against its strategic goals and objectives.

Presenter(s): Norma Pate, Deputy Director

Enclosures: None

Handouts:

- Strategic Plan – As adopted by the Commission.
- Portfolio at a Glance – Provides a high-level overview of the Commission's strategic goals, capabilities, and its current initiatives and priorities.
- Implementation Appendix
- PowerPoint slides

MISCELLANEOUS ENCLOSURES

April 25th, 2024 Commission Meeting

Enclosures (4):

(1) Evaluation Dashboard
(2) Innovation Dashboard
(3) Department of Health Care Services Revenue and Expenditure Reports Status Update
(4) Rolling Calendar

Mental Health Services
Oversight & Accountability Commission

Summary of Updates

Contracts

New Contracts: 0

Total Contracts: 3

Funds Spent Since the November Commission Meeting

Contract Number	Amount
21MHSOAC023	$ 0.00
22MHSOAC025	$ 0.00
22MHSOAC050	$ 0.00
TOTAL	**$ 0.00**

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (21MHSOAC023)

MHSOAC Staff: Rachel Heffley
Active Dates: 07/01/21 - 06/30/24
Total Contract Amount: $5,414,545.00
Total Spent:$ 3,183,262.56

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis activities including a summative evaluation of Triage grant programs.

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Complete	09/30/21	No
Quarterly Progress Reports	Complete	12/31/21	No
Quarterly Progress Reports	Complete	03/31/2022	No
Quarterly Progress Reports	Complete	06/30/2022	No
Quarterly Progress Reports	Complete	09/30/2022	No
Quarterly Progress Reports	Complete	12/31/2022	No
Quarterly Progress Reports	Complete	03/31/2023	No
Quarterly Progress Reports	Complete	06/30/2023	No
Quarterly Progress Reports	Complete	09/30/2023	No
Quarterly Progress Reports	Complete	12/31/2023	Yes
Quarterly Progress Reports	In Progress	03/31/2024	Yes
Quarterly Progress Reports	Not Started	06/30/2024	No

WestEd: MHSSA Evaluation Planning (22MHSOAC025)

MHSOAC Staff: Kai LeMasson
Active Dates: 06/26/23 - 12/31/24
Total Contract Amount: $1,500,000.00
Total Spent: $400,000.00

This project will result in a plan for evaluating the Mental Health Student Services Act (MHSSA) partnerships, activities and services, and student outcomes. The MHSSA Evaluation Plan will be informed by community engagement and include an evaluation framework, research questions, viable school mental health metrics, and an analytic and methodological approach to evaluating the MHSSA.

Deliverable	Status	Due Date	Change
Project Management Plan	Complete	August 1, 2023	No
Community Engagement Plan	Complete	September 1, 2023	No
Community Engagement Plan Implementation (a, b and c)	Complete In Progress	December 15, 2023 January 15, 2024 October 30, 2024	No
Evaluation Framework and Research Questions	In Progress	December 15, 2023	No
School Mental Health Metrics	Not Started	June 15, 2024	No
Evaluation Plan (draft and final)	Not Started	September 1, 2024 October 30, 2024	No
Consultation on Report to the California Legislature	Not Started	March 1, 2024	No
Progress Reports (a, b, and c)	Complete In Progress	September 15, 2023 January 15, 2024 June 15, 2024	No

Mental Health Services
Oversight & Accountability Commission

Third Sector: FSP Evaluation (22MHSOAC050)

MHSOAC Staff: Melissa Martin Mollard
Active Dates: 06/28/23 – 6/30/24
Total Contract Amount: $450,000.00
Total Spent: $150,000.00

This project will evaluate the effectiveness of FSPs through community engagement, outreach and survey activities culminating in a final report to the Commission with specific recommendations for strengthening the implementation and outcomes of FSP programs throughout the State.

Deliverable	Status	Due Date	Change
Community Engagement Plan (draft and final)	Complete	August 31, 2023 September 30, 2023	Yes
Statewide Survey (draft and final)	In Progress	October 31, 2023 December 31, 2023	No
Progress Reports (#1 and #2)	#1 Complete #2 In Progress	October 31, 2023 March 31, 2024	Yes
Final Report (draft and final	Not Started	March 31, 2024 May 31, 2024	No

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD

APRIL 2024

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	0	6	**6**
Participating Counties (unduplicated)	0	6	**6**
Dollars Requested	$0	**$13,506,738.00 (Estimated Amount)**	**$13,506,738.00 (Estimated Amount)**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2018-2019	54	54	$303,143,420	32 (54%)
FY 2019-2020	28	28	$62,258,683	19 (32%)
FY 2020-2021	35	33	$84,935,894	22 (37%)
FY 2021-2022	21	21	$50,997,068	19 (32%)
FY 2022-2023	31	31	$354,562,908.86	26 (44%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
2023-2024	10	10	$175,973,920	10

INNOVATION PROJECT DETAILS

DRAFT PROPOSALS – ANTICIPATED TO BE ON MAY COMMISSION CALENDAR						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	Ventura	Early Psychosis Learning Health Care Network – Multi-County Collaborative	$10,137,474.63	4 Years	01/29/2024	Pending
Under Review	Fresno	California Reducing Disparities Project - Extension	$2,953,244	2 Years	12/29/2023	Pending
Under Review	Mendocino	Native Crisis Line – A Partnership between Pinoleville Pomo Nation and Mendocino County BHRS	$1,001,395	4 Years	4/01/2024	Pending
Under Review	Fresno	PADs: Phase 2 – Multi-County Collaborative	$5,000,000 (estimated)	4 Years	3/13/2024	Pending
Under Review	Orange	PADs: Phase 2 – Multi-County Collaborative	$3,600,000 (estimated)	4 Years	3/13/2024	Pending
Under Review	Shasta	PADs: Phase 2 – Multi-County Collaborative	$450,000 (estimated)	4 Years	3/13/2024	Pending
Under Review	Shasta	Stipends for Foster Youth by California Youth Connections	$200,000	1 Year	01/26/2024	Pending
Under Review	Shasta	Level Up NorCal	$476,738	3 Years	01/26/2024	Pending

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC

APPROVED PROJECTS (FY 23-24)			
County	Project Name	Funding Amount	Approval Date
Santa Clara	TGE Center	$11,938,639	7/27/2023
San Luis Obispo	Embracing Mental & Behavioral Health for Residential Adult Care & Education (EMBRACE)	$860,000	9/28/2023
Santa Cruz	Crisis Now Multi-County Innovation Plan	$4,544,656	9/28/2023
Amador	Workforce Retention Strategies	$1,995,129	9/28/2023
Tri-City	Community Planning Process	$675,000	10/26/2023
Los Angeles	Kedren Children and Family Restorative Care Village	$100,594,450	11/16/2023
Sacramento	allcove Multi-County Collaborative	$10,000,000	11/16/2023
Sutter-Yuba	Multi County FSP Project	$1,226,250	01/25/2024
Sacramento	Community Defined Mental Wellness Practices for the African American/Black/African Descent Unhoused	$15,000,231	01/25/2024
Riverside	Eating Disorder Intensive Outpatient and Training Program	$29,139,565	02/22/2024

DHCS Status Chart of County RERs Received
April 25, 2024, Commission Meeting

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 March 29, 2024. This Status Report covers FY 2021 -2022 through FY 2022-2023, all RERs prior to these fiscal years have been submitted by all counties.

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these for Reporting Years FY 2012-13 through FY 2022-2023 on the data reporting page at: https://mhsoac.ca.gov/county-plans/.

The Department also publishes County RERs on its website. Individual County RERs for reporting years FY 2006-07 through FY 2015-16 can be accessed at: http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting years FY 2016-17 through FY 2021-22 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

DHCS also publishes yearly reports detailing funds subject to reversion to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). These reports can be found at: https://www.dhcs.ca.gov/services/MH/Pages/MHSA-Fiscal-Oversight.aspx.

DCHS MHSA Annual Revenue and Expenditure Report Status Update

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Alameda	1/31/2023	2/6/2023	2/7/2023	1/30/2024	1/31/2024	2/14/2024
Alpine	4/14/2023		4/17/2023			
Amador	1/31/2023	2/7/2023	2/17/2023	2/8/2024	2/8/2024; 2/14/24	2/16/2024
Berkeley City	1/31/2023	2/2/2023	2/7/2023	1/31/2024	2/2/2023	2/6/2024
Butte						
Calaveras	1/27/2023		2/7/2023	1/31/2024	2/2/2024	2/5/2024
Colusa	4/3/2023	4/4/2023	5/11/2023	3/15/2024	3/20/2024	
Contra Costa	1/30/2023		2/1/2023	2/13/2024	2/14/2024	2/15/2024
Del Norte	1/30/2023		2/7/2023	1/30/2024	1/31/2024; 2/1/24	2/5/2024
El Dorado	2/24/2023		2/28/2023	1/30/2024	1/30/2024	1/30/2024
Fresno	1/31/2023	2/2/2023	2/10/2023	1/29/2024	1/30/2024	2/1/2024
Glenn	12/14/2023	12/21/2023	2/16/2024			
Humboldt	1/31/2023		2/2/2023	1/30/2024	1/31/2024	2/2/2024
Imperial	1/20/2023	1/23/2023	2/1/2023	1/19/2024	1/24/2024; 1/30/24	2/7/2024
Inyo	5/19/2023		8/16/2023			
Kern	1/31/2023	2/1/2023	2/15/2023	2/2/2024	2/9/2024	2/23/2024
Kings	1/10/2023	1/19/2023	2/14/2023	2/8/2024	2/14/2024	2/16/2024
Lake	1/31/2023		2/1/2023			
Lassen	2/8/2023	2/9/2023	2/14/2023	2/29/2024	2/29/2024	3/5/2024
Los Angeles	1/31/2023	2/2/2023	2/17/2023	2/5/2024	2/6/2024	2/16/2024
Madera	2/8/2023	2/9/2023	2/14/2023	3/22/2024		
Marin	1/30/2023	1/31/2023	2/3/2023	1/31/2024	2/2/2024	2/5/2024

DHCS Status Chart of County RERs Received
April 25, 2024, Commission Meeting

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Mariposa	4/19/2023	4/20/2023	4/21/2023	2/7/2024	2/15/2024	2/15/2024
Mendocino	1/31/2023		2/2/2023	1/31/2024	2/5/2024	2/15/2024
Merced	1/19/2023		1/23/2023	1/18/2024	1/19/2024	1/23/2024
Modoc	3/23/23	4/4/2023	4/5/2023			
Mono	1/31/2023		2/2/2023	1/31/2024	2/5/2024	
Monterey	1/31/2023	2/2/2023	2/2/2023	1/31/2024	2/1/2024	2/6/2024
Napa	1/31/2023	2/1/2023	2/13/2023	2/6/2024	2/9/2024	3/11/2024
Nevada	1/31/2023	2/1/2023	2/2/2023	1/31/2024	2/9/2024	2/14/2024
Orange	1/31/2023		2/1/2023	1/31/2024	2/7/2024	2/15/2024
Placer	1/31/2023	2/1/2023	2/14/2023	1/31/2024	n/a	2/7/2024
Plumas	2/14/2023	2/15/2023	2/21/2023	2/9/2024	2/9/2024	2/15/2024
Riverside	1/31/2023	2/1/2023	2/15/2023	2/1/2024	2/8/2024	2/21/2024
Sacramento	1/25/2023	1/26/2023	1/27/2023	1/31/2024	2/14/2024	2/23/2024
San Benito	5/10/2023	5/11/2023	5/25/2023	3/18/2024	3/18/2024	3/22/2024
San Bernardino	1/31/2023		2/6/2023	1/31/2024	2/12/2024	2/21/2024
San Diego	1/31/2023	1/31/2023	2/14/2023	1/30/2024	2/5/2024	2/14/2024
San Francisco	1/31/2023	2/1/2023	2/16/2023	1/31/2024	2/8/2024	
San Joaquin	1/31/2023		2/1/2023	2/22/2024	3/7/2024	3/27/2024
San Luis Obispo	12/30/2023	1/6/2023	1/19/2023	1/25/2024	2/8/2024	2/14/2024
San Mateo	3/6/2023	3/24/2023	4/3/2023	2/16/2024	2/22/2024	
Santa Barbara	12/23/2023	2/7/2023	2/15/2023	1/30/2024	2/9/2024	2/12/2024
Santa Clara	1/31/2023	1/31/2023	2/16/2023	2/1/2024	2/15/2024	2/22/2024
Santa Cruz	4/6/2023	4/14/2023				
Shasta	1/31/2023	2/2/2023	2/16/2023	1/30/2023	2/15/2024	2/21/2024

DHCS Status Chart of County RERs Received
April 25, 2024, Commission Meeting

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Sierra	1/27/2023	1/30/2023	2/16/2023	12/18/2023	12/27/2023	1/15/2024
Siskiyou	2/6/2023	2/7/2023	2/9/2023	2/2/2024	2/15/2024	2/15/2024
Solano	1/31/2023	1/31/2023	2/15/2023	1/31/2024	2/15/2024	2/20/2024
Sonoma	1/31/2023	2/2/2023	3/6/2023	1/31/2024	2/7/2024	2/14/2024
Stanislaus	1/31/2023	2/2/2023	2/3/2023	1/31/2024	2/6/2024	2/9/2024
Sutter-Yuba	1/31/2023	2/2/2023	3/6/2023	3/29/2024		
Tehama						
Tri-City	1/25/2023	1/25/2023	2/16/2023	1/31/2024	2/6/2024	2/9/2024
Trinity	7/18/2023	7/24/2023	8/24/2023			
Tulare	1/31/2023	1/31/2023	2/15/2023	1/30/2024	2/20/2024	
Tuolumne	3/29/2023	3/30/2023	4/5/2023	3/1/2024	3/4/2024	3/7/2024
Ventura	1/30/2023	1/30/2023	1/31/2023	1/31/2024	2/15/2024	2/15/2024
Yolo	1/31/2023	2/2/203	3/15/2023			
Total	**57**	**42**	**57**	**49**	**46**	**44**

Mental Health Services
Oversight & Accountability Commission

Commission Meeting Calendar (Tentative)

Focus areas are identified through the Commission's Strategic Plan goals and objectives. The 2024-2027 goals include: Champion Vision into Action, Catalyze Best Practice Networks, Inspire Innovation and Learning, and Relentlessly Drive Expectations.

The Commission's 2024-27 North Star priority is to accelerate system-level improvements to achieve early, effective, and universally available services. This priority will guide the evolution and design of the Commission's initiatives and projects, further informed by three more clearly defined operational priorities: (1) Build foundational knowledge, (2) Close the gap between what is being done and what can be done, and (3) Close the gap between what can be done and what must be done.

The draft calendar below reflects efforts to align the Commission meeting focus areas with priorities outlined in the 2024-2027 Strategic Plan. **All topics and locations subject to change**.

Dates	Locations	Focus Areas*
April 24, 25	Chico Sacramento	**4/24** - Site Visit to a children's Full-Service Partnership program **4/25** – Transformational Change in Behavioral Health Overview
May 23	Sacramento	Strengthening Full-Service Partnerships Panel Mental Health Wellness Act- 0-5 Panel and Funding
June 27	No Meeting	
July 25	San Diego	Substance Use Disorder and Mental Health Integration Early Psychosis Strategic Plan Impact of Firearm Violence Draft Report Suicide Prevention Report Out
August 22	Sacramento	Housing and Behavioral Health Services Panel Universal Screenings Draft Report Rural County Perspectives and Needs
September 26	Sacramento	Behavioral Health Workforce Strategies Psychiatric Advanced Directives Report Out Research Agenda
October 24	Sacramento	Community Engagement Planning Master Plan on Aging Implementation

Mental Health Services
Oversight & Accountability Commission

November 21	Los Angeles	Annual Strategic Plan Report Out Behavioral Health Reform Progress Report

*NOTE: The priorities listed are not the only agenda items under consideration for each month.