WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Meeting Materials Packet

Commission Teleconference Meeting
May 25, 2023
9:00 AM – 4:30 PM

Omni Los Angeles Hotel at California Plaza
Rose/Burberry Room, Floor 2
251 S. Olive Street
Los Angeles, California

MHSOAC
Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING NOTICE & AGENDA

MAY 25, 2023

COMMISSION MEMBERS:
Mara Madrigal-Weiss, *Chair*
Mayra E. Alvarez, *Vice Chair*
Mark Bontrager
John Boyd, Psy.D.
Bill Brown, *Sheriff*
Keyondria D Bunch, Ph.D.
Steve Carnevale
Wendy Carrillo, *Assemblymember*
Rayshell Chambers
Shuo Chen
Dave Cortese, *Senator*
Itai Danovitch, MD
Dave Gordon
Gladys Mitchell
Alfred Rowlett
Khatera Tamplen

EXECUTIVE DIRECTOR:
Toby Ewing

NOTICE IS HEREBY GIVEN that the Commission will conduct a Regular Meeting on **May 25, 2023, 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 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: May 25, 2023

Time: 9:00 AM

Location: Omni Los Angeles Hotel at California Plaza
Rose/Burberry Room, Floor 2
251 S. Olive Street
Los Angeles, California

ZOOM ACCESS:

FOR COMPUTER/APP USE
Link: https://mhsoac-ca-gov.zoom.us/j/85609074559
Meeting ID: 856 0907 4559

FOR PHONE DIAL IN
Dial-in Number: 669-900-6833
Meeting ID: 856 0907 4559

Public participation is critical to the success of our work and deeply valued by the Commission. Please see the information contained after the Commission Meeting Agenda for a detailed explanation of how to participate in public comment and for additional meeting locations.

Our Commitment to Excellence

The Commission's 2020-2023 Strategic Plan articulates three strategic goals:

Advance a shared vision for reducing the consequences of mental health needs and improving wellbeing.

Advance data and analysis that will better describe desired outcomes; how resources and programs are attempting to improve those outcomes.

Catalyze improvement in state policy and community practice for continuous improvement and transformational change.

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Commission 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 AM

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 AM

2. **Announcements & Updates**
Chair Mara Madrigal-Weiss, Commissioners and Staff will make announcements and welcome Kalene Gilbert, LCSW, Mental Health Program Manager, Los Angeles County Department of Mental Health.

9:20 AM

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

9:50 AM

4. **April 27, 2023 Meeting Minutes** *Action*
The Commission will consider approval of the minutes from the April 27, 2023 Commission Meeting.
    - Public Comment
    - Vote

10:00 AM

5. **Consent Calendar** *Action*
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.
    - Monterey County Innovation Project: Approval of $7,883,562.86 in innovation funding over five years for their Rainbow Connections Innovation project.
    - San Bernardino County Innovation Project: Approval of $16,557,576 in innovation funding over five years for their Progressive Integrated Care Collaborative Innovation project.

- Imperial County Innovation Project Amendment: Approval of an amendment to Imperial County's Semi-Statewide Enterprise Health Record (EHR) Multi-County Innovation Project budget due to a clerical error, that increases the total amount of innovation funding from $2,974,849, approved on January 25, 2023, to $3,089,330.

  - Public Comment
  - Vote

10:10 AM

6. Governor's Proposed 2023-2024 Revised Budget Proposal, CYBHI Grant Program & Commission Expenditure Authority *Action*

- The Commission will be presented with the Governor's Proposed 2023-2024 Budget Revisions; *presented by Norma Pate, Deputy Director.*
- Children's Youth Behavioral Health Initiative Grant Program Update; *presented by Autumn Boylan, Deputy Director, Department of Health Care Services.*
- The Commission will be presented with an update of the Commission's 2022-2023 expenditures and consider approving a revised spending plan including associated contracts; *presented by Norma Pate, Deputy Director.*
  - Public Comment
  - Vote

10:30 AM

7. 2024-2027 Strategic Plan Outline *Action*

The Commission will be presented with a proposed outline for the 2024-2027 Strategic Plan that will include a timeline, community engagement efforts and an analytical framework; presented by *Commissioner Steve Carnevale, Norma Pate, Deputy Director and Boston Consulting Group (BCG).*

- Public Comment
- Vote

12:30 PM

8. Break

The Commission will take a short break and return for a working lunch.

Mental Health Services Oversight & Accountability Commission

1:00 PM

9. Legislative Update *Action*

The Commission will consider legislative priorities for the current legislative session including Assembly Bill 1282 (Lowenthal) relating to the impact of social media on youth mental health and Senate Bill 509 (Portantino) relating to behavioral health training in schools; *presented by Kendra Zoller, Deputy Director of Legislation.*

- Public Comment
- Vote

1:30 PM

10. Impacts of Firearm Violence Project *Information*

The Commission will hear from a panel of experts on the cycle of trauma and violence that underpins firearm-related harm, including community-based and culturally-responsive approaches to preventing and mitigating the trauma associated with firearm violence; *facilitated by Commissioner Keyondria Bunch, presenters include:*

- *J. Kevin Cameron, Executive Director, Center for Trauma Informed Practices*
- *Jose Osuna, Director, External Affairs and Manager, Housing Justice, Brilliant Corners and Consultant, Osuna Consulting*
- *Refujio "Cuco" Rodriguez, Chief Equity & Program Officer, Hope and Heal Fund: The Fund to Stop Gun Violence in California*
- *Sarah Metz, PsyD, Division Director, Trauma Recovery Center, University of California, San Francisco*
- *Lara Drino, Deputy City Attorney, City of Los Angeles and Leader, REACH Team, South Los Angeles*

- Public Comment

4:30 PM

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

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 fails, 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 Commission Chair will indicate when a portion of the meeting is to be open for public comment. **Any member of the public wishing to comment during public comment periods must do the following:**

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

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

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

May 25, 2023 Commission Meeting

Approve April 27, 2023 MHSOAC Teleconference Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the April 27, 2023 Commission teleconference meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Enclosures (2): (1) April 27, 2023 Meeting Minutes; (2) April 27, 2023 Motions Summary

Handouts: None.

Proposed Motion: The Commission approves the April 27, 2023 Meeting Minutes

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date April 27, 2023

Time 9:00 a.m.

Location MHSOAC
1812 9th Street
Sacramento, California 95811

Members Participating:

Mara Madrigal-Weiss, Chair
Mayra Alvarez, Vice Chair
Mark Bontrager
Sheriff Bill Brown
Keyondria Bunch, Ph.D.*
Steve Carnevale
Rayshell Chambers
Shuo Chen*
Itai Danovitch, M.D.
David Gordon
Gladys Mitchell
Alfred Rowlett

*Participated remotely.

Members Absent:

John Boyd, Psy.D.
Assemblymember Wendy Carrillo
Senator Dave Cortese
Khatera Tamplen

MHSOAC Meeting Staff Present:

Toby Ewing, Ph.D., Executive Director
Geoff Margolis, Chief Counsel
Norma Pate, Deputy Director, Administration and Performance Management
Kendra Zoller, Deputy Director, Legislation
Melissa Martin-Mollard, Ph.D., Chief, Research and Evaluation
Tom Orrock, Chief, Community Engagement and Grants
Sharmil Shah, Psy.D., Chief, Program Operations
Amariani Martinez, Administrative Support
Lester Robancho, Health Program Specialist
Cody Scott, Meeting Logistics Technician

1: Call to Order and Roll Call

Chair Mara 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.

Chair Madrigal-Weiss 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.

Geoff Margolis, Chief Counsel, called the roll and confirmed the presence of a quorum.

2: Announcements and Updates

Chair Madrigal-Weiss reviewed the meeting protocols and gave the announcements as follows:

Commission Meetings

- The March 2023 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.
- The next Commission meeting will take place on May 25th in Los Angeles with a site visit on the day before.

Future Site Visits

Chair Madrigal-Weiss asked Commissioner Bunch to share information on site visits coming up in May related to the Impact of Firearm Violence project.

Commissioner Bunch thanked Courtney Ackerman who stepped in to take over this project. Several upcoming engagements are planned for the Impact of Firearm Violence project:

- A site visit to Sacramento Gun Range will take place on Thursday, May 11th, to meet with the general manager, tour the facility, and learn about their Gun Shop project, which allows the safe storage of guns in a time of crisis at a reduced rate. This is an example of one of the ways to partner with gun store and gun range operators to reduce the incidence of suicide by firearm. Commissioners will also hear from one of the suicide prevention contractors on other suicide prevention measures happening in partnership with the gun-owning community. This site visit is not open to the public, but Commissioners are welcome to attend. Please let staff know if you plan to attend.
- A site visit to the Los Angeles Reach Team will take place on Wednesday, May 24th, the day before the May Commission meeting. The Reach Team is a collaborative effort between the Los Angeles City Attorney's Office, the Los Angeles Police Department, and the Children's Institute to provide immediate mental health support and assistance to children who have been exposed to firearm violence, with a goal of preventing the short- and long-term negative

impacts of trauma. The site visit will include an overview of the collaborative program, a stop at the Children's Institute's Watts Campus, and a ride-along in some of the areas that the Reach Team services. This site visit is not open to the public, but Commissioners are welcome to attend. Please let staff know if you plan to attend.

- On May 31st, Commission staff will present at the Los Angeles Psychological Services Committee Annual Training Event at The California Endowment. The topic for this year's training is firearm violence. Staff will give an update on the project and talk about what is happening at the state level to explore efforts being taken to address the impacts of firearm violence.

New Staff

Chair Madrigal-Weiss asked Mr. Orrock to share recent staff changes.

Tom Orrock, Chief, Community Engagement and Grants, stated that three new staff have joined the Commission since the last Commission meeting:

- Jay Schenirer, the new Special Consultant to assist the Community Engagement and Grants team with their strategy around expanding the voice of K-12 students through local- and state-level advocacy efforts.
- Catina Walker, who will assist with the Older Adults Mental Health Wellness Act project.
- Alishia Dauterive, the first Sally Zinman Peer Fellow.

Commissioner Chambers stated that, as a peer with lived experience, she is excited and happy to hear that Alishia Dauterive is coming on as a peer fellow. The voice of consumers throughout the mental health system is vital to success with the whole continuum of care. She stated that she is most excited about Sally Zinman's fellowship because Sally Zinman was her mentor and encouraged her to work across the board and collaborate, even when things looked dire. She stated that she looks forward to working with Alishia Dauterive and the other new staff on peer certification and integrating peers throughout the whole system of care, even in state government.

PEI Priorities Information Notice

- At the Commission's March Meeting in San Diego, the Commission not only adopted the PEI Report – *Well and Thriving* – it also adopted two additional priorities for the use of Prevention and Early Intervention (PEI) funds. On April 26, 2023, the Commission issued Information Notice Number 23-001, which adds transition age youth (TAY) not in college and community-defined evidence practices (CDEPs) as additional PEI priorities. The Informational Notice is in the Meeting Materials, was sent directly to the Counties, was distributed through the Commission's List-Serv, and can be found on the Commission's website.

Site Visit Report Out

Chair Madrigal-Weiss shared about yesterday's site visit to Turning Point Community Programs Full-Service Partnership. She thanked the team at Turning Point and Commissioner Rowlett for sharing their work with Commissioners.

- Commissioners interacted with staff and members in a climate and culture of care, compassion, and respect and heard about successes and some of the challenges.
- Members shared their experiences in advocacy for programming that has changed their lives.
- FSPs are essential programs on the front line of addressing homelessness for people with severe and persistent mental health needs.
- Recognizing the emphasis in the Governor's proposal on FSPs, it is important for the Commission to understand how well they are working and how they can be improved.

Chair Madrigal-Weiss invited Commissioner Carnevale to share his thoughts about yesterday's site visit.

Commissioner Carnevale stated that it was a learning experience and a wonderful thing to see. He stated that the leadership team has been there a long time and noted that this is a big statement in and of itself. The highlight was listening to the long-term residents who both had a typical journey that was challenged but, as a result of the wraparound services they experienced, have elevated their lives and are inspirational and filled with hope and are committed to the belongingness of the community they are in. He thanked Commissioner Rowlett for that opportunity.

Chair Madrigal-Weiss invited Commissioner Rowlett, Turning Point's Chief Executive Officer, to say a few words.

Commissioner Rowlett introduced Turning Point staff in attendance and thanked them for orchestrating yesterday's site visit. He stated that he has been a part of Turning Point for over 40 years, which is a testament that it is a privilege to do the compelling, compassionate, amazing work that FSPs do and to experience the truth with transparency that is shared by individuals who Turning Point is privileged to work with. By supporting individuals in a way that they identify, Turning Point can support them with change in the trajectory of their lives, including housing, which is a feature of FSPs. The Commission will hear more about that later in today's agenda. Commissioners will also hear about unique opportunities that are ahead because of the challenges being experienced. He stated appreciation that every Commissioner and staff member who attended the site visit was receptive and gracious in their remarks and support of the individuals who shared their stories yesterday. This is a reflection of the leadership of the Commission.

3: General Public Comment

Stacie Hiramoto, Executive Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), thanked the Commission for their vote at the last Commission meeting for the new PEI priorities. There was much celebration in the community. She commended staff for getting the Information Notice out quickly. She also thanked the Commission for having the Governor's administration come and present his plan for the modernization of the Mental Health Services Act (MHSA) and the other aspects of the behavioral health community. Although the administration held sessions, there was no

room for public comment. She thanked the Commission for allowing time for the public to comment today.

Stacie Hiramoto suggested that, when the Commission Committees are formed, public stakeholders – not just the ones contracted with – should be allowed to comment. She asked that any changes made to the Committee or Committee process be shared with the public prior to implementation so the public can provide feedback.

Laurel Benhamida, Ph.D., Muslim American Society – Social Services Foundation and REMHDCO Steering Committee, echoed the comments of the previous speaker. The Commission's prompt posting of the Information Notice about the PEI priorities is commendable. The Commission's community process showed that advocacy can make a difference. New refugees and immigrants come from places where the public cannot make a difference without having a revolution.

4: March 23, 2023, Meeting Minutes

Chair Madrigal-Weiss stated that the Commission will consider approval of the minutes from the March 23, 2023, Commission meeting. She stated that meeting minutes and recordings are posted on the Commission's website.

Public Comment. There was no public comment.

Action: Chair Madrigal-Weiss asked for a motion to approve the minutes. Commissioner Carnevale moved, and Commissioner Rowlett seconded, that:

- *The Commission approves the March 23, 2023, Meeting Minutes.*

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

The following Commissioners voted "Yes": Commissioners Bontrager, Brown, Bunch, Carnevale, Chambers, Danovitch, Gordon, and Rowlett, and Chair Madrigal-Weiss.

5: Consent Calendar

Chair Madrigal-Weiss stated that 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.

- Fresno County Innovation Project (Extension): Approval of $3,160,000 in Innovation funding over an additional two years for The Lodge: Researching Targeted Engagement Approach innovation project.
- Fresno County Innovation Project: Approval of $3,000,000 in Innovation funding over five years for the Participatory Action Research with Justice-Involved Youth using an Adverse Childhood Experiences (ACEs) Framework innovation project.
- Stanislaus County Innovation Project: Approval of $5,185,000 in Innovation funding over five years for the Embedded Neighborhood Mental Health Team innovation project.

Commissioner Comments & Questions

Chair Madrigal-Weiss referred to the Participatory Action Research with Justice-Involved Youth using an ACEs Framework innovation project and thanked Fresno County for engaging youth who have been and currently are in the system – not only engaging them in the work but in the development of this plan. She stated she hopes to learn from it and to have the county serve as peer mentors along the way, being thoughtful about what happened, how it can be addressed, and how the community can rally around. Having the youth part of that conversation from the inception is extremely valuable.

Public Comment. There was no public comment.

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

- *The Commission approves the Consent Calendar.*

Motion passed with 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Brown, Bunch, Carnevale, Chambers, Danovitch, Gordon, Mitchell, and Rowlett, and Chair Madrigal-Weiss.

6: Full Service Partnerships

Chair Madrigal-Weiss stated that the Commission will hear two panel presentations on Full-Service Partnerships (FSPs). The Commission identified FSPs as a priority area for this year. This initial public hearing is meant to provide information about the current state of FSPs across the state through presentations from subject matter experts representing different perspectives. She invited Commissioner Rowlett to provide introductory remarks.

Commissioner Rowlett stated that FSPs have been presented by the leadership of California as part of the solution to improve many of the unique challenges that California experiences today. He stated that not every person who is homeless has a mental health issue. It is important to understand that the unique housing crisis in California is not just germane to people who are experiencing symptoms associated with a psychiatric disorder or substance use disorder. California's housing crisis cuts across many sectors.

Commissioner Rowlett stated that it is also important to understand the history and array of services in FSPs and the commitment made by individuals involved in FSPs in the state and county. The workforce shortage is impacting FSPs and causing unique challenges. He noted that there was a commitment to improve data and outcomes and a portion of that commitment remains unfulfilled today. He stated the importance of developing data protocols that would inform services going forward.

Commissioner Rowlett stated that FSPs work because of the commitment of the individuals being served and the individuals doing the work. He stated the hope that this is not seen as a false panacea that will solve every challenge that the state of California has today, but it is an important part of the solution. All the individuals who will be

presenting today will provide insight and help in making sure that the next iteration of the FSP document is reflective of Commissioners' sentiment and includes the perspectives of every person in the room.

Chair Madigal-Weiss asked Dr. Martin-Mollard to introduce the presenters and facilitate the panels.

Panel 1

Melissa Martin-Mollard, Chief of Research and Evaluation, stated FSPs are the core investment of the MHSA. Counties are required to dedicate a majority of MHSA community services and supports (CSS) funding to support these programs. As part of the Commission's mission to support transformational change, the Commission has taken on this project to strengthen these essential investments. Commissioners will hear two panel presentations on FSPs. She introduced the members of the first panel, who will describe the history and promise of FSPs, include a consumer perspective, and provide an overview of current efforts to establish best practices for the model.

Dave Pilon, Ph.D., former CEO, Mental Health America, Los Angeles, acknowledged the lifelong contributions of Richard Van Horn who passed away a little less than two years ago and who served as a Commissioner on this body. He stated that none of what he has done in his career would have been possible without the leadership of Richard Van Horn.

Dr. Pilon provided an overview, with a slide presentation, of the background, structural features, service expenditure patterns, and highlights of the findings of the independent evaluation of the Village Integrated Services Agency (The Village). He stated that The Village was judged on outcomes rather than on any particular services it provided.

Dr. Pilon made three recommendations:

- Explore a true pay-for-value system that holds providers accountable for their outcomes.
    - Reduces the documentation and billing burdens that staff experience under Medicaid.
- Provide separate funding streams (de-coupled from FSPs) for psychosocial rehabilitation services like supported employment, supported education, and community integration services.
- Increase hiring of and reliance on non-licensed B.A. level staff to provide the aforementioned psychosocial rehabilitation services.

Michael Robinson, Former FSP Partner, shared his story of losing his spouse and becoming suicidal, an alcoholic, diagnosed with mental illness, and homeless, and then being invited to stay at Turning Point Crisis Residential. He described this as throwing him a lifeline that he could grab onto to pull himself up. He thanked Turning Point for being there when he needed them.

Commissioner Comments & Questions

Commissioner Bunch agreed with the importance of psychosocial rehabilitation services and stated that they unfortunately are often a small part of treatment and services and are typically done by case managers; however, since there are never enough case managers and they are not billable services, this is not provided for clients. This issue will worsen with payment reform.

Commissioner Brown asked for further detail on the barriers and challenges of the Trieste model in Hollywood.

Dr. Pilon stated that, in his limited understanding, Los Angeles County came back to the Commission and asked for changes to the original Trieste proposal because it originally was to be completely funded by innovation funding with no Medicaid match. Also, the COVID-19 pandemic hit during the beginning of implementation. The county is not trying to implement many of the original parts of the proposal. He stated Turning Point is talking to the county about carving out 5 or 10 percent of that original proposal to let Turning Point proceed without the Medicaid match to see if that makes a difference in outcomes. This is still in the community engagement process phase.

Commissioner Brown stated appreciation for Mr. Robinson’s comments and courage in sharing the story of his journey and successes and about the wonderful work of Turning Point. He told Mr. Robinson that he is a shining example of the proof that recovery is a process, not an event. So many people are frustrated because they want quick fixes and quick solutions but sometimes it takes a while.

Commissioner Brown stated that he worked very closely with Richard Van Horn and was an admirer of him as well. He stated that The Village concept is amazing. He told Dr. Pilon that he left a great legacy for Richard Van Horn.

Commissioner Bontrager thanked Mr. Robinson for his service and for sharing his story. He agreed that psychosocial rehabilitation services are critical. There currently is a crisis of culture and a sense of belonging as much as there is a mental health crisis. He asked for further detail on community integration services.

Dr. Pilon stated that community integration services are anything that is trying to reintegrate individuals into the communities that they may have lost because they have a mental illness. This can be through formal things like education and employment, but is also exposing individuals to activities in the community such as music, surfing, or being in a band to help them find their passion, sense of purpose, and sense of belonging. This is a heavy lift in some ways because the focus is usually on the latest crisis. That is why there must be dedicated staff, not to deal with the crises but to deal with the need for purpose and belonging.

Commissioner Carnevale stated that he enjoyed meeting with Mr. Robinson and his dogs yesterday during the site visit. He stated that someone outside of the mental health community may have difficulty understanding why there are many needs not being met. For example, most everyone is lucky enough to have a house and it is hard to fathom how to operate without a house. There is a delusion that it is enough to give a person a house, but he stated that he learned at the site visit that that is not nearly enough.

Commissioner Carnevale stated that he was moved by the idea of the need to move to an outcome system and that these outcomes need to be around belonging and purpose and measuring the number of individuals that make their way through this recovery process to education, employment, and being productively engaged in their communities.

Commissioner Carnevale stated that the Commission's report on FSPs states that, despite regulatory requirements, counties do not appear to be allocating mandatory minimum funding levels to support the FSP program. He asked why counties are not doing it and how they can get away with it since it is a requirement. The answer cannot be that they do not think it is a good idea because it clearly delivers needed results.

Dr. Pilon stated that crises take all the attention and do not allow focusing resources on anything else because there is always a crisis around the corner. He stated that people should not just maintain to a level of stability; the other things should be the aim of services to help move individuals on in their recovery where they can achieve normalized roles in the community.

Commissioner Carnevale asked why counties are not adopting this more.

Dr. Pilon stated that the service culture is about just getting people stable. Also, FSPs are working with great results but this is unknown because they are not reporting outcomes to reinforce that. It needs to be talked about more.

Commissioner Rowlett stated that FSPs are designed to have staff available 24 hours a day, 7 days a week, to be there when they are needed, but the workforce shortage is compromising that ability. The goal of FSPs is to support people with flourishing – to provide services until the person is no longer dependent on specialty mental health services. He asked about flourishing scales as an important outcome measure that is reflective of the perspective of the individual who is receiving the services.

Dr. Pilon stated that a particular scale is not as important as the need to measure outcomes. He stated the need to look at the scales to see if they capture what is hoped to be achieved. He agreed that the goal is for individuals to graduate from mental health services. He stated the importance of having a valid and reliable metric to determine that and flourishing scales can be a part of that.

Commissioner Rowlett stated the need for the Commission to support scales that reflect that the Commission is gathering the data and that the perspective of the individual receiving the services is included. He stated that the Commission supports community-defined practices, especially those practices that work in communities where individuals are unserved and underserved and have been successful but potentially are not evidence-based because of a variety of things. He asked Dr. Pilon to speak about community-defined practices.

Dr. Pilon spoke in favor of community-defined practices as long as they are in the process of providing evidence for their effectiveness. They must be evidence-based. If those practices are just starting up, they need to be given the time to develop the evidence as they work their process but, at some point, each practice must be considered to see if it is delivering on its promise.

Commissioner Carnevale stated that it is now a business cutting-edge best practice to be looking at wellness and flourishing scales in the private sector. The fact that the public sector is still debating and discovering that they should be outcomes in the public sector points to a huge equity gap between public and private that needs to be addressed.

Chair Madrigal-Weiss stated that, when she looks at scales and the numbers for The Village, the emphasis is in holistic categories – the whole person – the things that bring hope and belonging. She referred to the Service Expenditure Patterns presentation slide and stated that the comparison group is not about the human but is about the illness. She asked where current practices are between The Village and the comparison group.

Dr. Pilon stated that it varies tremendously across the system. FSPs are further towards the holistic than other parts of the system. It is a culture issue. In talking about recovery, a language has been created where individuals talk about recovery but they do not necessarily practice it. They assure that they are recovery-oriented and yet they have no staff focused on helping individuals get jobs, for example.

Dr. Pilon stated that the power of that slide is that it says that you have to put your money where your mouth is. It is not just about saying that you are in favor of recovery or recovery-oriented services, but rather if the services provided focus on those kinds of things. Not being holistic is not intentional; it is that they do not know how to do that because there is no culture of psychosocial rehabilitation. He asked the Commission to consider ways to make psychosocial rehabilitation a more significant aspect of the way to think about services. He stated that individuals will embrace it but they must be given technical assistance and support in moving towards that system.

Commissioner Mitchell asked how to change the thinking to help models improve.

Dr. Pilon stated that it is a culture shift to a large extent.

Commissioner Mitchell asked how to achieve that culture shift.

Dr. Pilon stated that the way mental health services are paid for and whether they are reimbursable have an enormous impact on what people feel that they can do. Medicaid does not make it easy to pay for things like employment services. If it is made easier to provide these things without the fear that they will have the money taken back by the federal government, then they will do them. It is not that people do not want to provide these kinds of services; it is just that they feel that their hands are tied. It is a huge disincentive to providing that kind of culture shift.

Commissioner Carnevale stated that Commissioners keep hearing about billing. He asked if that is something that is possible for the Commission to take on.

Executive Director Ewing stated that the intent of the site visit yesterday and this first hearing is to bring education and awareness and identify lines of inquiry. The Commission is required under law to provide a report to the Governor and the Legislature every other year. Staff will develop a plan from feedback received.

Panel 2

Dr. Martin-Mollard introduced the members of the second panel, which included representatives from county behavioral health agencies and FSP providers, who will share perspectives on systemic challenges and opportunities for improvement statewide.

Lisa Zepeda, LMFT, Program Manager, Kings View Behavioral Health Systems, Kings County, introduced the members of the team. She provided an overview, with a slide presentation, of the background, levels of care in adult services, FSP criteria, staffing, services provided as part of the FSP, and challenges and opportunities. She stated that all services are provided within the framework of the wellness and recovery based mental health model with supportive services that are easily accessible and culturally competent.

Fallon Martinez, Medi-Cal Certified Peer Support Specialist, Kings View Behavioral Health Systems, continued the slide presentation and discussed peer support certification, daily tasks, and different ways a Peer Support Specialist works with the other members of the treatment team and with members in the program. She stated that she continues her training by attending monthly trainings via Zoom to provide updated information on how to better support individuals as a Peer Support Specialist.

Phebe Bell, Director of Behavioral Health, Nevada County, and Past President, County Behavioral Health Directors Association (CBHDA), stated that she will share information around what FSP services can look like in a rural community. The FSP programs in Nevada County are Turning Point Community Programs, Victor Community Support Services, and Stanford Sierra Youth and Families. She provided an overview, with a slide presentation, of the context, unique aspects of FSPs in a rural area, MHSA revenue trends, outcomes, and challenges in the FSP work.

Ms. Bell stated that rural FSPs are not that different from urban FSPs in many ways, but in rural settings care can be personalized due to the lower numbers of individuals in the programs. This creates a web of support that is a little more flexible and seamless across levels of care with fluid movement back and forth between programs to meet people where they are with the needs they have to bring the highest level of care that is needed to keep individuals safe, stable, and well-supported in a community setting.

Nicole Kristy, MBA, Director, Third Sector Capital Partners, stated that Third Sector is a national non-profit technical assistance organization that has supported this project over the past three years. She provided an overview, with a slide presentation, of the context, vision and shared goals, design and implementation, sustainability planning and evaluation, and lessons learned during the Multi-County FSP Innovation Project. She stated that the project is a collaboration of nine counties working together to improve FSP services and outcomes. There is an opportunity to continue to expand community engagement to involve community voice in decision making, grow the statewide learning community, and explore opportunities for statewide capacity building. She stated that the next Statewide Learning Community Forum will be held on May 25th.

Commissioner Comments & Questions

Commissioner Carnevale thanked Third Sector for adding increased connectedness. He asked Dr. Pilon about recommended outcome measurements that the Commission could advocate to expand.

Dr. Pilon stated that he also was excited to hear about the increased connectedness. He stated that the Third Sector presentation also included looking at self-reports of social connectedness so there is a commonality between those two things. Social connections improve overall health; a self-report on whether social connections are being created is a good way to measure that.

Commissioner Carnevale asked about outcomes around education and employment.

Dr. Pilon stated education and employment can be measured by tracking if members are going back to school or getting jobs.

Commissioner Carnevale suggested that the Commission expand in those directions to measure those outcomes rather than looking at pieces that bill for that alone.

Commissioner Carnevale congratulated Nevada County for writing a great set of programs. He asked if one of the county's challenges is lack of funding or lack of flexibility of the funding.

Ms. Bell stated that it is both. Nevada County could serve more individuals with added funding and could more nimbly move between the existing buckets to meet the daily need with added flexibility. For example, when the county created its buckets 10 to 15 years ago, it could not have foreseen the housing crisis today.

Commissioner Carnevale stated that Ms. Bell is indicating a lot of variability and not enough funding, but when he looks at Nevada County on the Commission's website, he sees that there is $110 million of unspent funding, which will grow substantially over the next year. He asked, if there is a shortage of housing, why the county is not spending some of that money on housing. That funding does not need to go through the existing budget. He stated counties report that their budgets are limiting and the Commission sits here trying to figure out why. Taxpayers paid money into the system to solve mental health crises and there are billions of dollars being left in the system unspent. He asked Ms. Bell to explain this from a county perspective to help the Commission learn what it is missing.

Ms. Bell questioned that Nevada County has $110 million of unspent funding but stated that they would like to find it if they do. She referred to the MHSA Revenue Trends presentation slide and stated the need to recognize that it is difficult to spend the funding in the year it comes in because the county does not know what the amount will be and it most often substantially misses whatever it was projected to be. The county sets its spending goals based on projects that are unstable and volatile.

Ms. Bell stated that Nevada County has set its next three-year spending goal at approximately $7 million, which is less than it will take in next year but $3 million more than it will take in this year. It is about managing a very volatile funding stream in a responsible way and trying to get through a year like 2023 with 40 percent less revenue than was planned without cutting a single program in a time when programs are

desperately needed. The revenue fluctuations do not relate to the demand fluctuations, which is a challenge.

Ms. Bell stated that, secondly, it is the rigidity of the current buckets in which the county must spend money. After taking off innovation, 80 percent goes to CSS, and 50 percent of CSS must go to FSP, which means there is 50 percent for general systems work – this is where housing purchases can happen. But if there is, for example, $4 million of CSS and $2 million spent on FSP but suddenly there is $5 million this year because there was more revenue than expected, general services spending cannot be boosted to purchase a house because now the ratios are off and the county is not hitting the 51 percent on the FSP side. She stated she cannot call Commissioner Rowlett in the middle of February asking him to increase his program by $500,000 this year so the county can buy a house on the other side of the bucket. Programs are not nimble in that way so the county gets stuck in ways it did not plan to.

Commissioner Carnevale agreed that Nevada County does not have $110 million of unspent funding and stated that that figure was for multiple counties, but maintained that there are unspent funds available to the county. He stated that, if it were ten years ago, he would understand the argument that the county does not know what will happen over the next year, but the funding has only gone up over the past few years so that there is now close to $3 billion in the system that looks like it will grow to over $5 billion. He encouraged Ms. Bell to look at Nevada County's unspent fund amount. He stated that all counties may need to be more aggressive in thinking about spending that money because it is only getting larger.

Ms. Bell speculated that all Behavioral Health Directors would agree. The need is urgent, the need is now, and people are suffering. There is no question about that. She stated that counties are given three years to spend MHSA dollars because it is so volatile and so hard to predict in the same ways that the state struggles with spending unexpected revenues in the same year they come in. When looking at reversion, less than 1 percent of all MHSA dollars revert. Counties get the money out the door in their legally required timeframes.

Ms. Bell stated Nevada County worked with the community to set a buffer that everyone feels is important. The county typically has approximately 50 to 60 percent of a year of expenditures in its unspent funds so that, when there is a year like 2023 with 40 percent less, it can continue onward. She noted that the county's Three-Year Plan shows that the county plans to aggressively spend moving forward because some of those projections continue to not hit the mark, particularly around expenditures in a workforce crisis. She argued that Behavioral Health Directors are doing their utmost to spend this money effectively and efficiently.

Commissioner Carnevale stated that he stands corrected. He stated that he received the correct numbers and it turns out that Nevada County is one of the best counties in spending its money. He suggested using this discussion as an example to the many counties that are not spending their funding. He apologized and thanked Nevada County for the hard work that they do.

Commissioner Rowlett stated that the Nevada County presentation indicated that 79 percent of services are contracted. He stated this necessitates a particular type of

approach, which works in Nevada County. The approach is a partnership with contractors or non-government organizations, such as Turning Point, which has been a long-standing partner in Nevada County. One of the most important features of the partnership is a degree of transparency that is necessary but at times uncomfortable. He asked Ms. Bell to share why the county has taken this successful approach.

Ms. Bell stated that counties need providers more than the providers need the county's funding because money without people doing amazing work is just money. It will not help address the need. Also, the more doorways into support that exist versus the county building doorway, the more access and options there are to give community members that are more comfortable for them. Many people do not want to walk into county buildings; they want to find someone who is more comfortable, looks like them, has shared experiences, and has lived experience like theirs to connect with. It is a mutually-dependent system.

Ms. Bell stated that to make the best decisions possible for communities and the individuals being served, the knowledge of the big picture is necessary. That only happens when information can be shared honestly when partnering and hearing each other's input in making the hard decisions.

Ms. Bell stressed that she has gotten to know all the Behavioral Health Directors over the years and feels that there is no one with bad intentions. Everyone wants to do the right thing for their communities with their partners. This is complicated work; we are only as strong as all of us together can possibly be. Collaboration is critical to the system wellbeing.

Chair Madrigal-Weiss acknowledged Lisa's Zepeda's comments about the workforce shortage.

Ms. Zepeda stated Kings View is losing staff to the private sector, going into private practice, and working for online providers.

Chair Madrigal-Weiss stated telehealth services are being offered more and more even in the school community. This is weighing on the system.

Chair Madrigal-Weiss asked Ms. Bell if the county has a waiting list and if they are meeting the needs of the community.

Ms. Bell stated no one is waiting for FSP-level care who is not getting services. They are being supported with the outpatient staff; however, there are more individuals who can benefit from a more intensive level of service such as the FSPs can provide.

Chair Madrigal-Weiss thanked the panel members for presenting and answering questions.

Public Comment

Stacie Hiramoto thanked the panel members for their presentations. She suggested looking at Dr. Pilon's recommendations. The comments that going toward Medi-Cal changed the nature of the program and made it difficult holds true for many racial and ethnic organizations that serve those communities. Everyone wants to push them to Medi-Cal to get that dollar. It is important to save money but it changes the nature of the

program. The MHSA was to transform the mental health system. Going toward Medi-Cal is the wrong direction.

Dawan Utecht, Chief Development Officer, Telecare Corporation, stated that they were previously the Director of Behavioral Health for Fresno County. The speaker thanked the Commission for focusing on FSPs, such an integral part of the behavioral health continuum of care. The speaker provided an overview of Telecare Corporation, one of the largest providers of FSP and Assertive Community Treatment (ACT) services in California.

Dawan Utecht stated that Telecare Corporation recommends moving away from a fail-first system of FSP referrals. Currently, to qualify for a referral, individuals must have repeat hospitalizations, incarcerations, or crisis visits. While the need for an FSP is clear for these individuals, less rigid criteria could increase access to services earlier in their course of care.

Dawan Utecht stated that a challenge in the policy and practice arena is the need for a statewide credentialling system. Delays in credentialling can limit the ability of providers to quickly deploy staff and increase access to care.

Dawan Utecht stated that another challenge is the manual and at times arbitrary nature of data collection, developing the standardized datasets recommended across the system not just for MHSA, which could be built into electronic health records and then uploaded or transferred during information exchange would improve data collection, data validity, and help drive a more data-driven system of care. Further, the elimination of superfluous data collection increases the available time of staff to focus on person-centered, recovery-focused care. To build capacity, it would be helpful to understand if there are certain approaches or modalities that would better benefit.

Patricia Moreno-Gonzales, California Council of Community Behavioral Health Agencies (CBHA), stated that CBHA strongly believes that FSPs foster the much-needed capacity to serve adults with severe persistent mental illness and is in full support of the comments made by Commissioner Rowlett in discussing the importance of FSPs and the work that they do for communities.

Dr. Benhamida thanked Mental Health America for their work. She stated that she especially appreciated and recommends the first panel, not because the second panel was not good, but the first panel gave the background that many new advocates need to know as they learn about the MHSA and what has been done by the people who laid the foundation for the work that is being done now. She thanked the Commission for today's panels.

7: Lunch

8: Governor's Proposal to Modernize California's Information Behavioral Health System

Chair Madrigal-Weiss stated that the Commission will hear a presentation on Governor Newsom's three-part proposal to modernize and expand California's behavioral health system by (1) authorizing a $3-5 billion general obligation bond on the 2024 ballot to fund behavioral health expansion and housing for homeless veterans; (2) modernizing

the MHSA; and 3) improving statewide accountability and access to behavioral health services. She invited the presenters for this agenda item to come to the presentation table.

Stephanie Welch, Deputy Secretary of Behavioral Health, California Health and Human Services Agency (CalHHS or Agency), provided an overview, with a slide presentation, of the context and the three elements of the Governor's proposal to modernize and expand California's behavioral health system.

Authorize General Obligation Bond to Fund Behavioral Health Expansion and Housing for Homeless Veterans

Ms. Welch discussed the goals and objectives of the first element of the Governor's proposal, highlighting the goal of adding new behavioral health settings such as multi-property settings and cottage settings.

Modernize the Mental Health Services Act

Tyler Sadwith, Deputy Director of Behavioral Health, California Department of Health Care Services (DHCS), continued the slide presentation and discussed the goals and objectives of the second element of the Governor's proposal, highlighting the goals of updating local categorical funding buckets by lifting up housing interventions and workforce, broadening the target population, focusing on the most vulnerable, and improving fiscal accountability, county spending, and county processes.

Ms. Welch summarized the four ways that the Commission's role will be restructured as part of the Governor's proposal:

- The Commission will be moved under CalHHS to ensure their work is connected and coordinated with the state's overall behavioral health system.
- The Commission will continue to examine data and outcomes to identify key policy issues and emerging best practices and promote high-quality programs.
- The Commission will continue to report to the Legislature, include representation from the Legislature, and maintain their responsibilities related to community engagement.
    - The DHCS will provide oversight of the fiscal allocations and counties' use of funding, including accountability for contracted services.
- The Commission will become advisory and its Executive Director will be a gubernatorial appointee.

Improve Statewide Accountability and Access to Behavioral Health Services

Mr. Sadwith continued the slide presentation and discussed the goals and objectives of the third element of the Governor's proposal, highlighting the goals of fiscal transparency, county accountability and infrastructure, and alignment between Medi-Cal and commercial coverage of behavioral health services.

Next Steps

Ms. Welch stated that the next steps include working with the Legislature, system and implementation partners, and a broad set of interested parties, including those impacted

by behavioral health conditions, to set these reforms into motion to deliver equitable, accessible, and affordable community-based behavioral health care for all Californians.

Ms. Welch stated that the concern most often heard is that individuals with serious and persistent mental illness are being chosen over trying to intervene early. She stated that this is not what is being proposed; there are several funding sources to cover early intervention services.

Ms. Welch stated that another concern being heard most often is that including individuals with primary substance use disorder (SUD) would use too many resources. She stated that this is not what is being proposed; especially with the work that has been done by counties in the last five years to implement the Drug Medi-Cal Organized Delivery System, the proposal includes the ability to use the MHSA to be an engine to expand and provide more SUD services for Californians.

Commissioner Comments & Questions

Commissioner Carnevale stated that everyone is trying to get to the same end goal; however, priorities and organization are being fought over. He stated that he finds the term "modernization" of the MHSA interesting because the definition of the formation of the Commission is transformative change and Commissioners spend every meeting discussing modernization. The Commission has pursued goals around programs that have been outside this and other administrations' efforts around early psychosis and FSPs. He stated appreciation that housing will be connected to suicide prevention. That fulfils some of its responsibilities to be innovative.

Commissioner Carnevale stated that, with his business background, he thinks about the governance issue, which is not about this administration but is about the structure of government. It supersedes this administration because it will apply to many administrations after that. He stated that he does not understand the logic that it will be more efficient to pull all these together – that is like the Senate saying that they will bring the House into the Senate so that the government is more efficient, or eliminating the Congress and the courts to be even more efficient. The very nature of the structure of this country is to have checks and balances. That is precisely why this was set up the way it was.

Commissioner Carnevale stated that the reason private businesses are structured the way they are around innovation is because big companies do not innovate. For example, almost all new jobs are in small businesses. He stated that the Commission is smaller and more innovative and is structured to be that way. He stated that he does not understand why what is effectively the Silicon Valley of mental health for California will be eliminated by rolling it into the battleship that, by definition, has to serve everyone. Rolling it together from a government standpoint makes no sense. It does not accomplish anything. He asked what is not happening today that is wanted, because the door is open for the Commission to cooperate. He asked what would be better if it was all rolled together.

Commissioner Bontrager stated that community-based organizations do a lot of the heavy lifting and service delivery in the state for mental health. They are long on passion and often short on capacity because of their scarcity. One of the values of the

Behavioral Health Continuum Infrastructure Program (BHCIP) is that it has enabled many community-based organizations to expand facilities through public monies. He asked, as the General Obligation Bond is considered for these new settings, if the plan is to have a similar format where funding is disbursed to private non-profits, or if they will be publicly-funded facilities.

Ms. Welch stated CalHHS is pleased with the success of the BHCIP for many of the reasons mentioned and has explored building off of it, but many things are in play.

Commissioner Bontrager asked if, in the modernization of the MHSA, there will be a cost shift in what is currently provided by schools to now be paid for by MHSA funding for groups of students, such as the delivery of socioemotional learning curriculum.

Ms. Welch stated that she is not an expert on the Children and Youth Behavioral Health Initiative (CYBHI) but stated that the idea is to focus on services that cannot be tied to an individual. This is for universal population-based type things that may happen in a school, such as a whole-school approach for suicide prevention, stigma reduction efforts, etc.

Mr. Sadwith agreed and stated that the focus on school-wide interventions is to recognize and scale up that this is happening today. There are pockets in many schools and communities where this is a best practice, recognizing that it would be non-duplicative with what the CYBHI fee schedule will do regardless. The question about cost-shifting almost applies to the fee schedule itself irrespective of the MHSA proposal.

Commissioner Bontrager stated that he is in support of it being added but does not want it to supplant what schools are already obligated to provide under multi-tiered services and supports.

Chair Madrigal-Weiss asked the panel to respond to Commissioner Carnevale's questions about what is hoped to be gained by bringing this all together and what is not happening today that will happen tomorrow.

Ms. Welch stated that CalHHS sees the potential of a partnership inside and being part of the team that develops policy. She stated that she understands the points about the separation of power and governance but stated that she cannot speak to that. She stated that there is a lot of work to do and not only specific to the MHSA. She stated that Commissioner Carnevale mentioned that the Commission does a lot of work outside of the public system. CalHHS wants to create change for all Californians and is doing a lot of this work. There is an opportunity to do exciting work together with some of the things that are also required to be implemented.

Commissioner Carnevale asked why that could not happen today and why it would take a governance change in order to have that cooperation.

Ms. Welch stated that she does not have the answer to this question and will take the question back to CalHHS.

Commissioner Brown stated that some of the early pioneers of the MHSA, such as Darryl Steinberg, Richard Van Horn, and others, advocated strongly in the development of the MHSA for a disproportionate amount of resources to be spent on prevention over services (80 percent prevention and 20 percent services). He asked about the reason to

move away from the prevention aspect that maybe will prevent mental illness versus going seemingly almost all in on homelessness in particular. There are considerable needs in addressing the homeless population. There are housing and substance abuse issues that need to be addressed. He questioned using the limited amount of available funding on one issue rather than being more strategic.

Ms. Welch stated that early psychosis programs are part of the waiver. CalHHS has looked at the numbers and feels confident that it is not a choice and that there is more to do in the PEI section in particular that is not wedded to the structures of Medi-Cal. She stated that looking at intervention services that are now reimbursable that have another dollar to them frees up that bucket of PEI for more universal type prevention services – things that do not have any form of reimbursement with them.

Ms. Welch stated that work has been done for the last two decades to ensure that the Medi-Cal Managed Care Plan and commercial insurance pays for PEI services, not just the MHSA. This has been the focus of CalHHS. The theme of the MHSA reform is using the MHSA dollar where there is no other dollar available to do what needs to be done. There will be a local vetting process; CalHHS is not changing the fact that the communities can dictate how they want to spend that bucket – they may want to spend the majority of it on PEI. CalHHS feels confident in that. She stated the hope that these conversations will continue and that the data will continue to be reviewed.

Mr. Sadwith stated that the proposal to reallocate the local assistance components offers the ability to expand spending on prevention as well as early intervention and provide more local flexibility to adjust that so that it is not prescriptive from the state. It is not either/or. Under California Advancing and Innovating Medi-Cal (CalAIM), there are many new services covered under Medi-Cal that are on the prevention and early intervention side of the spectrum that are being funded through the MHSA in different types of ways today, but, by covering them under Medi-Cal, including many services under Medi-Cal Managed Care Plans, that frees up those funded under the MHSA, such as family therapy, dyadic services, community health workers, peer support services, mobile crisis, and coordinated specialty care for first episode psychosis. Then, moving into the more intensive FSP space, there are things like assertive community treatment and supported employment.

Mr. Sadwith stated that these are either covered under Medi-Cal today or will be covered under the waiver. With the additional average 66 percent federal match in all of that, it frees up local funding to be reinvested and reprioritized within the MHSA. The goal for providing the new 35 percent allocation for prevention, early intervention, and CSS is designed to allow potentially increased spending relative to today on PEI.

Commissioner Brown stated that the Commission’s status as an independent body comprised of a diverse group of professionals from all walks of private and public arenas is its strength. This proposal has caused concerns about essentially moving the Commission to CalHHS, the loss of the Commission’s independence, and the potential politization of the Commission, particularly with the Governor’s appointment of the Executive Director, which could, in theory, be a problem. It could change the workings of the organization and add the potential for mischief in the future.

Ms. Welch stated that, although she hears Commissioner Brown's concerns, she did not have the authority to respond to them. She stated that she will take the question back to CalHHS. She stated that CalHHS is familiar with and would expect that that is how the Commission would feel. She stated that she has already heard some of these concerns. She stated that she heard from legislative staff the concern about the Commission losing its independence and that that was part of why the Commission was created.

Commissioner Brown referred to the first bullet point under the MHSOAC slide that states that the Commission will be moved to CalHHS "to ensure their work is connected and coordinated with the state's overall behavioral health system," when the reality is that there are elements of behavioral health that occur in the state prison system, education, and other areas that are not covered by CalHHS. CalHHS is not an all-encompassing department. He stated concern that those areas, including the criminal justice system, will be shortchanged if the Commission is taken under the umbrella of a state department that has no interest in those areas.

Ms. Welch stated that she hears Commissioner Brown's concerns.

Commissioner Rowlett acknowledged that Ms. Welch stated that she does not have authority to answer Commissioner questions but stated that he endorsed Commissioner comments related to the Commission, especially Commissioner Carnevale's statement about being innovative. It is incumbent upon the Commission, if it is not perceived as being innovative, to respond to that and to have an opportunity to do so. He stated that smaller entities such as community-based organizations have a propensity to be more innovative because they are not constrained as the government is, which is appropriate.

Commissioner Rowlett stated that 30 to 35 percent of the individuals who are experiencing homelessness have a mental illness, and of that 30 to 35 percent, 20 to 25 percent suffer from co-occurring issues or SUD issues. He stated that what he heard today was different from what he has heard before. He stated that what is being implied in this presentation is that expanding the number of eligible recipients of MHSA services and not expanding the dollars will not adversely affect other MHSA funding streams. For example, if a county is required to serve individuals who have been diagnosed with an SUD and they have a percentage of their funding going to PEI, they will not have to reduce that because there are other funding streams that can leverage the federal match that they can pull down to serve an expanded number of eligible individuals. He asked if this summary is correct. He asked for an illustration of this for clarity.

Ms. Welch stated that CalHHS is working on a chart that will soon be available publicly that shows that the MHSA does not count for the federal participation. The more exciting piece is being reimbursed for dyadic services, community health workers, and things known to work. This is where CalHHS wants to grow capacity to utilize those new services that are also now tied to reimbursement without the use of a whole MHSA dollar but a percentage.

Mr. Sadwith stated that the DHCS would love to follow up and provide more information and clarification on the average drawdown. He asked for a written follow-up to ensure that responses to Commissioner questions are accurate.

Commissioner Rowlett restated his summary of what he heard in Ms. Welch's presentation that, in expanding eligibility and not expanding dollars, there will be other resources that will be available to serve the additional individuals who have been diagnosed with SUD without needing to reduce the funding for, simply put, prevention and early intervention.

Ms. Welch accepted Commissioner Rowlett's summary and stated that was not how she had originally understood Commissioner Rowlett's question.

Chair Madrigal-Weiss asked staff to provide the panel members with Commissioner comments and questions in writing.

Vice Chair Alvarez applauded that the Governor is raising the conversation of modernizing the MHSA. It has been over two decades and has included a number of changes. The question of whether the needs of communities are being met is a fair question to ask. She stated the belief that everyone is ready to have that conversation to determine the best path forward. She stated that, from what has been seen and read, the proposal misses the opportunity of a whole family, whole child approach that the administration has been behind since the Governor came into office.

Vice Chair Alvarez stated the opportunity to work and to create a partnership between the Commission and the department has been something the Commission has wanted to do for many years. She stated she is encouraged that CalHHS wants to see that happen and hoped that, in the months as the crisis continues to happen, opportunities can be identified for collaboration in ways that may not have been before.

Vice Chair Alvarez discussed PEI and the opportunity to draw down federal funds. She stated that the CYBHI is a $4 billion investment but it is a one-time investment, while the crisis of young people will continue. She stated that everyone is filled with hope for the all-payer fee schedule that will be used to allow schools to draw down Medi-Cal funds; however, those services will continue to be clinical services. Also, not all children go to school, especially infants and toddlers. She stated that the former Surgeon General highlighted how important the first few years of life are and that mental health issues show up in infants and toddlers in many different ways.

Vice Chair Alvarez stated Ms. Welch keeps referencing an analysis of funding sources for early intervention at the county level. She noted that it would be helpful to share that analysis with the Commission to help Commissioners better understand the information used to make these decisions and to better incorporate that analysis into any feedback or opportunities for improving the proposal moving forward. Commissioners are partners in this work. The shared responsibility to Californians is to ensure that the mental health system is responsive to their needs. That conversation can start now. It does not need to start when the measure moves forward. She stated appreciation for the conversation and dialogue and made the specific request to see the analysis, particularly around prevention and early intervention.

Commissioner Bunch stated that there was a lot of discussion this morning about how hard it is to bill and what services are considered to be billable. She asked if this proposal makes it easier or more difficult for providers, like FSPs, that do not do general

outpatient services. She stated concern that the proposal may decrease the ability to help the community.

Mr. Sadwith stated that he and Ms. Welch were not here for the morning discussion. He asked if Commissioner Bunch was referring to billing Medi-Cal or other insurance companies.

Commissioner Bunch stated that the discussion this morning was about the number of services that are provided, particularly in field-based services, that are not currently considered to be billable. Many things they do are not face-to-face or are case management who would technically not be billable. She asked if the proposal will help with billing.

Mr. Sadwith stated that the goal of this proposal is to strengthen, expand, and reenforce that Medi-Cal should be billed to the maximum extent possible. To support that goal, the CalAIM initiative includes several behavioral-health-focused program reforms or policy reforms that are designed to improve the provider experience, including with respect to billing in clinical documentation. Behavioral health payment reform should make providers' and clinicians' lives easier, as should documentation redesign, which is also being implemented under CalAIM.

Mr. Sadwith stated that the waiver helps to clarify existing Medi-Cal coverage for several intensive, in-home and family-based services for children and youth, including multisystemic therapy, functional family therapy, and others. In tandem with this proposal, there are several other initiatives to streamline Medi-Cal billing and make it easier to bill Medi-Cal. He suggested following up offline to learn more about experiences Commissioners have had in their counties about what is understood to not be billable today under Medi-Cal. Medi-Cal mental health coverage is generous, comprehensive, and includes the ability to bill in the community outside of a clinic setting. He stated that it may be the case that clarification rather than new policy would help support billing Medi-Cal today.

Commissioner Gordon amplified Vice Chair Alvarez's comment. He stated that, with respect to the schools, he gave the administration and the governor credit for the behavioral health initiative. Much of that flowed from the work of the Commission as an independent body trying to make the argument that schools were a piece of the community, and that the community itself needed to be heard and responded to. That has really paid off because, going through the initiative, the fact of working with managed-care organizations and getting the schools involved with them has built a lot of collaboration and trust for the future.

Commissioner Gordon stated concern with taking away the outside voice. The community and schools have confidence in the fact that there are individuals on an independent Commission who will bring independent advice to the administration. This has been very impactful and has resulted in good collaboration. He quoted the proverb, "If you want to go fast, go alone. If you want to go far, go together." This is a long journey and the Commission has strong, independent voices from early childhood leaders, community leaders, law enforcement leaders, and others.

Commissioner Mitchell stated that, in 2004, when the MHSA was first passed, the voters understood the need. She asked how CalHHS is communicating or marketing this to the public and what the public's response is to this.

Ms. Welch stated that CalHHS is one month out from announcing the proposal. She stated that she expects to have more public engagement. Once the legislation is in place, there is a process associated with it. She stated that there are many things that are unknown, such as if it will be a two-year bill or not and a coalition to support the bill. She asked if the Commission would be interested in partnering in this way.

Ms. Welch referred to Commissioner Gordon's point and stated that, in the work the Commission has done with its stakeholder bodies, bringing in law enforcement and understanding their perspective and bringing in education, First 5, and health plans is critically important. CalHHS would not envision any of that changing. She stated that she understands what was said about being independent, but, regarding that whole vision of what the Commission is able to do, that spirit of bringing all of the expertise and systems that are not insular to just the behavioral health system is particularly what the MHSA was based on and what it was written about, which is a publicly-funded county-administered system, is a huge asset that the Commission has that is work that CalHHS is interested in.

Ms. Welch stated that many Commissioners are personally and professionally involved in the CYBHI that has been the spirit of how CalHHS has implemented the CYBHI. It is the spirit of how CalHHS is implementing care through the Community Assistance, Recovery, and Empowerment (CARE) Act Working Group that is representative of all sorts of external stakeholders. She stated the hope that the Commission hears from her and from CalHHS that that work that the Commission does to engage all those other sectors is important. It is critical for this work to be successful.

Ms. Welch acknowledged Commissioner Mitchell's comment that there is a lot of work to do. She stated that, hopefully, the Commission might be interested in partnering with CalHHS in getting feedback or reaching out to constituents or networks.

Chair Madrigal-Weiss stated that community consultation was key during the creation of the MHSA. The Community helped shape the MHSA; they were there from the beginning. It was more than just informational meetings and hearing from them; the community was writing the MHSA alongside the creators. She stated the hope that every opportunity will be taken for community input in this process for the community to help shape every part of this.

Chair Madrigal-Weiss questioned what Ms. Welch meant when saying "I hear you" to Commissioner questions. She requested a response to the written list of questions asked in today's meeting that will be provided by staff.

Public Comment

Andrea Wagner, Executive Director, California Association of Mental Health Peer-Run Organizations (CAMHPRO), stated that she was here today to speak out to protect the MHSA. She stated that she did not know where the idea came from that, because a bill or proposition is old, it needs to be revised. Revising laws that are old is both tedious

and worthless. This should not be held as an argument for modernization; it is just a political term to push the Governor's agenda. She summarized five points:

- Stop going after MHSA funds and let it be fully developed as it was intended.
- Stop ignoring and eliminating the consumer voice. This was seen across the board with the CARE Act and is being seen again this year. Thousands of individuals with lived experience across the state are being silenced in this process because they do not agree with the Governor's plans.
- Leave the MHSOAC as an independent accountability organization. It is one of the few places that peers can come and actually be heard, that supports advocacy grants, such as the CAMHPRO Lived Experience, Advocacy, and Diversity (LEAD) Program, which goes to consumers across the state and speaks to hundreds and hundreds of peers all year long to bring their wants, needs, and priorities back to the state. The Commission is the only thing that does that. She stated her fear, after seeing how CalHHS developed under the CARE Act, that that will be eliminated once the Commission is moved under CalHHS.
- Leave prevention and early intervention alone as well as innovation. Those are pivotal and monumental pieces of the MHSA and they cannot be touched. It is deplorable to think that money will be taken away from programs that affect racial, ethnic, and peer support programs that are drastically needed and are why the MHSA was written by consumers all those years ago.
- I keep hearing about all this money that is going towards housing programs for behavioral health and we were promised that there would be peer respite funding in those. I looked into that funding and it is not built for grass roots or small organizations. It is built for a commercial system and a county system. It is prohibitive. It does not allow innovation. All small consumer-based organizations are excluded from that funding.

Andrea Wagner stated constituents are angry, scared, and disenfranchised. During a budget hearing on modernizing the MHSA, when this topic first came up in 2019, the room was filled with consumers and advocates who waited for over seven hours to give public comment. After all hearing members had left, the public stayed and provided comment for two hours while one after another went up to the microphone and said, "do not do this." She noted that these consumers and advocates are not in attendance today to provide public comment because they have been slowly and continually disenfranchised in this process.

Avery Hulog-Vicente, Advocacy Coordinator, CAMHPRO, echoed the comments of the previous speaker. She stated that CAMHPRO has several concerns regarding the modernization of the MHSA, and is united in its concerns alongside many fellow MHSA partners and advocates about PEI. Research proves that investment in upstream prevention can reduce the onset of mental health conditions and PEI services can provide the support, resources, and tools for children, transition age youth (TAY), and their supporters to address mental health needs and navigate their paths to recovery out of the more restrictive systems of care. She strongly urged Commissioners,

CalHHS, and the DHCS to consider these comments and concerns provided during public comment as decisions are made regarding the future of MHSA funding. She asked to please protect MHSA funds for services that are client-centered and voluntary, keeping them in the hands of communities that have the best knowledge of serving their peers.

Stacie Hiramoto echoed and thanked Andrea Wagner and Avery Hulog-Vicente for their testimonies. She thanked Commissioners for asking excellent questions and stated the hope that those questions will be answered. She stated that REMHDCO is concerned about this Commission going under CalHHS and does not understand what is to be gained by that. The Commission always has better opportunities than seen in the meetings on this proposal thus far for individuals to comment and to get their questions answered.

Stacie Hiramoto referred to a letter representing the racial, ethnic, Black and indigenous people of color (BIPOC), LGBTQ, children, and consumer communities. She stated concern that PEI is in jeopardy and asked why communities are not being listened to. She understood that one of the points in the presentation was that every county can make its own decision but noted that that means 58 different battles. This is not right. PEI is one of the only places where funding for CDEPs can be funded. She asked to hear what the other sources of funding will be for these PEI programs that are in jeopardy.

Richard Gallo, consumer and advocate and Volunteer State Ambassador, Cal Voices ACCESS California, discussed FSPs and peer certification that are currently happening throughout the state and stated that they hope to soon be a Certified Peer Specialist. The speaker suggested that, in the contract, the 50 percent of service providers be peer certified. It is about peers helping peers.

Richard Gallo stated that CARE Court was not intended for MHSA dollars. It is obvious that the county wants to use MHSA funding for CARE Court because they do not want to pay for it out of their General Fund.

Richard Gallo asked if “behavioral workforce” refers to social workers, clinicians, and nurses. If this is the case, then peers need to be a part of that workforce. There are already peers out there who are working these professions.

Richard Gallo stated that the deaf and hard of hearing community needs to be included in providing adequate mental health services throughout the state. The intellectual disability mental health community needs to be adequately served. There currently are only a few counties using MHSA dollars to help those members of the community. The rest are being left out or inadequately served. This is destroying families.

Richard Gallo stated that the community planning process needs to stay as it is or be expanded. Counties do not want community planning to be part of the process because they do not care about community feedback.

Richard Gallo stated that the severely mentally ill unhoused community has been neglected under the MHSA. The speaker suggested including programs for this community.

Mary Ann Bernard, retired lawyer, family member, and advocate for the severely mentally ill, applauded CalHHS and the Governor for proposing to take control of this institution due to its scandalous history repeated last night at 4:55 p.m. with a new directive to the counties on PEI, which continues the long history of robbing PEI funds directed by the voters for the poorest and sickest in a way that benefits the rich who are not sick and never will be. The speaker suggested an article in the San Diego Tribune called “Bait-and-Switch” that summarizes the meticulously documented PEI Bait-and-Switch report from 2013.

Mary Ann Bernard stated that, as always, this institution ignored a mandate of the MHSA for people who are already inflicted with severe mental illness, which is in the last clause of Welfare and Institutions Code Section 5840(c). The speaker stated that all the Commission had to do in last night’s document to keep thousands of severely mentally ill people out of jails and morgues and save millions of public dollars was to add that voter mandate in as one of the PEI priorities. Instead, the sickest people have been systematically excluded from those priorities because of this institution’s definition of TAY, which cuts off at age 25, when the average onset age of schizophrenia is 26 in men and 29 in women.

Mary Ann Bernard stated last night’s priorities were for kids and TAY, which is fine. The sickest schizophrenics never get to be older adults because they die 30 years early on average due to their diseases. The sickest group has been left out and has been left out since 2004. Most of the people still here are trying to do better, but there are some ridiculous upstream PEI programs that should never have been funded that are still getting funded. The sickest people cannot even talk to this institution because they cannot even get inside the door.

Laurie Hallmark, attorney and mental health advocate, stated that a person who is unhoused or who has disengaged from the system did not end up that way in a vacuum. They tried to get help and, based on their experiences, they essentially gave up on the system as a source of help. That is the end of the problem.

Laurie Hallmark stated it is critical to identify and address the procedural barriers to access. The speaker stated the need to know the exact steps a person must take to get the help they want and need. The speaker stated the need to look at how the system functions in practice – not how it is supposed to work or how it says it works, but how it really works on the ground. How many appointments? Where and when? How many documents must be provided? What do individuals have to do just to get inside the door to help? And when they are in, what is next? What services are available? How are they provided? How do they work in practice? Where are they succeeding? Where are they failing?

Laurie Hallmark stated that it is critical to obtain this on-the-ground information to be able to most effectively address the source of problems on the front end – the factors that lead to a human being in pain, suffering, who has given up on the system as a source of help and the help it is offering.

Laurie Hallmark stated that there is also an opportunity to improve service quality by providing an independent solid funding stream directly to community-based organizations and peer-run organizations. A secure independent funding stream can

enable community-based organizations to plan ahead. If they had secure funding, they can create strategic long-term plans and they would be able to carry them out. Depending upon grants prevents long-term planning and it also forces community-based organizations to tailor their services to the available grants. Additionally, if community-based organizations had secure funding streams that enabled them to not be dependent upon grants, they could assist in the on-the-ground accountability.

Laurie Hallmark stated that suffering hurts, whether it is an individual's personal suffering or that of someone around them. Human beings want to alleviate suffering. Perhaps, with meaningful accountability for the barriers to access to quality services, it will be possible.

Josefina Alvarado Mena, CEO, Safe Passages, and Chair, California Reducing Disparities Project (CRDP) Cross Population Sustainability Committee, spoke about three curiosities that the presentation brought up.

- Equity – The state has a commitment to reducing behavioral health disparities; yet, the presentation was almost devoid of any reference to that kind of priority. In fact, the word "equity" or "equitable" appears only once in the slide deck and was only mentioned a couple of times during the presentation. The speaker stated that multiple racial, ethnic, and LGBTQ communities, including but not limited to African Americans, are overrepresented among the most vulnerable populations sited in the CalHHS population for adults and for children and youth. It is difficult to imagine how the behavioral health system can address the needs of the most vulnerable populations in the state without a community-defined culturally-responsive approach, especially when considering the populations that need to be served.
- CYBHI – The CYBHI overlap was noted in the presentation but the CYBHI is a one-time investment that largely ends in 2025, the same year that this multi-year proposed implementation is supposed to begin. There is a gap, especially in terms of PEI work and for certain populations who will not continue to be served under the CYBHI sustainability efforts. This needs to be addressed.
- Data – Although data was referenced, there was no specific data presented that supports the reconstitution of the MHSA allocations, specifically data that shows the efficacy of reducing the MHSA's investment in prevention. It is important that there be a case made as to why this proposed reconstitution of the MHSA's investment will produce the desired outcomes. The value of prevention cannot be understated, particularly for communities of color and LGBTQ communities. There should be a continued prioritization on prevention in order to stop the continuous stream of vulnerable populations being spoken of today.

Paula Aiello, family member, Alameda County, stated that they are glad that more money is being put into the focus on the sickest as promised, but the speaker stated they cannot trust that. The MHSA has stated from the beginning that the focus of it was supposed to be on the seriously mentally ill, which is not the same as general mental illness, SUD, and homelessness. Conflating these diminishes the original recognition of the urgency of providing for the seriously mentally ill.

Paula Aiello stated appreciation for the Commissioner's question that more evidence is needed that expanding the pool of individuals without expanding the money will not reduce currently served populations. Despite Ms. Welch's assertion that spending on substance abuse services will not necessarily take funding away from the seriously mentally ill, the reality is that the Commission has let that happen. That prioritization has not been honored. The Commission needs to be corrected, but not by basically codifying what the Commission has already been doing.

Paula Aiello stated concern that the choices and priorities will continue to fail to prioritize the most vulnerable despite repeated insistence. There is clearly a problem in all those areas today – homelessness, SUD, and PEI services. The initial treatment services need to be quality. That has been noted by sociologist Alex Barnard, who pointed out that most of what is in the California psychiatric system has been private hospitals that do not want to provide costly, long-term care to people with the most chronic illnesses.

Tara Gamboa-Eastman, Senior Advocate, Steinberg Institute, stated that Steinberg Institute's founder, Darrell Steinberg, was proud to co-author the MHSA 20 years ago and has been proud to see the work that has been done, but it is hard to deny the suffering that is happening across the state and not ask whether it can be done better. She stated it can. The Steinberg Institute is proud to support the proposal and is particularly heartened by the focus on FSPs, outcomes, and accountability. She stated that she looks forward to continuing to partner with CalHHS, the DHCS, the administration, and the Commission as this proposal is developed.

Kelly Ferguson, Director of Development, Rainbow Community Center, stated that they are deeply concerned about the reduction and cutting of PEI funding for the LGBTQ community that is recommended in this proposal and leaving it up to county set-aside. PEI funds make up nearly half of the funding for the Rainbow Community Center. It was mentioned today that there are a number of alternative funding sources, but there is no such comparable funding for LGBTQ organizations such as the Rainbow Community Center, which supports school districts and provides emergency interventions where schools are not equipped to serve and protect LGBTQ students, follow state and local laws of protection, and meaningfully address and deal with the high rates of suicide, mental health challenges, physical attacks, and frequent bullying of LGBTQ students without school districts.

Kelly Ferguson stated that, if PEI is cut or reduced, it is very possible that the Rainbow Community Center will have to close its doors. Many LGBTQ centers in California are under-resourced and underfunded and rely on PEI funding. Services and programs would be decimated if PEI is reduced or cut in counties statewide. As the sole service provider for an entire county, thousands of LGBTQ and ally residents within Contra Costa County will have nowhere to go to get their urgent needs met were this change to be implemented.

Kelly Ferguson stated that PEI needs to be continued to be prioritized with ongoing funding with an inclusive process centering in community- and service-provider-identified needs and not redirected, cut, or reduced in order to continue to meet and address the safety and wellness of the LGBTQ community and to build inclusive communities throughout the state of California.

Adrienne Shilton, Director of Public Policy and Strategy, California Alliance of Child and Family Services (CACFS), stated that the Governor's proposal opens up an important dialogue about California's behavioral health system and has the potential to offer opportunity for better care for communities. The speaker stated appreciation for the dialogue today and the questions and comments from Commissioners. There are many components that the CACFS also wants to better understand.

Adrienne Shilton stated that, from the broad overview of the proposal that has been shared, however, the CACFS has concerns that this plan will scale back and perhaps even eliminate programs serving children's mental health needs, given the elimination of the set-aside that 51 percent of funding under PEI must be spent on children and youth. She stated that, when suicide rates in children and youth are increasing and other outcomes are going in the wrong direction, this component seems counterproductive.

Adrienne Shilton stated that the CACFS understands the need and supports strategies to address the crisis of homelessness in California, but this proposal would eliminate the two components of the MHSA that support critical interventions for children and youth and underserved communities – the prevention and early intervention and innovation components. MHSA funds are used now to provide mental health services to children so they succeed in school, to support interventions that prevent childhood trauma and prevent child welfare system involvement, and to support peer support strategies for communities of color and LGBTQ youth.

Adrienne Shilton stated that the MHSA's promise 20 years ago was to move to an upstream prevention approach. The speaker stated that, in order to maintain the investments in a public health approach to wellbeing and true upstream prevention of disparities that can begin in infancy and compounded across the lifespan, these existing protections and set-asides of MHSA resources for programs and services for children and youth ages 0 to 25 must be preserved and maintained.

Joel Baum, Safe Passages, shared a deep concern about the PEI funds and explicitly the lack of certainty being heard in all the language. He stated that it was mentioned several times that there are plenty of funding opportunities and yet the language referring to it was, at best, underwhelming. He stated he heard words like "this will offer the opportunity" for these kinds of fundings, or "local communities can decide" to do this kind of funding. The fact of the matter is that MHSA funding that is dedicated to PEI community work is a firewall for communities that have essentially faced biased spending patterns that historically have not addressed some of the most historically underserved and marginalized communities. He stated that, at times, it felt like today's presenters were offering a quick and careless promise to communities facing generations of trauma and unfulfilled promises.

Joel Baum stated that it cannot be left up to the goodwill of others for PEI funding to be in place for the communities that Safe Passages and many sister organizations work with. The MHSA is one of the few places that explicitly dedicates that money; it needs to be protected.

Joel Baum stated that one of the interesting points about false dichotomies, specifically talking about school work, was when the shift was being made to whole school

interventions with no interventions on the individual level. He stated he loves whole school interventions but if young people, particularly youth from marginalized communities, are prevented from accessing individual support services, they are being left without resources. This is unfair and against the spirit of the MHSA.

Eba Laye, President, Whole Systems Learning, stated that, if PEI is taken away, organizations such as Whole Systems Learning will be unable to serve community needs and those needs will go unmet. The speaker stated that they feel like the rug has been pulled out from underneath them. Whole Systems Learning has worked for years to ensure that PEI in Los Angeles County is more responsive and now this proposal is to take that funding away. The majority of the population of the state of California is people of color, i.e., underserved populations. To take away the opportunity for prevention and early intervention from people who are already unserved, underserved, and inappropriately served is a tragedy.

Daniel Thirakul, Public Policy Coordinator, California Youth Empowerment Network (CAYEN), agreed with the comments already stated on the PEI issue. He stated that he was speaking today to emphasize a potential adverse effect of the Governor's behavioral health modernization proposal. Funding for the CYBHI is one-time funding. He stated that the ability for counties to reduce or even eliminate PEI-funded programs poses a great threat to the process made in identifying mental health challenges in youth and providing PEI services and supports to promote lifelong health and resiliency.

Daniel Thirakul stated that early investments in prevention reduce the drivers of mental health risk, such as unmet basic needs, poverty, and trauma. LBGTQ and BIPOC youth are disproportionately impacted by these mental health risk factors and stand to be most negatively impacted by any reduction in PEI supports and services. CAYEN recognizes the long-term benefits associated with PEI strategies. He stated, if counties are no longer required to fund or must reduce PEI programs, it will impact a whole generation and can ultimately increase the number of individuals with serious mental illness. PEI funding provides youth with the best chances and outcomes. CAYEN urges reconsideration of the proposal to protect future generations and maintain the progress made to serve the most vulnerable communities.

Daniel Thirakul stated that it is difficult for youth to be involved in the decision-making process. Making this governing body an advisory body and taking away its authority would create an additional barrier for youth to be able to impact mental health policy that directly impacts them.

Lasara Firefox Allen, Executive Director, Pacific Center for Human Growth (PCHG), stated that they have seen how individuals benefit from PEI funding. The PCHG's free services are supported by PEI funding. They stated that they do not know how this proposal will impact PCHG's service delivery. The consideration to get funding is also a consideration that makes it difficult to plan. Having stable funding for PEI services allows the PCHG to serve the community in a way that it would be unable to without this funding. Many organizations are speaking out in this way and feeling the impact that removal of this funding would have on communities.

Vera Calloway, Peer Specialist, stated that she is a child of the Los Angeles County Behavioral Health System and credits them for saving her life. She stated concern

about the Governor’s lack of transparency. She questioned who he is consulting in terms of deciding on these initiatives, which are very harmful for community members and the people who are living unhoused and without support. She asked CalHHS and the DHCS to consider the peer voice and consumer voice, people who have received services and benefits from these services through PEI funding. She stated that she is hopeful but at the same time disappointed and is not optimistic about a positive outcome for the people of the state of California.

Steve Leoni, consumer and advocate, stated that they met Rusty Selix, Richard Van Horn, and Dave Pilon in the mid- to late-1990s and worked with them on several occasions. The speaker stated they were delighted with Dave Pilon’s presentation earlier today. The speaker stated Mr. Pilon talked about The Village that they knew and the MHSA that they knew that has inspired them as an advocate for the past 25 years. One of the things Mr. Pilon talked about this morning was shifting from billing they originally were using under the 3777 to Medi-Cal billing, which was difficult to accommodate, and how this has happened in most other programs when such a shift has been made.

Steve Leoni stated that the thing about Medi-Cal billing, which has been a long time coming, is that it is nowhere near doing what the MHSA does. Billing Medi-Cal is about billing illness; billing the MHSA is much freer and can focus on what will help the person be a better person. The speaker reminded everyone of that as this proposal is being heard this afternoon. It is vitally important that any proposal that says it will cut back on PEI funds but will substitute in Medi-Cal funds needs to be looked at very carefully or it will end up destroying something that had such good results 20 years ago. The new modernization says that Medi-Cal billing will have to be used when it is available for something, but that is already the law.

Angela Vazquez, Policy Director, Children's Partnership, thanked the Commission for hosting this important dialogue and for their excellent questions today. She stated that the Governor’s proposal opens an important dialogue around evaluating the impact to date of the MHSA in California’s behavioral health system. The work to modernize the state behavioral health system offers an opportunity to better care for communities; however, the current proposal of the reorganization of existing categorical funding seems to unfairly pit children and youth, particularly children and youth of color, who are most impacted by mental health disparities, against the varying and politically potent needs of county administrators, providers, and adults with severe mental illness for a small set of resources. Current information indicates that the proposal pits these two marginalized groups against each other for existing resources.

Angela Vazquez stated that community-based and community-oriented tier one primary prevention services are deprioritized in the proposal as it stands. Though current summaries of the proposal note that PEI dollars for schools should be focused on school-wide behavioral health support, as noted by many communities since the MHSA was enacted, it is unclear just how much counties will invest in these upstream prevention services without preserving existing set-asides. Furthermore, the proposal neglects to address the significant need and previous commitment to young children ages zero to five, particularly through the work of the Office of the Surgeon General, to reduce toxic stress and ACEs.

Angela Vazquez stated that, because many evidence-based services for young children are not tied to an individual child's acute needs, the health care system and Medi-Cal specifically do not consider them covered services. Dyadic care is a wonderful and very new exception to this general rule. Existing PEI dollars have funded many of these types of prevention services in counties and are imminently at risk of been deeply cut or wholly eliminated as a result of the current proposal. In order to incentivize and hold counties accountable to whole child investments and a public health approach, the Children's Partnership highly recommends that the existing set-asides be preserved and even more specificity with a child and youth set-aside be created to ensure that infant and toddler services are protected as well.

Courtney Armstrong, Director of Government Affairs, First 5 Association of California, stated appreciation for the questions raised and shared concerns of the earlier speakers about this proposal specifically around PEI funding. She stated that the presentation indicated that this proposal would potentially allow for increased funding for PEI services, but First 5 Association of California's experience has been that it has already been challenging for early childhood providers to access PEI funding because of all the other competing needs. She stated removing any requirements around that funding feels like it would decrease the amount of funding available for PEI because, as the previous speaker pointed out, counties would be faced with competing priorities and likely would choose to fund the more emergent or urgent issues and not fund the prevention services that are desperately needed.

Courtney Armstrong stated that PEI is a vital source of funding for early childhood providers that goes to services that are largely not Medi-Cal reimbursable. First 5 Association of California is anxious to see more details on this proposal, is concerned about losing this vital special source for early childhood services, and hopes that this can be considered as the decisions are made.

Natalie Ah Soon, Community Engagement and Government Affairs Director, Richmond Area Multi-Services (RAMS), stated that RAMS is acting in unison for the larger purpose and for the benefit of the wider community. RAMS is concerned about the proposed modernization bill to redefine what prevention and early intervention should be and what it should look like for historically invisible communities, such as the Pacific Islander, Southeast Asian, Asian, Black, and Latin communities. Addressing health disparities is not only important from an equity standpoint, but also for improving overall health and economic prosperity.

Natalie Ah Soon stated that community-defined and nuanced solutions to prevent mental illness from becoming severe and disabling are important. RAMS work in San Francisco and Alameda County has proven to be very effective in creating community-defined solutions that are outside of the health care system. RAMS is often asked about its evidence of success. The evidence is that not many members of the community come into the system of care because their needs are met. They are embraced in their own community in cultures and language that hold mental health and health in general as a priority.

Natalie Ah Soon stood in unison with everyone on the call to ask the Governor not to wordsmith the bill and not to medicalize PEI or other issues that come forth into the policy system.

Alej Fernandez Garcia, Community Advocacy Manager, California Pan-Ethnic Health Network (CPEHN), stated that CPEHN is invested in ensuring that any changes or reforms to the MHSA and the rest of the delivery system center on and advance racial equity by making it easier for all Californians to access coverage by improving the overall behavioral health in populations, and ensuring that culturally and linguistically appropriate behavioral health services are provided across the continuum of care. It must be ensured that diverse communities, especially BIPOC communities and all the beautiful intersections without those communities, are engaged in the development, delivery, and evaluation of services on an ongoing, continual basis, and that the delivery system is held accountable to the needs and priorities of those communities.

Alej Fernandez Garcia stated that any changes to the MHSA should be about advancing racial equity and should center on people with lived experience to drive this forward. No decisions about communities should be made without communities. Although CPEHN is a statewide organization, they express solidarity and the privilege it is to work alongside community partners, peers, promotoras, and community health workers, some of whom are on this call today and have many innovative practices and solutions to many challenges discussed today. CPEHN looks forward to participating in shaping any changes that are forthcoming.

Dana Paycao, National Center for Youth Law, shared the concern expressed by numerous others on this call that diverting funds from PEI will be harmful for children, youth, and young adults who rely on MHSA-funded programs and services for critical support. As the state has repeatedly recognized, including through its ongoing CYBHI, prevention and early intervention are powerful ways to address mental health needs early and mitigate negative life outcomes.

Dana Paycao stated that the National Center for Youth Law respectfully requests that the administration assess the long-term implications of diverting these funds from mental health services for children and youth, reconsider this aspect of the proposal, and instead identify alternative ways to increase funding for adding the critical homelessness crisis that do not lead to fewer resources for children and youth. All ages should have their basic needs met, including access to both state housing and needed mental health care. It should not be an either/or choice of which services to provide or which age ranges to serve.

Sharon Jennings, resident of Sacramento County and a consumer of mental health services for more than 50 years, asked, instead of diverting a significant portion of MHSA dollars, why funding is not requested from the Federal Emergency Management Agency (FEMA). Everyone knows this is a nationwide disaster and, in addition, approximately 30 percent of the homeless population is in California. It would be appropriate to ask FEMA for help. It cannot be done alone.

Susan Gallagher, Executive Director, Cal Voices, a continuation of Mental Health America of Northern California (NorCal MHA), stated that this proposal is disconcerting. One thing that stands out is the fact that more people will be served with less funds if it

is opened up to everyone with substance abuse. The speaker echoed Commissioner Rowlett's comments on this issue.

Susan Gallagher echoed the concerns of the PEI community. The speaker stated concern about what seems to be an erosion of the community planning process. The stakeholders that are coming into play are not consumers and family members. The speaker stated the presentation did not include the terms "client-driven," "family-oriented," "recovery-oriented systems of care," or "community-defined services." Those are the things that have emerged through the MHSA as best practices and truly the evidence base that is being created in California. It is sad to hear no mention of those terms. This proposal is a new ballot initiative, not a refresh or modernization of the MHSA. It looks nothing like what the MHSA looks like in its original intent.

Susan Gallagher stated that they are concerned about using MHSA funds to pay for rent. These costs are guaranteed to increase over time without a commensurate increase in available revenues. There was already a method, albeit imperfect, of controlling health care costs through the Medicaid reimbursement rates. The costs have skyrocketed in hospitals where counties cannot always control the rates, which is eating into the precious mental health realignment budget.

Susan Gallagher asked why get rid of the Commission when more accountability is needed. This is counterintuitive and does not make sense. Why put the Commission under CalHHS? If anything, more independence should be given to the Commission. The speaker stated that the Commission should not be marginalized in the process of seeking more accountability.

Susan Gallagher stated that they heard a lot of double-speak today where the MHSA is being opened up to be leveraged within CalAIM. The speaker stated that language is heard about needing to care for those who are the sickest of the sick, but then we hear about expanding to all these other entities, agencies, and other provider groups where the MHSA would be leveraged. This looks like a money grab. It sounds like a way to leverage the MHSA but it has nothing to do with the original intent of the MHSA. It looks nothing like it in its original form. Please stop this.

Ms. Martinez asked that further public comment be sent to Commission staff.

9: Adjournment

Chair Madrigal-Weiss stated that the next Commission meeting will take place on May 25, 2023, in Los Angeles County. There being no further business, the meeting was adjourned at 3:33 p.m.

MHSOAC
Mental Health Services
Oversight & Accountability Commission

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA 2004
WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
April 27, 2023

Motion #: 1

Date: April 27, 2023

Proposed Motion:
That the Commission approves the March 23, 2023 Commission Meeting Minutes

Commissioner making motion: Commission Carnevale

Commissioner seconding motion: Commissioner Rowlett

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

Name	Yes	No	Abstain	Absent	No Response
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Boyd	☐	☐	☐	☒	☐
3. Commissioner Brown	☒	☐	☐	☐	☐
4. Commissioner Bunch	☒	☐	☐	☐	☐
5. Commissioner Carnevale	☒	☐	☐	☐	☐
6. Commissioner Carrillo	☐	☐	☐	☒	☐
7. Commissioner Chambers	☒	☐	☐	☐	☐
8. Commissioner Chen	☐	☐	☐	☐	☒
9. Commissioner Cortese	☐	☐	☐	☒	☐
10. Commissioner Danovitch	☒	☐	☐	☐	☐
11. Commissioner Gordon	☒	☐	☐	☐	☐
12. Commissioner Mitchell	☐	☐	☐	☐	☒
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. Commissioner Tamplen	☐	☐	☐	☒	☐
15. Vice-Chair Alvarez	☐	☐	☐	☐	☒
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

MHSOAC
Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
April 27, 2023

Motion #: 2

Date: April 27, 2023

Proposed Motion:
The Commission approves the Consent Calendar.

Commissioner making motion: Commissioner Brown

Commissioner seconding motion: Commissioner Mitchell

Motion carried _10 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	No Response
1. Commissioner Bontrager	☒	☐	☐	☐	☐
2. Commissioner Boyd	☐	☐	☐	☒	☐
3. Commissioner Brown	☒	☐	☐	☐	☐
4. Commissioner Bunch	☒	☐	☐	☐	☐
5. Commissioner Carnevale	☒	☐	☐	☐	☐
6. Commissioner Carrillo	☐	☐	☐	☒	☐
7. Commissioner Chambers	☒	☐	☐	☐	☐
8. Commissioner Chen	☐	☐	☐	☐	☒
9. Commissioner Cortese	☐	☐	☐	☒	☐
10. Commissioner Danovitch	☒	☐	☐	☐	☐
11. Commissioner Gordon	☒	☐	☐	☐	☐
12. Commissioner Mitchell	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. Commissioner Tamplen	☐	☐	☐	☒	☐
15. Vice-Chair Alvarez	☐	☐	☐	☐	☒
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

AGENDA ITEM 5

Action

May 25, 2023 Commission Meeting

Consent Calendar

Summary: The Mental Health Services Oversight and Accountability Commission will consider approval of the Consent Calendar which contains one Multi-County innovation project budget amendment and two innovation project funding requests.

Items are placed on the Consent Calendar with the approval of the Chair and are deemed non-controversial. Consent Calendar items shall be considered after public comment, without presentation or discussion. Any item may be pulled from the Consent Calendar at the request of any Commissioner. Items removed from the Consent Calendar may be held for future consideration at the discretion of the Chair.

Imperial County Budget Amendment

A proposed amendment to Imperial County's Semi-Statewide Enterprise Health Record (EHR) Multi-County Innovation Project budget due to a clerical error, that increases the total amount from $2,974,849, approved on January 25, 2023, to $3,089,330.

Innovation Funding Requests

Monterey and San Bernardino Counties are requesting that the Commission authorize up to **$24,441,138.86** in Mental Health Services Act Innovation funds for the following two projects:

Project Name	Total Innovation Funding Requested	Duration of Innovation Project (years)
Rainbow Connections (Monterey County)	$7,883,562.86	5
Progressive Integrated Care Collaborative (San Bernardino County)	$16,557,576.00	5
Total:	**$24,441,138.86**	

RAINBOW CONNECTIONS (MONTEREY COUNTY):

Monterey County seeks to launch the Rainbow Connections Project using a systems approach to establish and demonstrate the effectiveness of a county-wide network of affirming care with providers who collaborate and interconnect to improve school climate and cultivate environments of belonging at home, school and in their communities. This will be

accomplished through the provision of an adapted Positive Behavioral Interventions and Supports (PBIS) model serving LGBTQ youth and building the capacity to surround and support that model. Capacity is to be built by creating dedicated staff positions within county behavioral health and by youth-serving organizations, by providing culturally responsive trainings to parents, school staff, health professionals, faith-leaders and community members, and through the creation of an online access point that will facilitate training requests and share resources.

The Community Program Planning Process:

Local Level

The idea for this project emerged during the community engagement process that is designed to guide and develop the draft MHSA FY2022/23 Annual Update. The County contracted with EVALCORP to support an assessment of local behavioral and mental health needs utilizing online surveys and focus groups intentionally designed and administered to reflect a diverse set of provider and community voices, including underserved communities.

Three additional community engagement sessions with school staff and parents were held, where themes emerged that refined this project to focus on developing a single service delivery model for LGBTQ youth up to age 25 such that the County and youth serving agencies focus on:

- increasing access to mental health and affirming medical care and linkage to community resources for LGBTQ youth;
- providing ongoing training and psychoeducation for providers of youth serving systems on LGBTQ-related topics; and
- expanding in-place, embedded culturally responsive care

Monterey County's community planning process included the following:

- A 30-day public comment period: March 17, 2023 through April 17, 2023
- A Local Mental Health Board Hearing: May 4, 2023
- County Board of Supervisor Approval: Pending Commission Approval

A final plan, incorporating community partner and public input, as well as technical assistance provided by Commission staff, was submitted on May 5, 2023.

Commission Level

This project was initially shared with Community Partners on March 29, 2023, and the final was shared on May 8, 2023.

No comments were received by the Commission in response to the sharing of this project.

PROGRESSIVE INTEGRATED CARE COLLABORATIVE (SAN BERNARDINO COUNTY):
Based on findings from a study focused on a 12-month collaborative care management of services for elderly patients with depression, San Bernardino County seeks innovation funding authority to establish a pilot clinic site where both behavioral and physical health care services will be provided for Medi-Cal enrollees. The County believes that this Innovation Project will help to address the problems related to the disproportionate number of mental health clients with unaddressed cardiometabolic disease as well as provide effective delivery of services to the nearly 20% of its population that resides in rural areas within the County, who have co-morbidities and who are not able to easily access health care services.

The Community Program Planning Process:

Local Level
The County indicates that the concept of the Integrated Care Collaborative Project was first identified during the Community Planning Process conducted in 2016 as a community need, in preparation of the Three-Year Program and Expenditure Plan for FYs 2017-2020. The County reports that at that time there was support for the project. Unfortunately, the project was "put on hold" (see page 20 of project) due to COVID and it was not until the summer of 2022 that the proposal was fully developed. It was then shared at public engagement meetings and 44 community program planning meetings in preparation of the FY 2023-2026 Three Year Program and Expenditure Plan. There are 14 cultural subcommittees in San Bernardino and 5 district advisory committees. Each of these groups had the opportunity to review and provide input and feedback on this plan.

San Bernardino County's community planning process included the following:
- A 30-day public comment period: April 6, 2023 through May 6, 2023
- A Local Mental Health Board Hearing: May 11, 2023
- Board of Supervisor Approval: Pending Commission Approval

A final plan, incorporating community partner and public input as well as technical assistance provided by Commission staff, was submitted on May 11, 2023.

Commission Level
This project was initially shared with Community Partners on March 29, 2023, and the final version was again shared on April 7, 2023.

No comments were received by the Commission in response to the sharing of this project.

Enclosures (3): (1) Commission Community Engagement Process; (2) Rainbow Connections Staff Analysis; (3) Progressive Integrated Care Collaborative Staff Analysis

Additional Materials (2): Links to the two final Innovation project plans are available on the Commission website at the following URLs:

Rainbow Connections (Monterey County)
https://mhsoac.ca.gov/wp-content/uploads/Monterey_INN-Plan_Rainbow-Connections.pdf

Progressive Integrated Care Collaborative (San Bernardino County)
https://mhsoac.ca.gov/wp-content/uploads/SanBernardino_INN_ProgressiveIntegratedCareCollab.pdf

Proposed Motion: That the Commission approves the budget amendment for Imperial County's EHR Project in the amount of $114,481; approves funding for Monterey County's Rainbow Connections Innovation Project for up to $7,883,562.86; and funding for San Bernardino County's Progressive Integrated Care Collaborative Innovation Project for up to $16,557,576.00.

Commission Process for Community Engagement on Innovation Plans

To ensure transparency and that every community member both locally and statewide has an opportunity to review and comment on County submitted innovation projects, Commission staff follow the process below:

Sharing of Innovation Projects with Community Partners

- **Procedure – Initial Sharing of INN Projects**
  1. Innovation project is initially shared while County is in their public comment period
  2. County will submit a link to their plan to Commission staff
  3. **Commission staff will then share the link for innovation projects with the following recipients:**
     - **Listserv recipients**
     - **Commission contracted community partners**
     - **The Client and Family Leadership Committee (CFLC)**
     - **The Cultural and Linguistic Competency Committee (CLCC)**
  4. Comments received while County is in public comment period will go directly to the County
  5. Any substantive comments must be addressed by the County during public comment period
- **Procedure – Final Sharing of INN Projects**
  1. **When a final project has been received and County has met all regulatory requirements and is ready to present finalized project (via either Delegated Authority or Full Commission Presentation), this final project will be shared again with community partners:**
     - **Listserv recipients**
     - **Commission contracted community partners**
     - **The Client and Family Leadership Committee (CFLC)**
     - **The Cultural and Linguistic Competency Committee (CLCC)**
  2. The length of time the final sharing of the plan can vary; however, Commission tries to allow community partner feedback for a minimum of two weeks
- **Incorporating Received Comments**
  1. Comments received during the final sharing of the INN project will be incorporated into the Community Planning Process section of the Staff Analysis.
  2. Staff will contact community partners to determine if comments received wish to remain anonymous
  3. Received comments during the final sharing of INN project will be included in Commissioner packets
  4. Any comments received after final sharing cut-off date will be included as handouts

STAFF ANALYSIS –Monterey County

Innovation (INN) Project Name:	**Rainbow Connections**
Total INN Funding Requested:	**$7,883,562.86**
Duration of INN Project:	**5 Years**
MHSOAC consideration of INN Project:	**May 25, 2023**

Review History:

Public Comment Period:	March 17, 2023-April 17, 2023
Date Project Shared with Stakeholders:	March 29, 2023 and May 8, 2023
Mental Health Board Hearing:	May 4, 2023
County submitted INN Project:	May 5, 2023
Approved by the County Board of Supervisors:	Scheduled for June 13, 2023

Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):

The primary purpose of this project is to *increase access to mental health services to underserved groups; and promote interagency and community collaboration related to mental health services or supports or outcomes.*

This Proposed Project meets INN criteria by *introducing a new practice or approach to the overall mental health system, and by making a change to an existing practice in the field of mental health, including but not limited to, application to a different population.*

Project Introduction:

Monterey County seeks to launch the Rainbow Connections project using a systems approach to establish and demonstrate the effectiveness of a county-wide network of affirming care with providers who collaborate and interconnect to improve school climate and cultivate environments of belonging at home, school and in their communities. This will be accomplished through the provision of an adapted Positive Behavioral Interventions and Supports (PBIS) model serving LGBTQ youth and building the capacity to surround and support that model. Capacity is to be built by providing creating dedicated staff positions within county behavioral health and in youth-serving organizations; by providing culturally responsive trainings to parents, school staff, health professionals, faith-leaders and community members;

and through the creation of an online access point to facilitate training requests and share resources.

What is the Problem:

Monterey County presents local, state, and national data indicating that LGBTQ youth struggle for acceptance in family, school and community environments and continue to experience increased rates of mental health symptoms and related negative outcomes. Nationally, a 2022 survey from the Trevor Project of LGBTQ youth found that 45% seriously considered attempting suicide in the past year. Locally, the California Healthy Kids Survey found that 60% of students who identify as gay or transgender experienced chronic sadness and feelings of hopelessness, while 40% of the gay respondents and 60% of the transgender respondents considered suicide.

Family

The County presents research from the Family Acceptance Project at San Francisco State University that LGBTQ youth in highly rejecting families experience higher rates of clinical depression, illegal drug use and suicide attempts than those youth with less family rejection.

The County points out that schools have not integrated family support for LGBTQ students in the way schools have integrated family support for students living with health and developmental needs. In addition, County Behavioral Health reports having difficulty engaging the family members of LGBTQ youth in trainings and other learning opportunities due to stigma and a siloed system of care.

School

For the past eight years, County Behavioral Health has successfully worked in close collaboration with the Monterey County Office of Education, multiple school districts and various community agencies to implement an Interconnected Systems Framework (ISF) that integrates mental health into PBIS implementation efforts at school sites across the county.

Through this work, County Behavioral Health serves 23 school districts as a contracted mental health provider and has clinical and support staff in 120 schools. The County reports that using ISF to implement the Continuum of Care for Learning Communities, has been successful and aligns with the PBIS framework, providing three tiers of services and supports:

- Tier 1 - universal/prevention supports address the mental health and wellness of learning communities and includes an array of mental health trainings for capacity building.
- Tier 2 – supports offer skills building social emotional groups.
- Tier 3 - services are provided 1:1 when intensive intervention, services and case management are needed to stabilize students due to high acuity mental health conditions.

The County reports that this service delivery model increased cross systems collaboration and has been instrumental in improving the delivery of mental health services and supports for youth and their families. However, because it focuses primarily on the general population of students and does not specifically address the specialized needs of LGBTQ youth and their families, community partners have identified a need in services and supports for LGBTQ students.

This need was further evidenced by 24 distinct requests from school districts received by County Behavioral Health over a two-year period, to:

- Provide LGTBQ trainings for school staff
- Assist in forming affirming social/leadership clubs
- Participate on school district LGTBQ task forces
- Provide LGBTQ affirming counseling/service referrals for students

The responsibility to service these requests largely fell to one County Behavioral Health staff who had the appropriate and necessary training and skillsets and were completed in addition to their regular work duties.

Although there are school districts in Monterey County actively working to cultivate safe and inclusive learning environments for LGBTQ students, including the use of bullying prevention curriculum, the County states that there remains a serious school climate issue in schools with LGBTQ students feeling unsafe and being the targets of bullying and harassment. Currently, there are no schools in Monterey County implementing bullying prevention curriculum specifically focused on LGBTQ youth.

Community

The County shares that there is currently no established network of providers across youth serving systems with shared knowledge, language, and clear pathways to specialized, coordinated care. LBGTQ youth are sometimes referred out of county when presenting mental health needs to their primary care doctor, mostly due to their physician's lack of knowledge about or connection to the existing LGBTQ resources available through the county.

Emergency psychiatric services are also lacking the training and knowledge needed to connect LGBTQ youth to specialized LGBTQ supports upon discharge.

While progress has been made, the County sees an opportunity to be responsive to community partners including students, family members, school staff and providers to improve access to care for LGBTQ youth by addressing the disconnected care coordination, poor communication between agencies, and lack of capacity and knowledge amongst behavioral health and physical healthcare providers to respond to the mental and medical needs of LGBTQ children and youth in an integrated, affirming, and culturally reflective manner.

How this Innovation project addresses this problem

Rainbow Connections will use a systems approach to establish a county-wide network of providers that collaborate and interconnect to improve school climate and cultivate environments of belonging for LGBTQ youth at home, school, and in their communities that empower, value, and embrace diversity. Through the launch of this project, the County seeks to establish and demonstrate the effectiveness of an LGBTQ Network of Affirming Care for LGBTQ youth and their families.

Key project activities to deliver services and promote interagency and community collaboration through the proposed multi-tiered interconnected approach include:

- Comprehensive training provided to build internal capacity within Behavioral Health and across youth-serving systems (including child welfare, primary care, first responders) and community stakeholder groups (including faith leaders).
- Coordination with the Monterey County Office of Education to link educators and other community stakeholders to training in LGBTQ affirming care and to develop a streamlined referral process for accessing the continuum of LGBTQ Affirming Care.
- Coordination with community-based organizations:
    - The Epicenter, to provide school and community outreach and LGBTQ youth mental health and wellness training and support in public schools across the county, including a streamlined referral process for mental health services to County Behavioral Health for LGBTQ youth.
    - Harmony at Home, to provide Bullying Prevention Programming and integrate the Welcoming Schools curriculum into the bullying prevention work they already provide in local schools.
    - Partners 4 Peace (P4P), and a research and training organization, the Family Acceptance Project (FAP), to provide culturally grounded parent/caregiver education and peer support for families of LGBTQ youth.

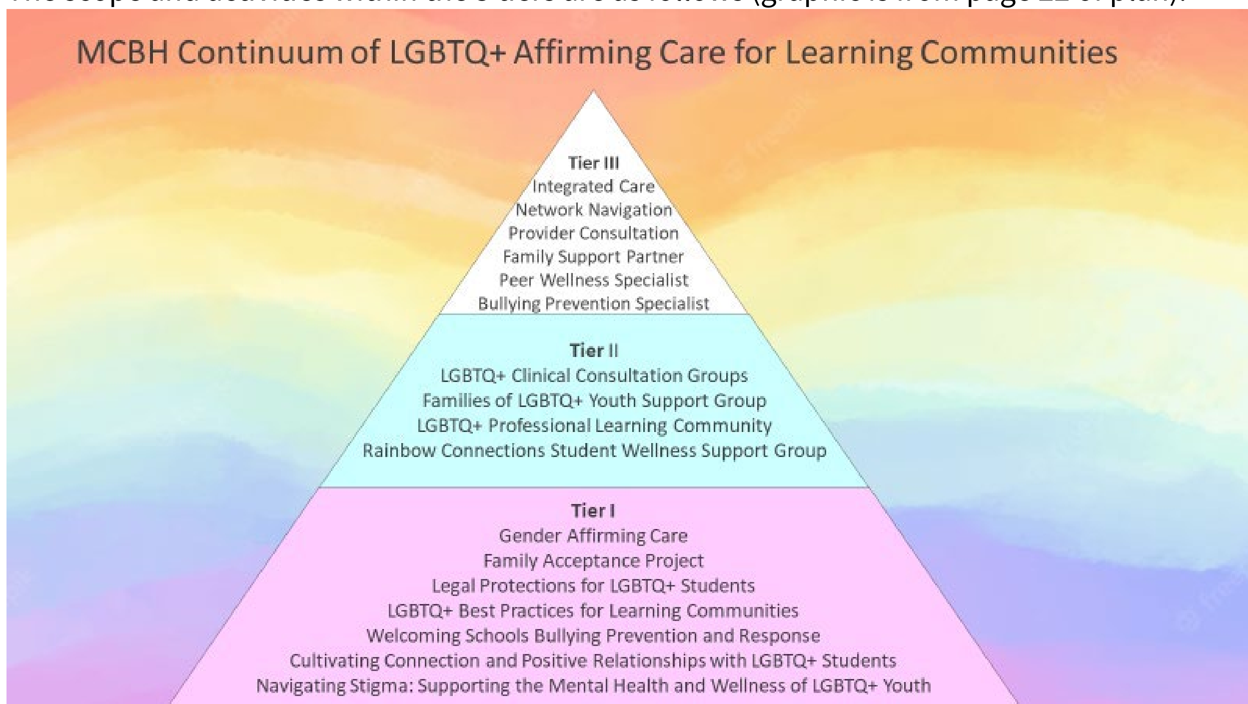
This Innovation project will adapt the PBIS framework to improve mental health and school climate outcomes for the general student population, to serve the LGBTQ student population by improving their school environments and engaging with family and community supports to improve their overall network of care.

Monterey County will leverage and expand existing relationships with multiple community partners, including the 24 local education agencies, county clinic services, and the existing MHSA agreements with 3 local LGBTQ allied community-based organizations currently serving the schools (Partners 4 Peace, The Epicenter and Harmony at Home) and create dedicated staff roles to facilitate and coordinate information sharing, referrals, and services.

The project will center schools as a nexus point for connection and coordination of care for LGBTQ youth and families by interconnecting and building on existing partnerships among service providers to the schools while aligning with PBIS and ISF implementation efforts.

<u>Adapted PBIS Model (please see pages 19-22 of plan for key details)</u>
Specialized services and supports within the County Behavioral Health Continuum of LGBTQ Affirming Care for Learning Communities model have been adapted from and organized in alignment with the 3 Tiers of the PBIS framework. This continuum will provide culturally responsive services and supports for LGBTQ youth, their families, school staff and administration, as well as access to community resources and coordinated care with medical providers.

The scope and activities within the 3 tiers are as follows (graphic is from page 22 of plan):



- Tier 1: training activities aim to build capacity and a foundation of knowledge and cultural understanding for school staff and administrators, parent(s)/caregiver(s), behavioral health and healthcare providers and other Monterey County agencies and organizations serving LGBTQ youth, such as child welfare, juvenile probation, first responders and law enforcement, and Mobile Response Team (MRT).
- Tier 2: Group activities aim to expand on the awareness and knowledge established in Tier 1, by fostering the growth of relationships, dialogue, and community.
- Tier 3: Activities focus on providing individualized treatment services and integrated care coordination. LGBTQ youth in need of Tier 3 level of care will be referred to Rainbow Connections via the online Request for Assistance Form through the following access points:
    - MCBH Services to Education program clinician at student's school site

- MCBH Clinicians in other CSOC programs
- MCCS Medical Social Worker at student's primary care clinic
- The Epicenter
- Harmony at Home
- Partners for Peace

Project Governance

To support community partner engagement throughout implementation and evaluation, the project will be guided by several oversight groups, including executive sponsors, the Rainbow Connections Service Strategy Committee, the Rainbow Connections Advisory Group, and the Rainbow Connections Youth Advisory Group.

Project Partners

In addition to the continuing collaboration with the County Office of Education and multiple school districts, the County will rely on the subject matter expertise of several community partners, including Harmony at Home, and The Epicenter.

The Community Program Planning Process (see pages 32-34 of plan)

Local Level

The idea for this project emerged during the community stakeholder process to guide and develop the draft MHSA FY2022/23 Annual Update. The County contracted with EVALCORP to support an assessment of local behavioral and mental health needs utilizing online surveys and focus groups intentionally designed and administered to reflect a diverse set of provider and community voices, including underserved communities.

Three additional community engagement sessions with school staff and parents were held, where themes emerged that refined this project to focus on developing a single service delivery model to serve LGBTQ youth up to age 25 where the County and youth serving agencies focus on:

- increasing access to mental health and affirming medical care and linkage to community resources for LGBTQ youth;
- providing ongoing training and psychoeducation for providers of youth serving systems on LGBTQ-related topics; and
- expanding in-place, embedded culturally responsive care

Monterey County's community planning process included the following:

- 30-day public comment period: March 17, 2023 through April 17, 2023
- Local Mental Health Board Hearing: May 4, 2023
- Board of Supervisor Approval: Following Commission Approval

A final plan, incorporating community partner and stakeholder input as well as technical assistance provided by Commission staff, was submitted on May 5, 2023.

Commission Level
This project was initially shared with Community Partners on March 29, 2023, and the final was shared on May 8, 2023.

No comments were received by the Commission in response to the sharing of this project.

Learning Objectives and Evaluation (please see pages 31-32 of full plan)
The County anticipates serving approximately 19,185 youth and their families over five years through the Rainbow Connections project.

By adapting the PBIS model and utilizing an integrated approach to serve the LGBTQ community, the County hopes to:

1. Increase capacity for parents, teachers, school administrators, and mental and physical healthcare providers to identify and affirmatively respond to the mental health needs of LGBTQ youth.
2. Increase interagency and community collaboration to effectively refer LGBTQ youth to care with the provision of an online referral resource.
3. Improve the access to, and quality of, supportive services for LGBTQ youth as a result of the culturally responsive and collaborative framework that is applied across the primary domains in which they live, learn and grow.

The County will partner with an external evaluation team to develop an evaluation plan to measure the quantitative and qualitative learning objectives of this project.

The Budget (please see pages 39-41 of full plan)

5 Year Budget	FY 23/24	FY 24/25	FY 25/26	FY 26/27	FY 27/28	**TOTAL**
Personnel	$ 927,217	$ 952,981	$ 979,312	$ 1,006,405	$ 1,032,305	$ 4,898,220
Operating Costs	$ 289,950	$ 234,021	$ 237,582	$ 245,533	$ 251,569	$ 1,258,655
Non-recurring costs	$ 6,850			$ 2,000		$ 8,850
Other	$ 40,000	$ 40,000	$ 40,000	$ 40,000	$ 40,000	$ 200,000
Contracts	$ 427,861	$ 291,286	$ 274,904	$ 261,332	$ 262,455	$ 1,517,837
						$ -
Total	$ 1,691,877	$ 1,518,288	$ 1,531,799	$ 1,555,270	$ 1,586,328	$ 7,883,563
Funding Source	FY 23/24	FY 24/25	FY 25/26	FY 26/27	FY 27/28	**TOTAL**
Innovation Funds	$ 1,691,877	$ 1,518,288	$ 1,531,799	$ 1,555,270	$ 1,586,328	$ 7,883,563

Monterey County is seeking authorization to use up to $7,883,562.86 in Innovation funding over a five-year period to fund the project, including:

- Personnel Costs total $4,898,220 (63% of the total project) and include contractor personnel costs and county personnel costs.

- County costs total $3,601,250.47 and include average annual salary costs (including a 2.5% annual increase) of the following positions to create the Rainbows Connections Integrated Care Team (ICT):
  - 1 FTE Senior Psychiatric Social Worker
  - 1 FTE Social Worker III
  - 0.5 FTE Psychiatrist
  - 0.4 FTE Behavioral Health Services Manager II
  - 0.2 FTE Behavioral Health Services Manager II
  - Indirect costs associated with these positions are calculated at 13.86% of salary.

- Additional Consultant/Contractor costs total $2,776,492 (35% of the total project) and include contractor operating costs, training costs, and include costs to perform and support the implementation and evaluation activities.

  The County will leverage partnerships and develop contracts with:
  - The Family Acceptance Project (FAP)
    - A series of FAP trainings will be provided
  - Partners4Peace (P4P)
    - Adds a 1.0 FTE FAP Family Support Partner (FSP)
  - Harmony at Home
    - Adds a 1.0 FTE on campus, Bullying Prevention Specialist
  - Epicenter
    - Adds a 1.0 FTE Wellness Outreach Coordinator
  - TBD for marketing and promotion
  - **Evaluation costs $325,000 (4% of the total project) associated with developing the evaluation plan, supporting data collection, analysis and preparing reports.**
- Other costs include $100,000 for youth engagement

<u>Sustainability</u>
If the project is determined to be successful, the County will consider the use of MHSA funds (PEI) and/or realignment funds.

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations; however, if the Innovation Project is approved, the County must receive and inform the MHSOAC of the certification of approval from the Monterey County Board of Supervisors <u>before</u> any Innovation funds can be spent.

STAFF ANALYSIS –SAN BERNARDINO COUNTY

Innovation (INN) Project Name:	**Progressive Integrated Care Collaborative**
Total INN Funding Requested:	**$16,557,576**
Duration of INN Project:	**5 Years**
MHSOAC consideration of INN Project:	**May 23, 2023**

Review History:

Date Project Shared with Stakeholders:	March 29, 2023 and April 7, 2023
Public Comment Period:	April 6, 2023-May 6, 2023
Mental Health Board Hearing:	May 11, 2023
County submitted INN Project:	May 11, 2023
Approved by the County Board of Supervisors:	Pending Commission Approval

Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):

The primary purpose of this project is to increase the quality of mental health services, including measured outcomes.

This Proposed Project meets INN criteria by introducing a new practice or approach to the overall mental health system, including but not limited to, prevention and early intervention.

Project Introduction:

Based on learnings from a study focused on a 12-month collaborative care management of services for elderly patients with depression, San Bernardino County seeks innovation funding authority to establish a pilot clinic site where both behavioral and physical health care services will be provided for Medi-Cal enrollees. The County believes that this Innovation will help to address the problems related to the disproportionate number of mental health clients with unaddressed cardiometabolic disease as well as provide effective delivery of services to nearly 20% of its population that resides in rural areas within the County, who have co-morbidities and who are not able to easily access health care services. Recipients of services and service providers will be able to "share access to medical information (with appropriate permissions), meet and confer about individual cases, and develop procedures and practices to ensure the

delivery of all needed care." (Pages 13-14) This pilot anticipates developing five areas of procedures and practices that will benefit the County's consumers: laboratory studies, electrocardiograms studies, data sharing, physical health specialist consultation and referrals and billing. (Pages 14-15)

What is the Problem:

San Bernardino has three designated population areas; urban, rural and frontier. Additionally, the County's rural areas have the highest populations of persons with co-morbidities and the fragmented systems of care (medical, substance and mental health treatment), require a consumer to access three separate systems, many of which are not co-located. This coupled with expenses related to appropriate treatments, transportation barriers to access treatments and trust/comfort between the provider and the recipient of services, has created a system in the County that is "illness focused and not wellness focused". (Page 10)

"This lack of timely and consistent medical treatment often results in death decades earlier than necessary, often from easily treatable health conditions. Additionally, the lack of consistent, ongoing care forces these individuals to utilize hospital and emergency department services at rates far higher than if a primary care physician provided the service." (Page 11)

How this Innovation project addresses this problem:

The County is proposing to establish a pilot clinical site that will provide behavioral and health care coordination for Medi-Cal enrollees. It is anticipated that this clinical site will be able to provide access to laboratory studies, electrocardiogram studies, data sharing, physical health specialist and establish new billing processes/payment models.

Because of the co-morbidity between mental health treatment and physical wellbeing, the clinic anticipates it will be able to provide the critical care that many of its constituents need but are not able to coordinate or navigate the multiple systems in one location. Consumers may now be able to access the following treatments in one location as opposed to making separate appointments and traveling to different locations within the County:

- Medication Management to have pharmaceuticals reviewed to avoid adverse interactions of medications
- Collection of blood samples to maintain appropriate/therapeutic dosage and as a diagnostic screening.
- Electrocardiogram studies for co-morbid cardiac issues related to medication, and for diagnostic screening,
- Chronic disease management for co-morbidities,
- Referrals to medical health specialists to allow for consumers to access ancillary medical screening and avoid long delay in service delivery.
- Peer navigation and supports to assist with navigation of services at the care facility,

- Comprehensive medical reconciliation to allow service providers access to other ongoing health care issues,
- Onsite group and individual nutrition coaching to facilitate behavioral changes related to co-morbidities whenever possible, and
- Mental health and substance use disorder treatments to provide comprehensive services related to any co-morbidities.

The County believes that by integrating the physical services into this clinic, consumers will be able to take advantage of the trust they may have established with their mental health providers, instead of having to reorient themselves to a new provider in a new location for any new medical issue.

Additionally, the County would like to study the economic benefits and cost savings of this "whole person care approach," identified in the 12 month study titled *Improving Mood Promoting Access to Collaborative Treatment (IMPACT)* for geriatric patients to determine if this whole person care approach can be replicated in their population of persons 18 years and older, experiencing mental illness, who are Medi-Cal beneficiaries and who are enrolled with the managed care plan. Based on the IMPACT study, it was estimated that persons in a collaborative care program were 87% more likely to have lower total healthcare costs.

Finally, in 2015 San Bernardino completed a demonstration project, "Whole Person Care Pilot" that provided "engagement and support through health navigation to coordination of services on behalf of county residents who meet criteria of having multiple, chronic conditions, both physical and behavioral with a focus on those individuals who are risk for homelessness" (page 11). More importantly, lessons learned from that project have informed this project in the following ways (see page 11 for complete list of lessons learned):

- Integration needs to be more than just co-location of physical and behavioral health services
- Peer navigators to assist with system navigation with appropriate linkages and referrals
- Co-location of services eased the transportation burdens of consumers

A search of other counties' innovative projects like this found that none included all of the service and programmatic elements as identified by San Bernardino. For example, Nevada County initiated a homeless outreach program that included counseling, medication and basic health screening and indicated that they would like to test the efficacy of multi-interagency case management. El Dorado County developed a nutrition program for seniors and added mental health screening, assessment, and linkages to the programs as an incentive for participation. Modoc County developed a health care program for mental health recipients who are prescribed psychotropic medications to prevent or reduce negative metabolic/health impacts. Other counties, namely, Siskiyou and Solano developed programs to provide

integrated care (mental and physical health, education consultation, etc.) however, none of these provide the array of opportunities proposed by San Bernardino.

The Community Program Planning Process (pages 5-8 and pages 20-25)

Local Level

The County indicates that the concept of the Integrated Care Collaborative project was first identified during the Community Planning Process conducted in 2016 as a community need, in preparation of the Three-Year Program and Expenditure Plan for FYs 2017-2020. At that time, the County reports that there was support for the project. Unfortunately, the project was "put on hold" (page 20) due to COVID and it was not until the summer of 2022 that the proposal was fully developed. It was then shared at Innovation Stakeholder meetings and included in 44 community program planning meetings for the FY 2023-2026 Three Year Program and Expenditure Plan. There are 14 cultural subcommittees in San Bernardino and 5 district advisory committees. Each of these groups had the opportunity to review and provide input and feedback on this plan.

Additionally the County collected written feedback via individual stakeholder feedback forms and polling was conducted online, via virtual platforms and in person. The County reports that 819 persons attended the community program planning processes and from those, 688 surveys were completed. The largest respondents were comprised of consumers, and friends and families of consumers.

During the public comment period, the County received and responded to comments (in English and Spanish) from stakeholders (see pages 6-8.) One comment spoke directly to the County's motivation for developing this proposal:

> "Integrated care sound like an important aspect to ensuring that patients received better care by providing services that are easier to navigate and also to allow prescribing physicians and pharmacists to make sure that the medications prescribed are accessible and not interfering with other prescriptions. It can be so hard as a patient to coordinate communication between different medical offices and the pharmacy, adding days or even weeks before prescriptions can be filled or worse, prescriptions that have negative interactions and no one catches them because multiple providers are prescribing and/or multiple pharmacies are filling the prescriptions and are not aware of other medications". (page 7)

The County held their public comment period between April 6, 2023 and May 6, 2023, followed by their Mental Health Board Hearing on May 11, 2023. San Bernardino will seek approval from their County Board of Supervisors pending Commission approval.

Commission Level

This project was initially shared with Community Partners on March 29, 2023, and the final version was again shared on April 7, 2023.

No comments were received by the Commission in response to the sharing of this project.

Learning Objectives and Evaluation:

The County is hoping to learn if the integration of services in this project results in the following outcomes:

- Overall improvement wellbeing for clients in a rural/developing area
- Efficacy of value-based forms of payment for types of services provided
- Improvement in the treatment coordination for clients
- Development of a universal consent form
- Determining if this this model is effective for an integrated psychiatric medical home.

Measurement of these intended learnings will be both qualitative and quantitative, stemming from a combination of interviews, data collected, cost analyses of Fee for Services model versus this model, as well as service provide satisfaction with credentialling process and improved treatment and time savings for consumers.

The Budget (see pages 30-32)

The County is requesting authorization to spend up to $16,557,576 in innovation funding over a five-year period.

Personnel costs in the amount of $12,778,366 are 77% of the total costs and will be used to pay for the following staff:

- Behavioral Health Psychiatrist
- Two Behavioral Health Physicians
- Two Behavioral Health Nurses
- Two Peer and Family Advocates
- One Mental Health Specialist
- Specialty staff (registered Dietician and Clinical Pharmacist) as needed
- Business Systems Analyst
- Health Information Coder
- Consultants
- County staff to cover the evaluation of this project
- County administrative and oversight costs in the amount of 15% of the total cost of county staff including:
    - .05 FTE each for an Innovation Program Manager
    - Innovation Program Specialist II

- Innovation Program Specialist I
- County staff that will be charged with the evaluation of this project.

The County anticipates:

- Contracting costs in the amount of $2,050,000 (12% of the total budget) to cover the costs of specialty health services, laboratory services, EKG consultations).
- The program evaluation cost in the amount of $1,691,264 (10% of the total budget) is added to the total personnel budget since staff will be conducting the evaluation.
- One-time and operating costs in the amount of $974,870 (5% of the total budget) will include the purchase of two vehicles to assist with transportation of clients, technology costs, for staff, and medical and general office equipment.

5 Year Budget	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**TOTAL**
Personnel	$ 2,406,864.00	$ 2,479,070.00	$ 2,553,442.00	$ 2,630,045.00	$ 2,708,946.00	$ 12,778,367.00
Operating Costs	$ 125,817.00	$ 129,592.00	$ 133,479.00	$ 137,484.00	$ 141,608.00	$ 667,980.00
Consultant Costs / Evaluation	$ 100,000.00	$ 300,000.00	$ 450,000.00	$ 600,000.00	$ 600,000.00	$ 2,050,000.00
Non-recurring Costs	$ 162,890.00	$ 144,000.00	$ -	$ -	$ -	$ 306,890.00
County Admin Costs	$ 142,083.00	$ 146,346.00	$ 150,736.00	$ 155,258.00	$ 159,916.00	$ 754,339.00
						$ -
						$ -
Total	$ 2,937,654.00	$ 3,199,008.00	$ 3,287,657.00	$ 3,522,787.00	$ 3,610,470.00	$ 16,557,576.00

Funding Source	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**TOTAL**
Innovation Funds	$ 2,937,654.00	$ 3,199,007.00	$ 3,287,657.00	$ 3,522,787.00	$ 3,610,471.00	$ 16,557,576.00
Total	**$ 2,937,654.00**	**$ 3,199,007.00**	**$ 3,287,657.00**	**$ 3,522,787.00**	**$ 3,610,471.00**	**$ 16,557,576.00**

If the Innovation Project is approved, the County must receive and inform the MHSOAC of this certification of approval from the San Bernardino County Board of Supervisors ***before*** *any Innovation Funds can be spent.*

AGENDA ITEM 6

Action

May 25, 2023 Commission Meeting

Governor's Proposed 2023-2024 Revised Budget,
CYBHI Grant Program & Commission Expenditure Authority

Overview of the Governor's Proposed 2023-24 Revised Budget

Governor Newsom released California's 2023-24 May Revision budget, projecting a $31.5 billion deficit. The May Revision reflects a $37.2 billion in total budgetary reserves and additional funds from the Managed Care Organization tax.

Governor Newsom maintains many of the Administration's and legislature's previous commitments and proposes no new cuts.

The May Revision maintains past budget agreements including expansion of Medi-Cal to all regardless of immigration status, reforming the Medi-Cal share-of-cost, and on-time implementation of food assistance for Californians 55 years of age or older, regardless of immigration status.

The proposed budget signals that, California has made progress in addressing poverty and systemic inequities, but there is more work to be done.

Below is the proposed budget by issue area, with a focus on changes from the January budget proposal.

Health

- **Health4All:** The May Revision maintains full funding to expand full-scope Medi-Cal eligibility to all income eligible adults ages 26-49 regardless of immigration status on January 1, 2024. The May Revision includes increases for previous expansions for adults 50 and older and ages 26-49 due updated managed care rates, higher share of state-only costs, higher caseloads, and higher acuity members.

- **Managed Care Organization (MCO) Tax:** The May Revision proposes the renewal of the MCO Tax with an earlier start date (April 2023 through end of 2026). This results in $19.4 billion in total funding, including $3.4 billion for 2023-24. $8.3 billion is proposed to offset General Fund and $11.1 billion is proposed to support Medi-Cal investments that improve access, quality, and equity over an 8-to-10-year period. These investments include rate

increases to at least 87.5% of Medicare for primary care, birthing care, and non-specialty mental health providers and the remainder will be put into a special fund reserve for future consideration.

- **California Behavioral Health Community-Based Continuum Demonstration):** The May Revision includes an update to the BH Demonstration to include a new Workforce Initiative and includes $480 million in funding for each year of the five-year demonstration period ($2.4 billion total funding and no General Fund). The Administration is currently seeking federal approval of BH Demonstration to expand behavioral health crisis, inpatient, and residential services through a staged implementation starting January 1, 2024.

- **Community Assistance, Recovery, and Empowerment (CARE) Act:** The May Revision includes $944.3 million over the next five years, and $290.8 million thereafter for the Department of Health Care Services and Judicial Branch to implement the CARE Act. Compared to the Governor's Budget, the annual increase is between $43 million and $54.5 million to account for refined county behavioral health department cost assumptions, additional one-time $15 million General Fund for Los Angeles County start-up funding. The May Revision also includes an additional $16.8 million in 2023-24, $29.8 million in 2024-25, and $32.9 million ongoing to double the number of hours per participant for legal services from 20 hours to 40 hours.

Significant Adjustments

- **2022-23 Budget Update:** The May Revision reflects lower Medi-Cal expenditures of approximately $1.4 billion General Fund in 2022-23 compared to the Governor's Budget. The decrease is due primarily to revised implementation updates to the Children and Youth Behavioral Health Initiative, the Behavioral Health Continuum Infrastructure Program, and the Behavioral Health Bridge Housing Program.

- **988 Update:** The May Revision includes a one-time augmentation of $15 million for a total of $19 million, from the 988 State Suicide and Behavioral Health Crisis Services Fund for California's 988 centers. This increase will support workforce expansion to handle increased answered call volume, extensions of service hours, and the availability of chat and text options for callers utilizing the 988 services.

- **CalHOPE:** The May Revision maintains funding to temporarily extend support for the CalHOPE program. In lieu of General Fund, the May Revision includes $50.5 million one-time Mental Health Services Fund in 2023-24.

- **Opioid and Fentanyl Response:** Building on the opioid response investments proposed at the Governor's Budget, the May Revision includes an additional $141.3 million in Opioid Settlements Fund over four years for the Department of Health Care Services to support the Naloxone Distribution Project, for a total of $220.3 million over four years.

- **Advancing Older Adults:** The May Revision includes $50 million over four years for the Department of Aging to support the continuation of the Older Adult Friendship Line to help address older adult behavioral health and substance use disorder needs.

- **Health and Human Services Innovation Accelerator Initiative:** The May Revision includes an augmentation of $9 million ($10 million total) for the Health and Human Services Agency to establish a new public-private partnership that will create the environment for researchers and developers to create solutions to the greatest health challenges facing Californians, with a focus on innovations that help to directly address disparities and inequities in California's safety-net programs.

Homelessness & Housing

The May Revision preserves the full $3.7 billion in funding for homelessness programs, as committed in previous budgets, including $1 billion for the Homeless Housing, Assistance and Prevention grant program.

- **Housing:** The May Revision reflects a steady commitment to Homelessness investments, the May Revision also culminated in a weakening of housing investments totaling $17.5 million in General Fund reductions and $345 million in deferrals related to housing programs.

Significant Adjustments:

- **Behavioral Health Bridge Housing Program:** $500 million one-time Mental Health Services Fund in 2023-24 in lieu of General Fund. This investment eliminates the January Budget proposed delay of $250 million General Fund to 2024-25 and restores the $1.5 billion commitment funded in the 2022 Budget Act for the program.

The Governor's entire proposed budget can be accessed at https://www.ebudget.ca.gov/

CYBHI Grant Program & Commission Expenditure Authority

The Governor's 2023-24 budget proposal includes $47.9 million to the Commission.

Mid-Year 2022-23 Commission Budget Update

Summary: Each year, the Mental Health Services Oversight and Accountability Commission is presented with a mid-year report on the budget in January, which coincides with a presentation on the Governor's proposed budget for the following fiscal year. Staff also provides a budget presentation in May, that coincides with the Governor's May Revision, and again in July at the beginning of the new fiscal year. The goal of these presentations is 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.

Budget by Fiscal Year and Specific Category

	Fiscal Year 2020-21	Fiscal Year 2021-22	Fiscal Year 2022-23	Fiscal Year 2023-24
Operations				
Personnel	$5,528,000	$6,720,000	$8,100,000	$8,968,000
Core Operations	$5,256,000	$3,890,000	$3,168,000	$4,295,000
Total Operations	**$11,063,000**	**$10,610,000**	**$11,268,000**	**$13,263,000**
Budget Directed				
COVID-19 Response*	$2,020,000			
Covid 19/Suicide Prevention*	$2,000,000			
Anti-Bullying Campaign*		$5,000,000		
MHSSA Admin Augmentation*		$15,000,000		
MHSSA Admin/Evaluation*		$10,000,000	$16,646,000	
Evaluation of FSP Outcomes			$400,000	$400,000
Fellowship/Transformational Change*			$5,000,000	
Total Budget Directed	**$4,020,000**	**$30,000,000**	**$22,046,000**	**$400,000**
Local Assistance				
Children & Youth Behavioral Health Initiative*			$42,900,000	
Community Advocacy Partnership	$1,398,000	$5,418,000	$6,700,000	$6,700,000
Mental Health Student Services Act (MHSSA)**	$8,830,000	$188,830,000	$8,830,000	$7,606,000
Mental Health Wellness Act / Triage	$20,000,000	$20,000,000	$20,000,000	$20,000,000
Total Local Assistance Funds	**$30,228,000**	**$214,487,000**	**$78,430,000**	**$32,306,000**
Grand Total	**$45,032,000**	**$255,097,000**	**$111,744,000**	**$47,969,000**

*one-time funds

**one-time funds and ongoing funds

Presenter: Norma Pate, Deputy Director

Enclosures: None

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

The Commission will be presented with an update to the expenditure plan and associated contracts for 2022-23.

Proposed Motion: The Commission approves the Fiscal Year 2022-23 updated expenditure plan and associated contracts.

AGENDA ITEM 7

Action

May 25, 2023 Commission Meeting

2024-2027 Strategic Plan Outline

Background

In January, the Commission reviewed progress made under the 2020-23 strategic plan, challenges in accomplishing some of the goals, and identified four priorities for 2023: Data, Full-Services Partnerships, Impact of Firearm Violence, and development of the 2024-27 Strategic Plan. Commissioner Carnevale was appointed as the lead Commissioner for the 2024-2027 strategic planning efforts and approval was given for a consultant to be selected to support the development of the 2024-27 plan.

In May, Boston Consulting Group was engaged to work with internal and external community partners to collect perspectives on the Commission's projects, to assess the Commission's model for catalyzing transformational change, to develop a decision-making framework to guide the transformational of mental health care, and provide an outline for the new strategic plan. The plan will be developed over the next several months with several opportunities to engage community partners for guidance. Similarly, the Commission will be routinely briefed and consulted in the development of the draft plan.

Presenter(s): Commissioner Steve Carnevale, Norma Pate, Deputy Director and Boston Consulting Group

Enclosures: PowerPoint slides

Handouts: None

Proposed Motion: None

Draft: Pre-decisional and for discussion only

2024-2027 Strategic Plan Outline

Pre-read materials for discussion

MAY 25TH, 2023

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Draft – pre-decisional – for discussion only

Context

Draft - pre-decisional - for discussion only

Context | 2024-2027 Strategic Plan effort

The Commission is in the **early stages of developing the Strategic Plan** for the coming years (2024-2027)

As part of this effort, we aim to

- Reflect on the **Commission's work to date and lessons learned** from the last three years
- Understand and articulate **how our work fits into context** amid an evolving mental health landscape
- Surface and evaluate **opportunities to catalyze transformational change**

Today is the **first of many opportunities to engage**

…designed to be an inclusive and collaborative process

- Commission seeks to meaningfully engage community partners, experts and the public throughout
- Diverse opportunities for input (e.g., interviews, listening sessions, public forums) will continue through the rest of 2023
- Complete draft plan will be publicly released by November 30th
- Plan will be considered for adoption in January 2024

Objectives for this session

Provide context on the Strategic Plan process & status

Discuss and collect feedback on core components of the Strategic Plan

Solicit input from the Commissioners & public

Strategic Plan discussion

Design principles for the effort

- **Understandable and accessible** for the Commission and community partners
- **Collaborative and inclusive,** developed with partners, reflecting a breadth of perspectives
- **Forward-looking and innovative**, responding to current demands and new opportunities
- **Rigorous and analytical**, supporting the Commission to prioritize opportunities and initiatives for impact
- **Mission-driven,** consistent with the Commission's vision, core principles, and mandate
- **Outcome-oriented** to deliver transformational change, improve outcomes, and reduce disparities

Key components of the Strategic Plan

- Foreword & Purpose of plan
- Introduction

Focus of this session

1. Emerging trends
2. Transformational change model and Role of the Commission
3. Decision-making framework
4. Priorities & objectives for 2024-2027

- Conclusion "from Plan to Action"

Prompt for discussion | Emerging context & trends in mental health care

Illustrative not exhaustive

Increasing awareness of and need for mental health care

- Significant increase in public **understanding and reduced stigma**
- Increased **incidence of illness, worsened by the pandemic**
- Growing **structural threats and diminished social safety net**
- Additional obstacles for **marginalized and at-risk;** over-represented in **criminal justice system**

Mental health elevated as a shared priority

- **Employers, schools and communities** engaged, see as a shared priority
- Large, one-time **public investments;** increased **philanthropic** and **private investment**
- **Public agencies and community resources** directed to mental health
- Proposed **modernization of MHSA funding**

Evolutions in treatment and care delivery

- Growing focus on **prevention and early intervention**; shift to integrated care with "no wrong door"
- Innovation in **diagnosis and treatments** (e.g., precision medicine)
- Expanding **infrastructure & supports**
- Expanding **alternative delivery models** (e.g., telehealth, startups)

Extreme strain on practitioners & resources

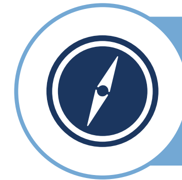
- **Shortage and burnout of workforce**
- **Shifting needs for practitioners** exacerbate significant capacity gaps
- **Care driven by financing**, with low reimbursement rates & difficulty billing insurers
- Hospitals and traditional care delivery models facing **financial strain**

Do these trends resonate? What would you add or update?

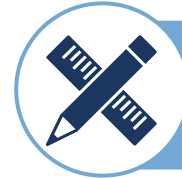
Emerging trends
Initial questions for discussion

- Which of these trends present the **biggest opportunities** and/or **require the most urgent attention** in the next four years?
- Which of these trends is the Commission **best positioned to address** (e.g., prevention and early intervention, expanding infrastructure and supports, etc.)?
- What **major changes in science, technology or society** in the next 5-10 years should the Commission be planning for? How can the Commission **future-proof California's mental health system**?

Recall
Commission's role


Oversight and Accountability

Program Review and Data Collection


Policy Projects

Strategic Partnerships

Grant Programs

Source: 2020-2023 MHSOAC Strategic Plan

Transformational change model & Commission's role

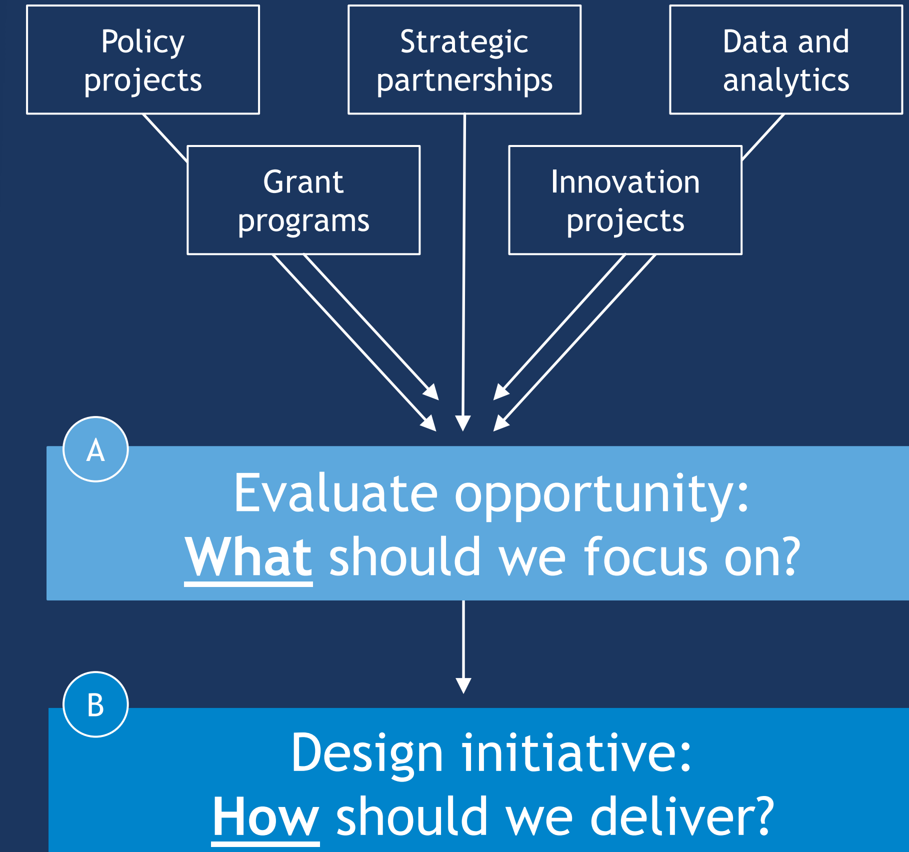
Initial questions for discussion

- How is the Commission **differentiated in its role**? What has been our **highest impact effort**?
- To be most effective in the coming years, how will the Commission need to **evolve or expand** our roles?
- What is the right **balance of effort** across our activities to deliver on these roles?

We are building a decision-making framework to guide our assessment of opportunities…

This tool will be designed to help us:

- **Standardize our approach** to collect data and **measure the potential impact** of an initiative
- **Prioritize** across initiatives and make funding decisions accordingly
- **Look across our portfolio** to understand opportunities for impact and collaboration
- **Consider tradeoffs** between addressing current challenges and new, emerging threats
- **Design and monitor programs** in a way that maximizes outcomes for target populations



Draft – pre-decisional – for discussion only

Decision-making framework
Initial questions for discussion

- What **key factors should we consider** in our decision-making framework to evaluate opportunities (e.g., need, impact, fit, feasibility, etc.)?
- How should the Commission **balance our portfolio** between (1) **addressing ongoing challenges with proven interventions** and (2) **building new solutions in emerging areas**?

Recall | Priorities and Objectives in 2020-2023 Strategic Plan

Strategic goals

Objectives

Advance a Shared Vision

The Commission will **advance a shared vision for reducing the consequences of mental health needs and improving wellbeing** - and promote the strategies, capacities and commitment required to realize that vision

A. **Promote school mental health** to reach and serve at-risk children, families & neighborhoods

B. **Develop and advance a strategy** aligning public and private resources and actions toward the **prevention and early intervention**

C. **Establish and promote the adoption of voluntary standards for the workplace** to reduce stigma, increase awareness & guide strategies

Leverage Data & Analytics

The Commission will **advance data collection and analysis to identify desired outcomes, better deploy resources and programs**, and seek opportunities to transform & connect programs

A. **Develop the Transparency Suite at MHSOAC.CA.GOV** to capture more detailed information that is easier to find and interpret

B. **Management of county-level info. to better inform decision-making** by policymakers & administrators

C. **Aggregate and integrate cross-system data** (e.g., health, education, etc.) to assess system performance & **identify opportunities for improvement**

Catalyze Improvement in Policy & Practice

The Commission will support the **positive transformation of policies & practices** by (1) **providing info. & expertise**; (2) **facilitating networks & collaboratives**; and (3) **identifying opportunities for improvement**

A. **Support and evaluate multi-county collaboratives to improve data analysis, knowledge transfer,** and the management capacity required

B. **Support implementation of Striving for Zero, the State's suicide prevention plan** for 2020-25

C. **Support youth-led efforts** to advance and expand consumer-led and **consumer-centric services & expand access to youth-focused services**

Source: 2020-2023 MHSOAC Strategic Plan

Priorities and objectives
Initial questions for discussion

- Where does the Commission need to **double down on existing efforts** to be successful in the coming years?
- What **new priorities** should the Commission consider?
- What is the Commission **over- or under-invested in**?

Path forward

Incorporate feedback from you and other community partners over coming months to shape Strategic Plan

Develop Strategic Plan draft that builds on lessons learned and narrows in on opportunities for change

Continue to create diverse opportunities to engage, collect input and shape the Strategic Plan

Thank you!

Draft – pre-decisional – for discussion only

AGENDA ITEM 9

Action

May 25, 2023 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 May Commission meeting, Commissioners will have the opportunity to discuss new legislation and consider taking positions on existing legislation that will create continuous improvement and transformational change to the mental health system.

Item for Consideration:

- AB 1282 (Lowenthal)
  The Office of Assemblymember Lowenthal is asking the Commission to consider supporting AB 1282 which would require the Commission to develop a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth. This bill is supported by the California Academy of Family Physicians who believes this bill takes the necessary step to collect data and recommendation on the negative impact that social media has on children and youth and will aid in gathering recommendations on how to reduce the negative outcomes that may result from untreated mental illnesses. AB 1282 in unopposed and has received bi-partisan support in the Legislature.

  Location (as of 5/19/23): Assembly Floor

  Pending Amendments: Assembly Member Lowenthal has indicated intent to amend the bill to also consider the mental health risks associated with Artificial Intelligence.

Assembly Member Lowenthal:

Assemblymember Josh Lowenthal was elected to the California State Assembly in November of 2022 to represent the 69th Assembly District encompassing Avalon, Carson, Long Beach, and Signal Hill. He has worked as an entrepreneur and business owner with a long, successful record of accomplishment in tech and telecom startups. Growing up and working in Long Beach, Assembly Member Lowenthal has committed himself to improving the community by working to alleviate homelessness, help at-risk children, and create good, 21st-century jobs. He is the son of previous Assembly Member Bonnie Lowenthal and previous Assembly Member, U.S. Representative, and U.S. Senator Alan Lowenthal. He worked as a local teacher, is a local business owner, and has three daughters in public schools.

Assembly Member Lowenthal serves on the several committees including Appropriations, Business and Professions, Privacy and Consumer Protection, and Transportation.

- SB 509 (Portantino)
  The Office of Senator Portantino is asking the Commission to consider supporting SB 509 which requires a local educational agency (LEA), on or before January 1, 2027, to certify to the California Department of Education (CDE) that 75 percent of its classified and certificated employees who have direct contact with pupils at each school have received specified youth behavioral health training. SB 509 is sponsored by the California Council of Community Behavioral Health Agencies and supported by the California Alliance of Child and Family Services and others. The California Teachers Association opposes the bill because it could raise liability issues for school employees and/or the school district, employee youth behavioral health training must be collectively bargained at the local level, and they prefer the training mandate be replaced with a grant program for LEAs to apply to the CDE for funding to conduct behavioral health training.

  Location (as of 5/19/23): Senate Floor

  Senator Portantino:

Senator Portantino was elected to the California State Senate in 2016 to represent the 25th Senate District which stretches along the 210 Freeway from Sunland/Tujunga to Upland. Supporting public education, mental health, and sensible gun control have been priorities for Senator Portantino during his time in office. He previously served the California State Assembly from 2006-2012. Prior to his years as a representative, he spent many years working in film and television production, served on the California Film Commission, and spent nearly eight years on the La Cañada Flintridge City Council, with two terms as Mayor. Senator Portantino grew up in New Jersey, where he attended public schools and graduated from Albright College in Reading, Pennsylvania, where he met his future wife, Ellen, a longtime business executive at Warner

Brothers and Disney. They have two daughters. He is currently running for California's 30th congressional district to replace Adam Schiff.

Senator Portantino serves as chair of the Senate Appropriations Committee and sits as a member on several committees including Banking and Finance, Governmental Organization, Insurance, and Joint Legislative Budget.

Items for Future Consideration:

The Commission is currently reviewing several bills which may be considered at a future Commission meeting:

- **AB 599 (Ward).** This bill, beginning July 1, 2025, no longer allows a student to be suspended or expelled from school for possessing or using tobacco or nicotine products or possessing certain controlled substances. In addition, this bill requires the California Department of Education to develop and make available a model policy for a public health approach to addressing student possession and use of drugs on school property. This bill is sponsored by the California Youth Empowerment Network, California Alliance of Child and Family Services, and Children Now. The California Teachers Association opposes this bill because their members believe an "impaired" student may pose a safety and/or security threat to themselves and others and they assert that effective discipline is unique to each student's situation and all options should be available. *Location (as of 5/19/23): Assembly Floor*

- **SB 10 (Cortese).** This bill would require local educational agencies to include protocols for the prevention and treatment of an opioid overdose in their comprehensive school safety plans. This bill would also require the California Department of Education to establish the State Working Group on Fentanyl Education in Schools to promote public education, awareness, and prevention of fentanyl overdoses. This bill is sponsored by the California Consortium of Addiction Programs and Professionals, the County of Santa Clara, and the Santa Clara County Office of Education. It is supported by many organizations and has received no opposition. *Location (as of 5/19/23): Senate Floor*

Enclosures (6):

(1) AB 1282 (Lowenthal)
(2) AB 1282 (Lowenthal) Assembly Privacy and Consumer Protection Committee Analysis
(3) SB 509 (Portantino)
(4) SB 509 (Portantino) Assembly Education Committee Analysis
(5) 2023 Legislative Calendar
(6) The Life Cycle of Legislation

Proposed Motion: That the Commission supports AB 1282 (Lowenthal) and directs Commission Staff to communicate its position to the Governor and the Legislature; and, that the Commission supports SB 1209 (Portantino) and directs Commission Staff to communicate its position to the Governor and the Legislature.

AMENDED IN ASSEMBLY APRIL 20, 2023

AMENDED IN ASSEMBLY APRIL 6, 2023

AMENDED IN ASSEMBLY MARCH 9, 2023

CALIFORNIA LEGISLATURE—2023–24 REGULAR SESSION

ASSEMBLY BILL No. 1282

Introduced by Assembly Member Lowenthal

February 16, 2023

An act to add and repeal Part 4.3 (commencing with Section 5887) of Division 5 of the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1282, as amended, Lowenthal. Mental health: impacts of social media.

Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Oversight and Accountability Commission, and authorizes the commission to take specified actions, including advising the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.

This bill would require the commission to report to ~~the relevant~~ *specified* policy committees of the Legislature, on or before July 1, 2026, a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth. The bill would require the report to include, among other things, (1) the degree to which individuals negatively impacted by social media are accessing and receiving mental health services and (2)

recommendations to strengthen children and youth resiliency strategies and California's use of mental health services to reduce the negative outcomes that may result from untreated mental illness, as specified. The bill would require the commission to explore, among other things, the persons and populations that use social media and the negative mental health risks associated with social media, as specified. The bill would repeal these provisions on January 1, 2029.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Part 4.3 (commencing with Section 5887) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 4.3. IMPACTS OF SOCIAL MEDIA ON MENTAL HEALTH

5887. As used in this part, the following definitions shall apply:

(a) "Children and youth" means individuals up to 26 years of age.

~~(a)~~

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

~~(b)~~

(c) "Social media" means a ~~public or semipublic internet-based service or application that has users in California and that meets both of the following criteria:~~ *social media platform, as defined in Section 22675 of the Business and Professions Code.*

~~(1) A substantial function of the service or application is to connect users in order to allow users to interact socially with each other within the service or application. A service or application that provides email or direct messaging services shall not be considered to meet this criterion on the basis of that function alone.~~

~~(2) The service or application allows users to do all of the following:~~

~~(A) Construct a public or semipublic profile for purposes of signing into and using the service or application.~~

~~(B) Populate a list of other users with whom an individual shares a social connection within the system.~~

~~(C) Create or post content viewable by other users, including, but not limited to, on message boards, in chat rooms, or through a landing page or main feed that presents the user with content generated by other users.~~

5887.1. (a) The commission shall report to the *Senate and Assembly Committees on Health, the Senate Committee on Judiciary, the Assembly Committee on Privacy and Consumer Protection, and other* relevant policy committees of the Legislature a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth. The report shall include all of the following:

(1) The degree to which individuals negatively impacted by social media are accessing and receiving mental health services.

(2) Recommendations to strengthen children and youth resiliency strategies and California's use of mental health services to reduce the negative outcomes that may result from untreated mental illness enumerated in subdivision (d) of Section 5840.

(3) Any barriers to receiving the data relevant to completing this report.

(b) In preparing the report, the commission shall explore all of the following:

(1) The types of social media.

(2) The persons and populations that use social media.

(3) Opportunities to support resilience.

(4) Negative mental health risks associated with social media, including all of the following:

(A) Suicide.

(B) Eating disorders.

(C) Self-harm.

(D) Prolonged suffering.

(E) Depression.

(F) Anxiety.

(G) Bullying.

(H) Substance abuse.

(I) Other mental health risks as determined by the commission.

(c) In formulating this report, the commission shall prioritize the perspectives of children and youth through a robust engagement process with a focus on ~~transition-aged~~ *transition-age* youth, at-risk

populations, in-need populations and underserved cultural and linguistic populations. The commission shall also consult with the California mental health community, including, but not limited to, consumers, family members, providers, and other subject matter experts.

(d) The report shall be submitted on or before July 1, 2026.

~~(e) A report to be submitted pursuant to this section shall be submitted in compliance with Section 9795 of the Government Code.~~

5887.2. This part shall remain in effect only until January 1, 2029, and as of that date is repealed.

O

Date of Hearing: April 25, 2023

ASSEMBLY COMMITTEE ON PRIVACY AND CONSUMER PROTECTION
Jesse Gabriel, Chair
AB 1282 (Lowenthal) – As Amended April 20, 2023

Proposed Consent

SUBJECT: Mental health: impacts of social media

SYNOPSIS

This author-sponsored measure requires the Mental Health Services Oversight and Accountability Commission (Commission) to report to the Legislature a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth.

A recent report by the Centers for Disease Control points to a significant deterioration in high school students' mental health in the decade between 2011 and 2021. During that time, the percentage of male high school students who had experienced persistent feelings of sadness or hopelessness during the past year increased from 21% to 29%. For female students, the increase over the same period was tragically higher, from 36% to 57%.

A number of studies suggest that social media use may be a contributing factor to young people's deteriorating mental health. Rather than simply characterize all social media use as negative, this bill calls on the Commission to include in its inquiry topics like "the types of social media" and "the persons and populations that use social media." It is hoped that this exploration is sufficiently nuanced so as to help separate the benefits from the harms of social media use for various sub-groups among children and youth.

Moreover, as noted by the author, this bill is intended to fill a gap. Much of the legislation addressing the harms of social media use is prospective: that is, it is intended to prevent harm for future internet users. Yet studies suggest that many youth in the present may have already suffered significant harm to their mental health from social media use. By helping the Legislature "understand…mental health risks associated with the use of social media by children and youth" and "[t]he degree to which individuals negatively impacted by social media are accessing and receiving mental health services," this bill may help address the needs of those whose mental health has already deteriorated due to unhealthy social media use.

This bill is supported by California Academy of Family Physicians. There is no opposition on file.

This bill was previously heard by the Assembly Health Committee, where it passed on consent.

SUMMARY: Requires the Mental Health Services Oversight and Accountability Commission (Commission) to report to the Legislature a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth. Specifically, **this bill**:

1) Requires the Commission, on or before July 1, 2026, to report to the Senate and Assembly Committees on Health, the Senate Committee on Judiciary, the Assembly Committee on Privacy and Consumer Protection, and other relevant policy committees of the Legislature a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth.

2) Requires the report to include all of the following:

   a) The degree to which individuals negatively impacted by social media are accessing and receiving mental health services.

   b) Recommendations to strengthen children and youth resiliency strategies and California's use of mental health services to reduce the following negative outcomes that may result from untreated mental illness:

      i) Suicide.

      ii) Incarceration.

      iii) School failure or dropping out.

      iv) Unemployment.

      v) Prolonged suffering.

      vi) Homelessness.

      vii) Removal of children from their homes.

   c) Any barriers to receiving the data relevant to completing this report.

3) Requires the Commission to explore all of the following in preparing the report:

   a) The types of social media.

   b) The persons and populations that use social media.

   c) Opportunities to support resilience.

   d) Negative mental health risks associated with social media, including all of the following:

      i) Suicide.

      ii) Eating disorders.

      iii) Self-harm.

      iv) Prolonged suffering.

      v) Depression.

      vi) Anxiety.

vii) Bullying.

viii) Substance abuse.

ix) Other mental health risks as determined by the Commission.

4) Requires the Commission, in formulating the report, to prioritize the perspectives of children and youth through a robust engagement process with a focus on transition-age youth, at-risk populations, in-need populations, and underserved cultural and linguistic populations.

5) Requires the Commission to consult with the California mental health community, including, but not limited to, consumers, family members, providers, and other subject matter experts.

EXISTING LAW:

1) Establishes the Mental Health Services Act (MHSA), enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs, and integrated service plans for mentally ill children, adults, and seniors through a 1% income tax on personal income above $1 million. (Proposition 63, Nov. 2, 2004 gen. elec.)

2) Specifies that MHSA can only be amended by a two-thirds vote of both houses of the Legislature and only as long as the amendment is consistent with and furthers the intent of the MHSA. Permits provisions clarifying the procedures and terms of the MHSA to be amended by majority vote. (*Ibid.*)

3) Establishes the 16 member Commission to oversee the implementation of the MHSA. (Welf. & Inst. Code § 5845.)

4) Defines "social media platform" as a public or semipublic internet-based service or application that has users in California and that meets both of the following criteria:

   a) A substantial function of the service or application is to connect users in order to allow them to interact socially with each other within the service or application. (A service or application that provides email or direct messaging services does not meet this criterion based solely on that function.)

   b) The service or application allows users to do all of the following:

      i) Construct a public or semipublic profile for purposes of signing into and using the service or application.

      ii) Populate a list of other users with whom an individual shares a social connection within the system.

      iii) Create or post content viewable by other users, including, but not limited to, on message boards, in chat rooms, or through a landing page or main feed that presents the user with content generated by other users. (Bus. & Prof. Code § 22675(e).)

FISCAL EFFECT: As currently in print the bill is keyed fiscal.

COMMENTS:

1) **Background.** When the Centers for Disease Control released its *Youth Risk Behavior Survey Data Summary & Trends Report 2011-2021* earlier this year, the report's findings resonated nationwide. Among the most concerning results were the following:

- In the decade between 2011 and 2021, the percentage of male high school students who had experienced persistent feelings of sadness or hopelessness during the past year increased from 21% to 29%. For female students, the increase over the same period was tragically higher, from 36% to 57%.

- In 2021, 22% of high school students reported seriously considering attempting suicide during the past year.

- In 2021, 42% of high school students felt so sad or hopeless almost every day for at least two weeks in a row that they stopped doing their usual activities. Female students were more likely than male students to experience persistent feelings of sadness or hopelessness.

The full report may be found at https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf.

The connection between findings such as these and teens' increased use of technologies such as smartphones and social media applications is increasingly the subject of both research and legislation. A meta-analysis of 20 research studies published worldwide between January 2010 and June 2020 revealed that "while social media can create a sense of community for the user, excessive and increased use of social media, particularly among those who are vulnerable, is correlated with depression and other mental health disorders." (Ulvi, et al., *Social Media Use and Mental Health: A Global Analysis*, Epidemologia (Jan. 11, 2022), *available at* https://pubmed.ncbi.nlm.nih.gov/36417264/.) And, as can be seen from the "Related legislation" section of this analysis below, regulation of social media platforms, with an eye to ensuring children's well-being online, has been a topic of significant bipartisan interest in the Legislature for several years.

In 2022, concerns about children's health and its connection to their online activity prompted this Committee and the Assembly Arts, Entertainment, Sports, and Tourism Committee to hold a joint informational hearing on the topic of "Protecting Kids Online: Challenges & Opportunities in a Digital World." The background paper for the informational hearing (Background Paper), which is referenced below, is available at https://privacycp.assembly.ca.gov/sites/privacycp.assembly.ca.gov/files/Background_032922pdf.pdf.

2) **Author's statement.** According to the author:

> The presence and use of social media platforms globally has exploded over the last two decades. Many of the original platforms were designed to keep people connected and networked with one another for both personal and professional purposes; however, social media platforms have evolved into one of the primary means that individuals and organizations share ideas and information globally and this digital marketplace of ideas and information remains largely unregulated. Social media has proven to be a powerful tool that

is capable of influencing people. As the world has watched social media's exponential growth, we have witnessed the good and bad that these platforms can manifest. Many countries around the world, including the United States, are taking a much closer look at the impacts that social media has on its users and are trying to develop laws to regulate this digital space. As this policy and regulatory conversation unfolds, California has explored and passed legislation to help appropriately regulate social media platforms and more legislation is forthcoming in the state. While there has been legislation focused on regulating social media, including how to regulate this space to reduce future negative impacts on users, especially children and youth, the state does not currently have a game plan to address the current impacts that are being experienced by users who are children and youth and develop strategies that promote resilience and help the state to understand, communicate, and mitigate mental health risks associated with the use of social media.

AB 1282 will create a game plan to make sure that children and youth throughout the state are receiving the support and resources they deserve to create resilience and mitigate the negative mental health impacts associated with social media use.

3) **Analysis of this bill**. This bill would require the Mental Health Services Oversight and Accountability Commission (Commission) to report to the Legislature a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth. In its analysis of this bill, the Assembly Health Committee explained the role of the Commission as follows:

Proposition 63, the [Mental Health Services Act (MHSA)] was passed by voters in November, 2004. The MHSA imposes a 1% income tax on personal income in excess of $1 million for the purpose of addressing a broad continuum of prevention, early intervention and service needs as well as providing funding for infrastructure, technology, and training needs for the community mental health system. The MHSA creates the 16 member Commission charged with overseeing the implementation of MHSA. The MHSA requires each county mental health department to prepare and submit a three-year plan to the Department of Health Care Services (DHCS) that must be updated each year and approved by DHCS after review and comment by the Commission. Counties must submit their plans for approval to the Commission before the counties. There are five specific areas of expenditures authorized by MHSA: Community Services and Support, Prevention and Early Innovation, Capital Facilities and Technological Needs, and Workforce Education and Training. […] It is estimated that the MHSA will generate revenues of nearly $4 billion in the current fiscal year.

The question of whether it is appropriate, given the Commission's various duties, to also task it with producing the report this bill calls for is a question within the jurisdiction of the Assembly Health Committee. Also within the Health Committee's jurisdiction is the bill's requirement that the report provide "[r]ecommendations to strengthen children and youth resiliency strategies and California's use of mental health services to reduce the negative outcomes that may result from untreated mental illness," such as dropping out of school, homelessness, and incarceration. It remains to be seen whether these outcomes and recommendations tie to social media use.

The question presented for this Committee is whether the report the Commission would produce would assist the Legislature in formulating policy to protect and strengthen young people's mental health given their heavy social media use.

The answer is undoubtedly yes. One of the most notable points made in the informational hearing Background Paper cited above was the difficulty of disentangling the benefits from the harms of youths' online activity, and the consequent nuance that is required when policymaking in this area:

> Though the harms of digital technology are substantial, they are not insurmountable, and are particular to certain types of content, patterns of internet use, and design features. Adequately addressing online media that are problematic to the wellbeing of young people could accordingly allow children to utilize the considerable advantages online media provide over traditional media without endangering their mental and physical health. (Background Paper p. 8.)

Under this bill, the Commission, in preparing its report, is tasked with exploring topics like "[t]he types of social media" and "[t]he persons and populations that use social media." It is hoped that this exploration is sufficiently nuanced so as to help separate the benefits from the harms of social media use for various sub-groups among children and youth.

Moreover, as noted by the author, this bill is intended to fill a gap. Much of the legislation addressing the harms of social media use is prospective: that is, it is intended to prevent harm for future internet users. Yet studies, such as the ones cited above, suggest that many youth in the present may have already suffered significant harm to their mental health from social media use. By helping the Legislature "understand…mental health risks associated with the use of social media by children and youth" and "[t]he degree to which individuals negatively impacted by social media are accessing and receiving mental health services," this bill may help address the needs of those whose mental health has already deteriorated due to unhealthy social media use.

4) **Related legislation.** AB 1394 (Wicks, 2023) requires social media platforms to provide a mechanism for users to report child sexual abuse material in which they are depicted; provides platforms 30-60 days after receiving a report to verify the content of the material and block it from reappearing. The bill also provides victims of commercial sexual exploitation the right to sue social media platforms for having deployed features that were a substantial factor in causing their exploitation. Status: Assembly Judiciary Committee.

SB 287 (Skinner, 2023) would prohibit a social media platform from using a design, algorithm, practice, affordance, or feature that the platform knows or should have known causes child users to experience specified harms, including receiving content that facilitates purchase of a controlled substance and developing an eating disorder. Status: Senate Appropriations Committee.

SB 764 (Padilla, 2023) prohibits a social media platform from adopting or implementing a policy or practice related to the targeting of content to minors that prioritizes user engagement of minor users over the safety, health, and well-being of the minor users, if the social media platform knows or, should know that it has caused harm to minor users or it is reasonably foreseeable that it will cause harm to minor users. Status: Senate Judiciary Committee.

SB 845 (Stern, 2023) requires large social media platforms, as defined, to create, maintain, and make available to third-party safety software providers a set of real-time application programming interfaces, through which a child or a parent or legal guardian of a child may delegate permission to a third-party safety software provider to manage the child's online interactions, content, and account settings on the platform. Status: Senate Judiciary Committee.

AB 2273 (Wicks, Chap. 320, Stats. 2022) established the California Age-Appropriate Design Code.

AB 2879 (Low, Chap. 700, Stats. 2022) required a social media platform to disclose its cyberbullying reporting procedures in its terms of service and to have a mechanism for reporting cyberbullying that is available to individuals whether or not they have an account on the platform.

AB 2408 (Cunningham, 2022) would have prohibited a social media platform from using a design, feature, or affordance that the platform knows, or should know by the exercise of reasonable care, causes a child user to become addicted to the platform. The bill was held in the Senate Appropriations Committee.

AB 1138 (Gallagher, 2019) would have prohibited a for-profit social media website or application from allowing a person under 16 years of age to create an account without first obtaining the consent of the person's parent or guardian. The bill was vetoed by Governor Newsom.

ARGUMENTS IN SUPPORT: The California Academy of Family Physicians explains the importance of this bill:

> Without proper guardrails in place around social media usage, impressionable young children's mental health is at risk. AB 1282 brings awareness to children and youth struggles with mental health. This bill takes the necessary steps to collect data and recommendations on the negative impact that social media has on children and youth and will aid in gathering recommendations on how to reduce the negative outcomes that may result from untreated mental illnesses.

REGISTERED SUPPORT / OPPOSITION:

Support

California Academy of Family Physicians

Opposition

None on file

Analysis Prepared by: Jith Meganathan / P. & C.P. / (916) 319-2200

AMENDED IN SENATE APRIL 20, 2023

AMENDED IN SENATE APRIL 11, 2023

SENATE BILL No. 509

Introduced by Senator Portantino
(Coauthor: Senator Roth)
(Coauthors: Assembly Members Jackson, Lackey, Mathis, and Waldron)

February 14, 2023

An act to amend Sections 49428.15 and 51925 of the Education Code, relating to pupil health.

LEGISLATIVE COUNSEL'S DIGEST

SB 509, as amended, Portantino. School employee and pupil training: youth mental and behavioral health: mental health education.

(1) Existing law, subject to an appropriation, requires the State Department of Education to recommend best practices and identify training programs for use by local educational agencies to address youth behavioral health, on or before January 1, 2023, as provided. Existing law requires the department to ensure that each identified training program, among other requirements, provides instruction on recognizing the signs and symptoms of youth behavioral health disorders, including common psychiatric conditions and substance use disorders, and on how school staff can best provide referrals to youth behavioral health services or other support to individuals in the early stages of developing a youth behavioral health disorder.

This bill would delete the *term "common" from the* specific examples ~~from~~ *included in* the above-described training requirement of youth behavioral health disorders. The bill would require, on or before ~~January~~ *July* 1, 2027, local educational agencies to certify to the department that 75% of each of its classified and certificated employees, who have

direct contact with pupils at school, have received that youth behavioral health training, as specified. The bill would prohibit the training in youth behavioral health to be a condition of employment or hiring. By imposing training certification duties on local educational agencies, the bill would impose a state-mandated local program.

(2) Existing law requires, if a school district, county office of education, state special school, or charter school offers one or more courses in health education to pupils in middle school or high school, that the course or courses include instruction in mental health that meet certain requirements, including, among others, defining signs and symptoms of common mental health challenges and the ability to identify warning signs of common mental health problems, as specified.

This bill instead would require a school district, county office of education, state special school, or charter school to ensure that all pupils in grades 1 to 12, inclusive, receive evidence-based, age-appropriate mental health education from instructors trained in the appropriate courses at least once in elementary school, at least once in junior high school or middle school, as applicable, and at least once in high school, as provided. The bill would delete the term "common" from the above-described requirements. By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program. The bill also would make legislative findings and declarations related to the benefits of mental health education for those pupils.

~~(3) Under existing law, each school district and county office of education is responsible for the overall development of a comprehensive school safety plan for each of its schools operating kindergarten or any of grades 1 to 12, inclusive, in cooperation with certain local entities. Existing law requires that the plan identify appropriate strategies and programs that will provide or maintain a high level of school safety and address the school's procedures for complying with existing laws related to school safety. Existing law requires a charter school to annually update its school safety plan that includes certain safety topics and procedures.~~

~~This bill would additionally require a county office of education, school district, or charter school that serves pupils in any of grades 7 to 12, inclusive, to annually include in its comprehensive school safety plan or school safety plan, as applicable, the number of school employees that have received the youth behavioral health training described in paragraph (1) above and the percentage of total school employees that received that training. By imposing new duties on local~~

~~educational agencies, the bill would impose a state-mandated local program.~~

~~(4)~~

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

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

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

1 SECTION 1. (a) The Legislature finds and declares all of the
2 following:
3 (1) Mental health is critical to overall health, well-being, and
4 academic success.
5 (2) Mental health challenges affect all age groups, races,
6 ethnicities, and socioeconomic classes.
7 (3) Millions of Californians, including at least one in five youths,
8 live with mental health challenges. Millions more are affected by
9 the mental health challenges of someone else, such as a close friend
10 or family member.
11 (4) Mental health education is one of the best ways to increase
12 awareness and the seeking of help, while reducing the stigma
13 associated with mental health challenges. The public education
14 system is the most efficient and effective setting for providing this
15 education to all youth.
16 (b) For the foregoing reasons, it is the intent of the Legislature
17 in enacting this measure to ensure that all California pupils in
18 grades 1 to 12, inclusive, have the opportunity to benefit from a
19 comprehensive mental health education.
20 SEC. 2. Section 49428.15 of the Education Code is amended
21 to read:
22 49428.15. (a) For purposes of this section, the following
23 definitions apply:
24 (1) "Evidence-based" means peer-reviewed, scientific research
25 evidence, including studies based on research methodologies that

control threats to both the internal and the external validity of the research findings.

(2) "Evidence-informed" means using research that is already available and has been tested for efficacy and effectiveness. This evidence is then combined with the experiences and expertise of the training program developers to best fit the population intended to be served.

(3) "Local educational agency" means a county office of education, school district, state special school, or charter school that serves pupils in any of grades 7 to 12, inclusive.

(4) "Youth behavioral health disorders" means pupil mental health and substance use disorders.

(5) "Youth behavioral health training" means training addressing the signs and symptoms of a pupil mental health or substance use disorder.

(b) The department shall, on or before January 1, 2023, recommend 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.

(c) In identifying one or more evidence-based or evidence-informed youth behavioral health training programs for use by local educational agencies to train school staff or pupils pursuant to subdivision (b), the department shall ensure that each training program meets all of the following requirements:

(1) Provides instruction on recognizing the signs and symptoms of youth behavioral health ~~disorders.~~ *disorders, including psychiatric conditions and substance abuse disorders such as opioid and alcohol abuse.*

(2) Provides instruction on how school staff can best provide referrals to youth behavioral health services or other support to individuals in the early stages of developing a youth behavioral health disorder.

(3) Provides instruction on how to maintain pupil privacy and confidentiality in a manner consistent with federal and state privacy laws.

(4) Provides instruction on the safe deescalation of crisis situations involving individuals with a youth behavioral health disorder.

1 (5) Is capable of assessing trainee knowledge before and after
2 training is provided in order to measure training outcomes.
3 (6) Is administered by a nationally recognized training authority
4 in youth behavioral health disorders or by a local educational
5 agency.
6 (7) (A) Includes in-person and virtual training with certified
7 instructors who can recommend resources available in the
8 community for individuals with a youth behavioral health disorder.
9 (B) For purposes of this paragraph, "certified instructors" means
10 individuals who obtain or have obtained a certification to provide
11 the selected youth behavioral health training.
12 (d) Subject to subdivision (e), on or before ~~January~~ *July* 1, 2027,
13 a local educational agency shall certify to the department that 75
14 percent of its classified employees and 75 percent of its certificated
15 employees having direct contact with pupils at each school have
16 received the youth behavioral health training described in
17 subdivision (c) in accordance with all of the following:
18 (1) Except as provided in paragraph (2), the youth behavioral
19 health training is provided to classified and certificated employees
20 during regularly scheduled work hours.
21 (2) If a classified or certificated employee receives the youth
22 behavioral health training in a manner other than through an
23 in-service training program provided by the local educational
24 agency, the employee may present a certificate of successful
25 completion of the training to the local educational agency for
26 purposes of satisfying the requirements of this subdivision.
27 (3) The youth behavioral health training shall not be a condition
28 of employment or hiring for classified or certificated employees.
29 (e) A local educational agency ~~shall~~ *may* exclude a licensed
30 mental health professional who holds a pupil personnel service
31 credential from the youth behavioral health training required by
32 this section.
33 (f) Notwithstanding paragraph (6) of subdivision (c), a local
34 educational agency may meet the requirements of this section by
35 having a school employee of the local educational agency who
36 holds a pupil personnel service credential provide the youth
37 behavioral health training to the school employees of the local
38 educational agency, if the training program is identified by the
39 department on a list pursuant to subdivision (c). *School employees*
40 *who provide the youth behavioral health training to other school*

employees are required to complete any training requirements necessary, as established by the training program identified, to provide training to other school employees.

~~(g) A local educational agency shall include in its school safety plan, in addition to the safety topics listed in subparagraphs (A) to (J), inclusive, of paragraph (2) of subdivision (a) of Section 32282, the number of school employees and the total percentage of school employees that annually have received the youth behavioral health training required by this section.~~

~~(h)~~

(g) This section shall be implemented only to the extent that an appropriation is made in the annual Budget Act or another statute for these purposes.

SEC. 3. Section 51925 of the Education Code is amended to read:

51925. Each school district, county office of education, state special school, and charter school shall ensure that all pupils in grades 1 to 12, inclusive, receive evidence-based, age-appropriate mental health education from instructors trained in the appropriate courses at least once in elementary school, at least once in junior high school or middle school, as applicable, and at least once in high school. This instruction shall include all of the following:

(a) Reasonably designed instruction on the overarching themes and core principles of mental health.

(b) Defining signs and symptoms of mental health challenges. Depending on pupil age and developmental level, this may include defining conditions such as depression, suicidal thoughts and behaviors, schizophrenia, bipolar disorder, eating disorders, and anxiety, including post-traumatic stress disorder.

(c) Elucidating the evidence-based services and supports that effectively help individuals manage mental health challenges.

(d) Promoting mental health wellness and protective factors, which includes positive development, social and cultural connectedness and supportive relationships, resiliency, problem solving skills, coping skills, self-esteem, and a positive school and home environment in which pupils feel comfortable.

(e) The ability to identify warning signs of mental health problems in order to promote awareness and early intervention so that pupils know to take action before a situation turns into a crisis. This shall include instruction on both of the following:

1 (1) How to seek and find assistance from professionals and
2 services within the school district that includes, but is not limited
3 to, school counselors with a pupil personnel services credential,
4 school psychologists, and school social workers, and in the
5 community for themselves or others.
6 (2) Evidence-based and culturally responsive practices that are
7 proven to help overcome mental health challenges.
8 (f) The connection and importance of mental health to overall
9 health and academic success and to co-occurring conditions, such
10 as chronic physical conditions, chemical dependence, and substance
11 abuse.
12 (g) Awareness and appreciation about the prevalence of mental
13 health challenges across all populations, races, ethnicities, and
14 socioeconomic statuses, including the impact of race, ethnicity,
15 and culture on the experience and treatment of mental health
16 challenges.
17 (h) Stigma surrounding mental health challenges and what can
18 be done to overcome stigma, increase awareness, and promote
19 acceptance. This shall include, to the extent possible, classroom
20 presentations of narratives by trained peers and other individuals
21 who have experienced mental health challenges and how they
22 coped with their situations, including how they sought help and
23 acceptance.
24 SEC. 4. If the Commission on State Mandates determines that
25 this act contains costs mandated by the state, reimbursement to
26 local agencies and school districts for those costs shall be made
27 pursuant to Part 7 (commencing with Section 17500) of Division
28 4 of Title 2 of the Government Code.

O

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

Bill No:	SB 509	**Hearing Date:**	April 19, 2023
Author:	Portantino		
Version:	April 11, 2023		
Urgency:	No	**Fiscal:**	Yes
Consultant:	Kordell Hampton		

Subject: School employee and pupil training: youth mental and behavioral health: mental health education.

SUMMARY

This bill requires 1) 75 percent of a local educational agency's (LEA's) classified and certificated employees to receive youth behavioral health training on or before January 1, 2027, as specified; 2) requires each LEA, county office of education (COE), state special school, and charter school teach evidence-based, age-appropriate mental health education from instructors trained in the appropriate courses, as specified; and 3) include, as a part of an LEA and COE's, comprehensive school safety plan (CSSP), the total percentage of school employees that annually have received the youth behavioral training.

BACKGROUND

Existing Law

Education Code (EDC)

1) Defines "Youth behavioral health disorders" to mean a pupil mental health and substance use disorders. (EDC § 49428.15 (a)(4))

2) Defines "Youth behavioral health training" to mean training addressing the signs and symptoms of a pupil mental health or substance use disorder. (EDC § 49428.15(a)(5))

3) Requires the California Department of Education (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, but not necessarily limited to, staff and pupil training, and requires the CDE, in identifying one or more evidence-based or evidence-informed youth behavioral health training programs for use by LEAs to ensure that each training program meets all of the following requirements:

   a) Provides instruction on recognizing the signs and symptoms of youth behavioral health, including common psychiatric conditions and substance use disorders such as opioid and alcohol abuse.

b) Provides instruction on how school staff can best provide referrals to youth behavioral health services, or other support to individuals in the early stages of developing a behavioral disorder.

c) Provides instruction on how to maintain pupil privacy and confidentiality in a manner consistent with federal and state privacy laws.

d) Provides instruction on the safe deescalation of crisis situations involving individuals with a youth behavioral health disorder.

e) Is capable of assessing trainee knowledge before and after training is provided in order to measure training outcomes.

f) Is administered by a nationally recognized training authority in youth behavioral health disorders.

g) Includes in-person and virtual training with certified instructors who can recommend resources available in the community for individuals with a youth behavioral health disorder. For this purpose "certified instructors" means individuals who obtain or have obtained a certification to provide the selected training. (EDC § 49428.15 (c))

4) Requires the governing board of a school district to give diligent care to the health and physical development of pupils, and authorizes the district to employ properly certified persons for the work. (EDC § 49400)

5) Requires the governing board of any LEA(LEA) that serves pupils in grades seven to twelve, inclusive, to adopt a policy on pupil suicide prevention, intervention, and postvention. The policy shall specifically address the needs of high-risk groups, including suicide awareness and prevention training for teachers, and ensure that a school employee acts within the authorization and scope of the employee's credential or license. (EC § 315)

ANALYSIS

This bill requires 1) 75 percent of a local LEAs classified and certificated employees to receive youth behavioral health training on or before January 1, 2027, as specified; 2) requires each LEA, COE, state special school, and charter school teach evidence-based, age-appropriate mental health education from instructors trained in the appropriate courses, as specified; and 3) include, as a part of an LEA and COE's, CSSP, the total percentage of school employees that annually have received the youth behavioral training. Specifically, this bill:

Identification of Youth Behavioral Health Training by the CDE by January 1, 2023

1) Strikes the specification to include psychiatric conditions and substance abuse disorders such as opioid and alcohol abuse as part the youth behavioral health trainings identified by the CDE.

Youth Behavioral Health Training For Classified and Certificated Employees

2) Requires an LEA, on or before January 1, 2027, to certify to the CDE that 75 percent of its classified employees and certificated employees, who have direct contact with pupils at each school, received youth behavioral health training, identified by the CDE, subject to all of the following conditions:

   a) The youth behavioral health training is provided to classified and certificated employees during regularly scheduled work hours.

   b) If a classified or certificated employee receives the youth behavioral health training in a manner other than through an in-service training program provided by the LEA, the employee may present a certificate of successful completion of the training to the LEA for purposes of satisfying the requirements of this bill.

   c) The youth behavioral health training shall not be a condition of employment or hiring for classified or certificated employees.

3) Requires an LEA to exclude a licensed mental health professional who holds a pupil personnel service credential from the youth behavioral health training identified by the CDE.

4) Specifies that an LEA may meet the requirement to train 75 percent of its certificated and credentialed staff school employees, who have direct contact with pupils at each school, by having a school employee of the LEA who holds a pupil personnel service credential provide the youth behavioral health training to the school employees of the LEA if the training program is identified by the CDE.

Mental Health Instruction To Pupils

5) Requires each LEA, COE, state special school, and charter school to ensure that all pupils in grades 1 to 12 receive evidence-based, age-appropriate mental health education from instructors trained in the appropriate courses at least once in elementary school, at least once in junior high school or middle school, as applicable, and at least once in high school.

Comprehensive School Safety Plan

6) Requires LEAs to include in its school safety plan the number of school employees and the total percentage of school employees that annually have received the youth behavioral training.

Findings and Declarations

1) Adds findings and declarations related to the need for mental health intervention in California schools.

STAFF COMMENTS

1) ***Need for the bill.*** According to the author "Under SB 14 (Portantino, Chapter 672, Statutes of 2021), the completion of a state-identified training program to address

youth behavioral health is not required. This bill, SB 509, builds upon the law by requiring a LEA, as defined, to certify to the department that 75 percent of both classified and certificated employees having direct contact with pupils received the youth behavioral health training identified. This bill ensures that designated staff is trained to recognize and respond to signs of mental health challenges and substance use, strengthening opportunities to intervene and guide youth to appropriate resources and services."

2) ***CDE Youth Behavioral Health Programs.*** Pursuant to SB 14 (Portantino) Chapter 672, Statutes of 2021, he 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.

   The provision of this bill remove the specification to include psychiatric conditions and substance abuse disorders such as opioid and alcohol abuse. While "youth behavioral health disorders" is defined as "pupil mental health and substance use disorders" (EDC 49428.15), statute also specifies that common psychiatric conditions and substance use disorders such as opioid and alcohol abuse should also be included. By removing this specification the CDE, in identifying one or more evidence-based or evidence-informed youth behavioral health training programs for use by LEAs to train school staff or pupils, and could miss a critical piece to ensuring vital information to provide to LEAs.

   The committee may wish to consider if removing this specification, as mentioned above, would eliminate essential information to LEAs, school personnel, and students in recognizing the signs and symptoms of psychiatric conditions and substance use disorders such as opioid and alcohol abuse be eliminated. (See Staff Comment #6)

   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."

   This bill permits a school employee of the LEA who holds a pupil personnel service credential provide the youth behavioral health training to the school employees of

the LEA, if the training program is identified by the CDE. However, it is unclear if that employee needs to have already taken the training before providing the training to others.

The author may wish to consider clarifying that a school employee who provides the youth behavioral health training to other school employees must complete any training requirements necessary, as established by the training program identified, before providing training to other school employees. (See Staff Comment #6)

In addition to allowing school employees to train other school employees, this bill also requires, on or before January 1, 2027, to certify to the CDE that 75 percent of its classified employees and certificated employees, who have direct contact with pupils at each school, received youth behavioral health training, identified by the CDE. However, this bill does not specify the frequency in which an LEA must certify with the CDE. The author may wish to consider how frequently LEAs should certify with the CDE to ensure that 75 percent of an LEA's certificated and classified employees have received the youth behavioral health training, identified by the CDE.

3) ***What is a 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 credential 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:

<u>School Counseling:</u> 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.

<u>School Social Work:</u> 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.

<u>School Psychology:</u> 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 requires an LEA to exclude mental health professional who hold a pupil personnel service credential from the youth behavioral health training. This seems consist with the program identified by the CDE. While the training is not intended for staff with a" mental health background such as school psychologists, social workers, clinicians," the program may still contain important information.

The author may wish to consider providing LEAs the flexibility to decide if mental health professionals holding a PPS credential should be excluded from training identified by the CDE completely. (See Staff Comment #6)

4) ***Comprehensive School Safety Plan.*** The law requires that each school update and adopt its CSSP by March 1 annually. LEAs, COEs, and charter schools serving pupils in grades kindergarten through twelve are required to develop and maintain a CSSP designed to address campus risks, prepare for emergencies, and create a safe, secure learning environment for students and school personnel. The law requires designated stakeholders to annually engage in a systematic planning process to develop strategies and policies to prevent and respond to potential incidents involving emergencies, natural and other disasters, hate crimes, violence, active assailants/intruders, bullying and cyberbullying, discrimination, and harassment, child abuse and neglect, discipline, suspension and expulsion, and other safety aspects.

The author may wish to consider if the requirement to include the number of school employees and the total percentage of school employees that annually have received the youth behavioral training in their CSSP is an appropriate location to make such information known.

5) ***Joint Curriculum Policy.*** The committee on March 15, 2023, adopted the joint Assembly and Senate curriculum policy of 2023-24 that discourages the introduction of policy bills that propose to require, or require consideration of, modifications to state curriculum frameworks, to require that specified content be taught, or to require the development of new model curricula. As specified, this bill requires each LEA, COE, state special school, and charter school to ensure that all pupils in grades 1 to 12, receive evidence-based, age-appropriate mental health education from instructors trained in the appropriate courses at least once in elementary school, at least once in junior high school or middle school, as applicable, and at least once in high school.

This portion of SB 509 (Portantino, 2023) violates the committee's policy on curriculum, as it requires specific content to be taught to pupils.

6) ***Committee Amendments.*** *Committee staff recommends, and the author has agreed to, the following amendments which address questions raised in comments # 2, 3, and 4:*

   a) Restores the specification that the youth behavioral health trainings identified by CDE to include psychiatric conditions and substance abuse disorders such as opioid and alcohol abuse;

   b) Strike the requirement for an LEA and COE to include, as part of their CSSP, the number of school employees and the total percentage of school employees that annually have received the youth behavioral training;

   c) Align the requirement for an LEA to certify to the CDE that 75 percent of its classified and certificated employees have having direct contact with pupils at each school have received the youth behavioral health training with the beginning of the school year;

   d) Permit, rather than require, an LEA to exclude a licensed mental health professional who holds a pupil personnel service credential from the youth behavioral health training; and

   e) Specify that school employees who provide the youth behavioral health training to other school employees must complete any training requirements necessary, as established by the training program identified by the CDE, to provide training to other school employees.

7) ***Related Legislation.***

SB 387 (Portantino, 2021) requires a LEA, on or before January 1, 2025, to certify to the CDE that 75 percent of its classified and certificated employees who have direct contact with pupils at each school have received specified youth behavioral health training. *This bill was never herd in Assembly Education Committee.*

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.

SB 428 (Pan, 2019) requires the CDE to identify an evidence-based training program for LEAs to use to train classified and certificated school employees having direct contact with pupils in youth mental and behavioral health. This bill was vetoed by Governor Newsom with the following message:

> *Providing support for students facing mental health is of critical importance. Multiple public agencies beyond CDE hold a responsibility for addressing the mental health crisis impacting young people today. That is why I worked with the Legislature to appropriate $50 million in this year's budget to create the Mental Health Student Services Act. Mental health partnerships among county mental health or behavioral health departments, school districts, charter schools and county offices of education are best positioned to address the diverse mental health needs of young people.*

SUPPORT

American Foundation for Suicide Prevention
California Access Coalition
California Alliance of Caregivers
California Alliance of Child and Family Services
California Coalition for Mental Health
California State Association of Psychiatrists
California Youth Empowerment Network
Children Now
Children's Institute
Community Solutions for Children, Families and Individuals
Democratic Club of Claremont
Depression and Bipolar Support Alliance California
East Bay Children's Law Offices
Hillsides
Mental Health America of California
Monarch School
National Association of Social Workers, California Chapter
National Council for Mental Wellbeing
NextGen California
Pallet Shelter
PathPoint
Steinberg Institute
Sycamores
Tessie Cleveland Community Services Corporation
The California Association of Local Behavioral Health Boards and Commissions
The Kennedy Forum
18 individuals

OPPOSITION

California Teachers Association

-- END --

2023 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE ASSEMBLY CHIEF CLERK AND THE OFFICE OF THE SECRETARY OF THE SENATE
Revised 11-4-22

DEADLINES

JANUARY							
	S	M	T	W	TH	F	S
	1	2	3	4	5	6	7
Wk. 1	8	9	10	11	12	13	14
Wk. 2	15	16	17	18	19	20	21
Wk. 3	22	23	24	25	26	27	28
Wk. 4	29	30	31				

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 4 Legislature reconvenes (J.R. 51(a)(1)).

Jan. 10 Budget must be submitted by Governor (Art. IV, Sec. 12(a)).

Jan. 16 Martin Luther King, Jr. Day.

Jan. 20 Last day to submit **bill requests** to the Office of Legislative Counsel.

FEBRUARY							
	S	M	T	W	TH	F	S
Wk. 4				1	2	3	4
Wk. 1	5	6	7	8	9	10	11
Wk. 2	12	13	14	15	16	17	18
Wk. 3	19	20	21	22	23	24	25
Wk. 4	26	27	28				

Feb. 17 Last day for bills to be **introduced** (J.R. 61(a)(1), J.R. 54(a)).

Feb. 20 Presidents' Day.

MARCH							
	S	M	T	W	TH	F	S
Wk. 4				1	2	3	4
Wk. 1	5	6	7	8	9	10	11
Wk. 2	12	13	14	15	16	17	18
Wk. 3	19	20	21	22	23	24	25
Wk. 4	26	27	28	29	30	31	

Mar. 30 **Spring Recess** begins upon adjournment (J.R. 51(a)(2)).

Mar. 31 Cesar Chavez Day observed.

APRIL							
	S	M	T	W	TH	F	S
Wk. 4							1
Spring Recess	2	3	4	5	6	7	8
Wk. 1	9	10	11	12	13	14	15
Wk. 2	16	17	18	19	20	21	22
Wk. 3	23	24	25	26	27	28	29
Wk. 4	30						

Apr. 10 Legislature reconvenes from **Spring Recess** (J.R. 51(a)(2)).

Apr. 28 Last day for **policy committees** to hear and report to fiscal committees **fiscal bills** introduced in their house (J.R. 61(a)(2)).

MAY							
	S	M	T	W	TH	F	S
Wk. 4		1	2	3	4	5	6
Wk. 1	7	8	9	10	11	12	13
Wk. 2	14	15	16	17	18	19	20
Wk. 3	21	22	23	24	25	26	27
No Hrgs.	28	29	30	31			

May 5 Last day for **policy committees** to hear and report to the Floor **nonfiscal bills** introduced in their house (J.R. 61(a)(3)).

May 12 Last day for **policy committees** to meet prior to June 5 (J.R. 61(a)(4)).

May 19 Last day for **fiscal committees** to hear and report to the Floor bills introduced in their house (J.R. 61(a)(5)).

Last day for **fiscal committees** to meet prior to June 5 (J.R. 61(a)(6)).

May 29 Memorial Day.

May 30-June 2 **Floor session only**. No committee may meet for any purpose except Rules Committee, bills referred pursuant to A.R. 77.2, and Conference Committees (J.R. 61(a)(7)).

*Holiday schedule subject to final approval by Rules Committee.

2023 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE ASSEMBLY CHIEF CLERK AND THE OFFICE OF THE SECRETARY OF THE SENATE

Revised 11-4-22

JUNE							
	S	M	T	W	TH	F	S
No Hrgs.					1	2	3
Wk. 4	4	5	6	7	8	9	10
Wk. 1	11	12	13	14	15	16	17
Wk. 2	18	19	20	21	22	23	24
Wk. 3	25	26	27	28	29	30	

June 2 Last day for each house to pass bills introduced in that house (J.R. 61(a)(8)).

June 5 Committee meetings may resume (J.R. 61(a)(9)).

June 15 Budget Bill must be passed by midnight (Art. IV, Sec. 12(c)(3)).

JULY							
	S	M	T	W	TH	F	S
Wk. 3							1
Wk. 4	2	3	4	5	6	7	8
Wk. 1	9	10	11	12	13	14	15
Summer Recess	16	17	18	19	20	21	22
Summer Recess	23	24	25	26	27	28	29
Summer Recess	30	31					

July 4 Independence Day.

July 14 Last day for **policy committees** to meet and report bills (J.R. 61(a)(10)).

Summer Recess begins upon adjournment, provided Budget Bill has been passed (J.R. 51(a)(3)).

AUGUST							
	S	M	T	W	TH	F	S
Summer Recess			1	2	3	4	5
Summer Recess	6	7	8	9	10	11	12
Wk. 2	13	14	15	16	17	18	19
Wk. 3	20	21	22	23	24	25	26
Wk. 4	27	28	29	30	31		

Aug. 14 Legislature reconvenes from Summer Recess (J.R. 51(a)(3)).

SEPTEMBER							
	S	M	T	W	TH	F	S
Wk. 4						1	2
No Hrgs.	3	4	5	6	7	8	9
No Hrgs.	10	11	12	13	14	15	16
Interim Recess	17	18	19	20	21	22	23
Interim Recess	24	25	26	27	28	29	30

Sept. 1 Last day for **fiscal committees** to meet and report bills (J.R. 61(a)(11)).

Sept. 4 Labor Day.

Sept. 5-14 **Floor session only**. No committees may meet for any purpose, except Rules Committee, bills referred pursuant to Assembly Rule 77.2, and Conference Committees (J.R. 61(a)(12)).

Sept. 8 Last day to **amend** on the Floor (J.R. 61(a)(13)).

Sept. 14 Last day for each house to pass bills. (J.R. 61(a)(14)).

Interim Recess begins upon adjournment (J.R. 51(a)(4)).

IMPORTANT DATES OCCURRING DURING INTERIM RECESS

2023

Oct. 14 Last day for Governor to sign or veto bills passed by the Legislature on or before Sept. 14 and in the Governor's possession on or after Sept. 14 (Art. IV, Sec. 10(b)(1)).

2024

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 3 Legislature reconvenes (J.R. 51(a)(4)).

*Holiday schedule subject to final approval by Rules Committee.

THE LIFE CYCLE OF LEGISLATION

From Idea into Law

ASSEMBLY MEMBER

ASSEMBLY BILL PREPARED BY LEGISLATIVE COUNSEL

INTRODUCED BY MEMBER, NUMBERED, FIRST READING, PRINTED

RULES COMMITTEE ASSIGNS BILL TO COMMITTEE

Bill may not be heard by committee until 31st day after introduction

COMMITTEE HEARING:
Policy or Appropriations
CHAIRPERSON AND MEMBERS
TESTIFY:
BILL AUTHOR
CITIZENS
EXPERTS
LOBBYISTS

HELD IN COMMITTEE

COMMITTEE RECOMENDATIONS PASS

SECOND ASSEMBLY READING

THIRD ASSEMBLY READING DEBATE VOTE

PASSAGE REFUSED

Proposed Amendments

Revised Third Reading Analysis

TO SENATE

FIRST SENATE READING

RULES ASSIGNS BILLS TO COMMITTEE

COMMITTEE HEARING:
Policy or Appropriations
CHAIRPERSON AND MEMBERS
TESTIMONY BY:
BILL AUTHOR
CITIZENS
EXPERTS
LOBBYISTS

HELD IN COMMITTEE

COMMITTEE RECOMENDATIONS PASS

SECOND SENATE READING

THIRD SENATE READING DEBATE VOTE

PASSAGE REFUSED

Proposed Amendments

Revised Third Reading Analysis

PASSED

WITH SENATE AMENDMENTS

WITHOUT SENATE AMENDMENTS

SUGGESTIONS FOR NEEDED LEGISLATION FROM
Agencies, Citizens, Governor, Lobbyists

THE CALIFORNIA LEGISLATURE

ASSEMBLY RULES COMMITTEE

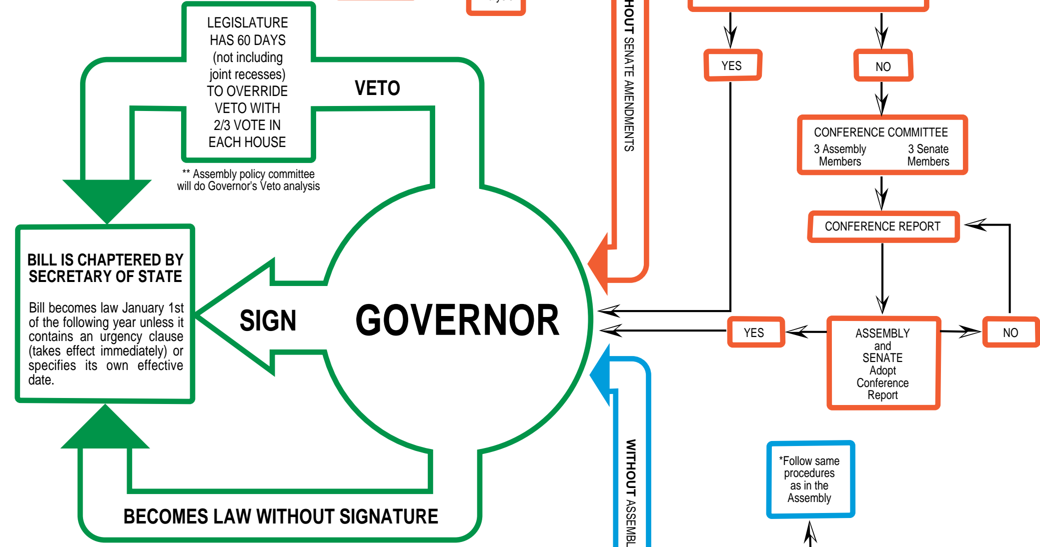
Although the procedure can become complicated, this chart shows the essential steps for passage of a bill.

Typical committee actions are used to simplify charting the course of legislation.

Some bills require hearings by more than one committee, in which case a committee may re–refer the bill to another committee. For example, bills with monetary implications must be re–referred to the proper fiscal committee in each House before they are sent to the second reading file and final action.

A bill may be amended at various times as it moves through the Houses. The bill must be reprinted each time an amendment is adopted by either house. All bill actions are printed in the DAILY FILES, JOURNALS and HISTORIES.

If a bill is amended in the opposite House, it is returned to the House of Origin for concurrence in amendments. If House of Origin does not concur, a Conference Committee Report must then be adopted by each House before the bill can be sent to the Governor.



WITHOUT ASSEMBLY AMENDMENTS

PASSED

WITH ASSEMBLY AMENDMENTS

SENATOR

SENATE BILL PREPARED BY LEGISLATIVE COUNSEL

INTRODUCED BY MEMBER, NUMBERED, FIRST READING, PRINTED

RULES COMMITTEE ASSIGNS BILL TO COMMITTEE

Bill may not be heard by committee until 31st day after introduction

COMMITTEE HEARING:
Policy or Appropriations
CHAIRPERSON AND MEMBERS
TESTIFY:
BILL AUTHOR
CITIZENS
EXPERTS
LOBBYISTS

HELD IN COMMITTEE

COMMITTEE RECOMENDATIONS PASS

SECOND SENATE READING

THIRD SENATE READING DEBATE VOTE

PASSAGE REFUSED

Proposed Amendments

Revised Third Reading Analysis

TO ASSEMBLY

FIRST ASSEMBLY READING

RULES COMMITTEE ASSIGNS BILLS TO COMMITTEE

COMMITTEE HEARING:
Policy or Appropriations
CHAIRPERSON AND MEMBERS
TESTIMONY BY:
BILL AUTHOR
CITIZENS
EXPERTS
LOBBYISTS

HELD IN COMMITTEE

COMMITTEE RECOMENDATIONS PASS

SECOND ASSEMBLY READING

THIRD ASSEMBLY READING DEBATE VOTE

PASSAGE REFUSED

Proposed Amendments

Revised Third Reading Analysis

AGENDA ITEM 10

Action

May 25, 2023 Commission Meeting

Impacts of Firearm Violence Project

Summary: The Mental Health Services Oversight and Accountability Commission will hear informational presentations on the Impacts of Firearm Violence project and discuss future directions for the project and opportunities for the Commission to contribute towards solutions.

Background:
The Impacts of Firearm Violence subcommittee was formed in August 2022 to explore the impacts of firearm violence on mental health, identify and collaborate with key firearm violence prevention and recovery partners, and develop an action agenda with recommendations to address the impacts of firearm violence.

Firearm violence perpetuates a well-known cycle of trauma and violence, leading to negative outcomes in the form of short- and long-term mental health challenges (including PTSD), arrest and incarceration, disability and other difficulties securing employment, and disconnection from loved ones and the community. People who are already disadvantaged (due to their race/ethnicity, neighborhood, income, etc.) are at greater risk of being impacted by firearm violence, contributing to even larger disparities. The key to preventing the impacts of firearm violence on mental health and wellbeing is to interrupt this cycle at key intervention points.

The panel of presenters on this topic will explore these themes and identify opportunities for intervention, recovery, and healing on an individual and community level. These presentations will help Commissioners consider what actions can be taken by the Commission to elevate and support best practices in these areas and to guide the IFV project as it progresses.

Enclosures (2): (1) Presenter Bios; (2) Impacts of Firearm Violence Brief

Handouts (2): PowerPoint slides from presenters

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Impacts of Firearm Violence Project
Presenter Biographies

May 25, 2023

Mr. Kevin Cameron led the crisis response during the 1999 school shooting incident in Taber, Alberta, eight days after the Columbine school shooting. Shortly thereafter he was seconded by the Alberta Government to a 13-month initiative where he studied traumatic aftermath from a "human systems approach." Through consultation with several American sites that had experienced school shootings, and other trauma sites throughout North America, Mr. Cameron developed the Traumatic Event Systems (TES) Model.

In concert with the Royal Canadian Mounted Police, Behavioural Sciences Unit, he developed Canada's first comprehensive, multidisciplinary Violence Threat Risk Assessment training program. In March 2001, Mr. Cameron was invited to Washington, D.C. by the United States Secret Service and the U.S. Department of Education, where he presented parts of the TES Model and opened international collaborative relations for the development of threat assessment protocols and related training. He is a "Subject-Matter Expert" for Threat Assessment and Trauma Response for the
Province of British Columbia's ERASE initiative as well as the Lead Clinician for the Surrey Wrap Youth Gang Prevention Program.

Mr. Cameron is also a trained Marital and Family Therapist (MFT) and Registered Social Worker (RSW) with years of experience working with high-risk children and their families in both the Child Welfare and Youth Criminal Justice systems. He has conducted court ordered parenting and family assessments for active child protection files in Alberta and provides comprehensive case reviews nationally. He has served as Adjunct Faculty with Loma Linda University (2000-2005) where he taught Crisis Intervention Counselling in the Graduate School of Marital and Family Therapy. He is the past Clinical Director of Family Ties Association and the former Clinical Supervisor of Family Centre in Lethbridge, Alberta.

As well, his experience working with "human systems" impacted by trauma (families, schools, communities) has led to the further development of the systems oriented "Traumatic Events Systems (TES) Model of Crisis and Trauma Response" for the purpose of training multidisciplinary crisis response teams. He is also internationally known for the broad application of his work in the field of multidisciplinary Violence Threat Risk Assessment (VTRA) which is built on the foundation of understanding the offender in the context of family, peer group, workplace and society.

Dr. Sarah Metz, PsyD, is the Director of the UCSF Division of Trauma Recovery Services and the UCSF Trauma Recovery Center. She is an Associate Clinical Professor in the UCSF

Department of Psychiatry and Behavioral Sciences and the Chief Psychologist for San Francisco General Hospital. Dr. Metz has extensive experience working with survivors of trauma, substance use disorders, combat Veterans, survivors and perpetrators of violent crime, justice-involved adults, and complex PTSD. Prior to coming to UCSF, she worked for the VA Palo Alto Healthcare System (VAPAHCS) at the National Center for PTSD and the Homeless Veterans Rehabilitation Program (HVRP).

Refujio "Cuco" Rodriguez is the Chief Equity & Program Officer at Hope and Heal Fund. Prior to joining the fund, Cuco served as a Program Officer for the W.K. Kellogg Foundation and was a member of the foundation's Racial Equity and Community Engagement team. He was responsible for developing and coordinating strategic grantmaking activities aimed at addressing racial equity, community engagement, and nurturing opportunities for positive systemic change for historically marginalized communities and vulnerable children. Cuco also supported the development of a Racial Equity Leadership Curriculum for the W.K. Kellogg Fellowship Program; leading research and developing curriculum models; and developing strategic external partnerships with other foundations, businesses, governmental agencies, and other key partners. Most recently, he led efforts to integrate racial equity principles into technology initiatives which included working on new collaborative platforms and developing a racial equity-focused grantee application.

Prior to joining the field of philanthropy, Cuco served as division chief and ethnic services manager with the Santa Barbara County Department of Behavioral Wellness, where he was responsible for the implementation of the new Mental Health Services Act (MHSA). MHSA is a statewide initiative intended to transform the mental health system in CA counties. Cuco was also responsible for engaging multiple cross-sector and multi-ethnic community stakeholders in coordination of the MHSA. Cuco established Santa Barbara's first Latino Mental Health Consumer and Family Advocacy Network in order to engage Latino stakeholders in the implementation of the MHSA.

Cuco has served as department director for Family and Youth Services with the Community Action Commission, where he led the implementation and execution of all Family and Youth Services programming; funding development; development of policies procedures and training; and budget development and oversight. Cuco has worked with communities on issues including teen pregnancy, reproductive health, youth violence, gang intervention, rites of passage facilitation, mental health, father involvement strategies, and community engagement. He has served as an adjunct faculty member for the Human Services

Department at Allan Hancock College in Santa Maria, California. Cuco has held various community service positions and served as the board chair of the National Compadres Network.

Jose Osuna has been a leading voice in the fight for justice for those that have experienced incarceration for well over a decade. His journey began at Homeboy Industries, the world's largest gang rehab program, under the leadership of Father Gregory Boyle. Having experienced over 13 years of incarceration himself, Jose was able to enter the Homeboy Industries program as a participant and eventually was named their Director of External Affairs, a role through which he was able to utilize his voice and his experiences to lead many efforts in the name of justice for the formerly incarcerated, including the fight to Ban the Box at the state, county and city levels. He is also an advocate for crime survivors' rights, having lost his son, Moises, to gun violence in 2017. Jose has been asked to speak on his experiences throughout the country, including The White House and the U.S. Congress. Jose is currently the Housing Justice Manager for Brilliant Corners, a statewide housing organization that focuses on the development of permanent supportive housing for many types of special needs communities, including those that have experienced incarceration and those with developmental disabilities. In his role Jose is tasked with leading Brilliant Corners' advocacy efforts in addressing the many housing justice issues that exist in our communities today, as well as building out the organization's government relationships. Jose is a member of the L.A. County Public Safety Realignment Team, representing the 4th District for Supervisor Janice Hahn. He is also a member of the Long Beach City Prosecutor's Multi-Cultural Advisory Commission and is Lead Coordinator for the Long Beach Coalition for Safety and Justice.

Lara A. Drino is the Director of the Children Exposed to Violence Unit for the Los Angeles City Attorney's Office: Lara leads the Children Exposed to Violence Initiative for the City Attorney in partnership with Children's Institute and LAPD to address Children Exposed to Violence through the REACH Team® program. The REACH Team® is currently operating in South Los Angeles. Lara is also working with other agencies to explore new ways to intervene, educate and be proactive in reducing trauma for Children Exposed to Violence both in the home and in the community. As a prosecutor for 29 years, she has tried approximately130 plus jury trials to verdict. Most of her trials were crimes against children and domestic violence. She works closely with many multi-disciplinary agencies in Los Angeles to prosecute, develop policy, intervention and more all centering around child abuse/trauma issues. Lara is a regular instructor for the Los Angeles City Attorney's office, teaches classes for law enforcement, social workers, child advocates, as a guest teacher at UCLA, USC and Cal State LA, parent

groups, and community organizations on a variety of topics all related to child abuse prosecution, prevention, and trauma. Lara is passionate about making sure that children's voices are heard in the criminal justice system and the community.

Overview

Subject matter experts have been invited to present on the mental health impacts of firearm violence during the State Mental Health Commission's May 25th, 2023 hearing. Below is a brief description of the relationship between mental health and firearm violence and the Commission's Impacts of Firearm Violence Subcommittee and its project. An overview of May 25th, 2023 presentations and considerations for Commissioners concludes this brief.

Firearm Violence and its Impact on Mental Health

Over 3,400 people die by firearm each year in California.[1] About half of these deaths are homicides and around 45 percent are suicides.[2] In addition to firearm-related deaths, thousands of people are injured by firearms every year. In 2020, there were 5,719 emergency department visits and 3,855 hospitalizations due to firearm injury.[3] In addition to this tragic human toll, firearm violence costs an estimated $557 billion a year in the United States.[4] California's portion of that total cost is about $42 billion.

Californians are concerned about firearm violence in their communities and the impact of such violence on mental health and wellbeing. Over one-fourth of all Californians consider sounds of gunshots and shootings to be a concern in their neighborhood, and two in three Californians report experiencing at least one exposure to violence in their community.[5] This exposure can lead to a toxic stress response, which may result in long-term impacts on wellbeing, including physical ailments and post-traumatic stress disorder, among other mental health challenges.[6,7]

People with mental health challenges are more likely to be the victims of firearm violence, including those who die by firearm suicide.[8] Factors other than mental health often drive firearm violence against others; those factors include firearm ownership, substance use, and a history of violence.[9] Community risk factors also contribute to the likelihood of firearm violence, including living in neighborhoods with a high rate of poverty, transiency, family disruption, and social isolation.[10] This results in increased risk for people who are already disadvantaged, contributing to a continuing cycle of violence and trauma.

The Impacts of Firearm Violence Project

Following several consecutive mass shootings in the U.S., the Commission's Impacts of Firearm Violence Subcommittee was formed at the August 25th, 2022 Commission meeting, with Commissioner Keyondria Bunch as chair and Commissioner and Santa Barbara County Sheriff Bill Brown as vice chair. The subcommittee leads the Commission's Impacts of Firearm Violence Project, which has the following goals:

a. Explore the impacts of firearm violence on mental health using data and information on state and local programs, systems, and policies.

b. Collaborate with firearm violence prevention partners to leverage existing efforts and to consider policy recommendations that have been developed by public health entities and others.

c. Develop an action agenda with research, policy, and practice recommendations that show promise in addressing the impacts of firearm violence on mental health and wellbeing, while reducing mental health stigma and discrimination.

Since the project's launch, the Commission has met with dozens of experts representing firearm ownership and shooting sports, firearm violence research, the intersection of firearm violence and mental health, threat assessment and management, physical and mental health care providers, trauma-informed perspectives, and youth and community development, among others. Several key takeaways have emerged from these meetings, including the weak link between mental illness and the perpetration of violence, the importance of assessing and intervening early in cases where there is a risk of violence, the need to collaborate across systems to address the multi-faceted problem of firearm violence, and the need to consider community trauma and resilience when working to prevent and heal from firearm violence. Firearm violence is a community problem, and it will require community solutions.

The subcommittee met virtually on September 28th, 2022. During this meeting, Commissioners and members of the public heard a project overview from Commission staff and presentations from California Department of Public Health staff on the data relevant to firearm violence. An open public discussion followed these presentations. Public participants stated that the Commission should consider in its project:

- Adopting a data-driven approach, using relevant and reliable data
- Exploring the assessment of risk for violence and effective interventions
- Including youth and those with lived experience in identifying solutions
- Focusing on racial equity to avoid stigmatizing disadvantaged communities
- Reducing stigma against those with mental health challenges

On November 9th, 2022, the Commission visited representatives of the Los Angeles REACH Team, which brings together the Los Angeles City Attorney's Office, the Children's Institute, Inc., the Los Angeles Police Department, and other community partners and schools to provide support and service linkage to children who have been exposed to firearm violence. Lara Drino from the City Attorney's Office provided an overview of the team and arranged a ride-along for project staff to gain an understanding of the program context. On May 24th, 2023, the Commission will return to the REACH Team for a more in-depth site visit with all Commissioners invited to attend.

On January 24th, 2023, the subcommittee met virtually for a second time. The subcommittee heard a presentation on threat assessment and management from Dr. Melissa Reeves, a nationally certified school psychologist and expert in threat assessment in schools. The meeting also included a panel discussion with representatives from school psychology, law enforcement, and the youth perspective. Several important insights were identified, including:

- The importance of a prevention perspective to avoid crises before they occur.
- The protective effects of building positive relationships between youth, educators, other school staff, and law enforcement.
- The need to intentionally create a positive school climate, including building in social and emotional learning into the curriculum and providing students with opportunities to connect with each other.
- Empowering students to talk about their concerns and break the "code of silence" is necessary for threats to be reported.
- It is vital to engage in each step of the threat assessment and management process.
- Collaboration between different partners (including students, teachers, law enforcement, school administration, mental health professionals, and others) is key to a successful threat assessment and management system.
- An effective threat management system treats the individual and their family as partners in the process and designs an individualized case management plan.

May 25th Hearing

Subject matter experts have been invited to present on the mental health impacts of firearm violence during the State Mental Health Commission's May 25th, 2023 hearing. In a series of presentations, experts will outline the relationship between mental health and firearm violence, the trauma and other impacts to mental health associated with direct and indirect exposure to firearm violence, and opportunities to equitably address harm and increase resiliency across California's communities.

Kevin Cameron, Executive Director of the Center for Trauma-Informed Practices, first will present the Commission with an overview of the topic of trauma as it relates to firearm violence. Following Mr. Cameron's presentation, a panel of experts have been invited to present on the mental health impacts of firearm violence on communities and potential opportunities for reducing harm and building resiliency. Invited panelists are Sarah Metz, Psy.D., Director of the Division of Trauma Recovery Services at the UCSF Trauma Recovery Center and Chief Psychologist at Zuckerberg San Francisco General Hospital; Refujio "Cuco" Rodriguez, the Chief Equity and Program Officer at Hope and Heal; Jose Osuna, principal consultant at Osuna Consulting, community advocate, and individual with lived experience related to firearm violence and gang rehabilitation; and Lara Drino, Deputy City Attorney in Los Angeles and leader of the LA REACH Team.

Considerations for Commissioners:

- How should the Commission use its role as the State Mental Health Commission to elevate and disseminate practices, policies, and programs – particularly those that are community-based – that are effective in reducing or mitigating the mental health impacts of firearm violence?

- What approaches could the Commission incentivize in its programs, grants, and projects that contribute to a safer, healthier community with reduced risk factors for firearm violence?

- How can the Commission promote community healing as a preventative measure to interrupt the cycle of firearm violence?

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[3] ibid
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[10] Dahlberg, L. L. (1998). Youth violence in the United States: Major trends, risk factors, and prevention approaches. *American Journal of Preventive Medicine, 14*(4), 259-272. https://doi.org/10.1016/S0749-3797(98)00009-9

MISCELLANEOUS ENCLOSURES

April 27, 2023, 2023 Commission Meeting

Enclosures (4):

(1) Delegated Authority – Marin County Innovative Project Extension
- Staff Analysis
- Approval Letter
- Project Plan – From Housing to Healing

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

STAFF ANALYSIS – MARIN COUNTY
Extension Request

Innovation (INN) Project Name:	**From Housing to Healing, A Re-Entry Community for Women**
Original Approval History:	
Original Commission Approval Date:	May 27, 2021
Original Commission Approved Funding:	$1,795,000
Original Approved Duration of INN Project:	5 years
Project Start Date:	January 15, 2022
Current Request:	
Total INN Funding Request:	$560,300
Request for additional time:	Not applicable
MHSOAC Consideration of the INN Project:	April 2023
Review History:	
Approved by the County BOS:	March 21, 2023
Mental Health Board Hearing:	February 21, 2023
Public Comment Period:	December 9, 2022 – February 21, 2023
County submitted FINAL INN Extension Request:	March 8, 2023
Project Shared with Community Partners:	December 16, 2022, and March 9, 2023

Project Introduction:

Marin County is requesting an extension of up to $560,300 of spending authority, for their Innovation Project: ***From Housing to Healing: A Re-Entry Community for Women.*** The request stems from unanticipated early success of the project identifying that the women residing in these communities formed "incredible" bonds together, highlighting the importance of "connection is the intervention" as an early learning goal. To build on this early success, the County plans to increase the number of women served, provide additional peer support, strengthen support as the women transition back into the community, and through an additional learning goal, provide the immediate dissemination of the learnings.

This project was originally approved by the Commission on May 27, 2021, for Innovation funding up to the amount of $1,795,000 over five years. This project was intended to establish a supportive services and housing program designed to address severe mental illness, adverse

childhood experiences (ACEs), a screening tool for childhood trauma, and substance use disorders in women, including transwomen, after their release from jail. The alternative and varied treatment modalities offered to build necessary skills to support the women to be successful upon reentry to the community post incarceration.

The "Carmelita House" provides housing for recently released female inmates, trans-inclusive, in a safe environment while helping them to understand how their adverse childhood experiences (ACEs) may have contributed to their mental illness, substance use and/or incarceration. This housing program, however, is more than just a place for women to live; it is designed to be a holistic, healing centered community, with various alternative treatments and modalities designed to assist the women with understanding, addressing, and managing the effects of their mental illness including traumatic events and elevated ACEs scores.

What is the Problem:
Marin County designed this consumer-led innovation project to address the effects of trauma post-incarceration utilizing a myriad of evidenced-based and non-traditional therapeutic strategies such as somatic therapies, to find the right individualized treatment combination for each participant. The women live together in a safe place at the Carmelita House sharing similar traumatic experiences, while building a community of support and obtaining the skills needed for successful re-entry into the community for women with a history of severe mental illness and justice involvement.

This project has allowed women to create a sense of community in a loving and supportive environment and the County would like to increase the number of women served, and as a result, the **County reports that they have room to expand the program to include two additional women, which will assist in addressing the increased demand for services.** One of the early successes of the program revealed that the women were able to create a community of healing, highlighting that being connected to other women was instrumental in the recovery and healing process. This finding led to the realization that additional support and therapeutic intervention is needed to assist the women in addressing their fears and help build additional skills to transition out of the Carmelita House and retain the critical sense of connection and community for success.

As a result of these early findings, the County would like to disseminate these outcomes throughout the Behavioral Health and Homelessness systems of care as rapidly as possible to assist other programs in implementing these programmatic services. It is the County's desire to share data and the information gathered.

How this Innovation project addresses this problem:
Marin County requests additional funding to enhance the successful learnings from this project to **expand housing capacity from six women to eight in the Carmelita House**. The selected contractor for this program has the capacity to provide bedrooms for two additional women. The expansion provides the opportunity to serve more women in the community who are eager

to receive intervention services while they may be cycling through homelessness and incarceration.

The County states that some of the women are hesitant to leave the supports of the Carmelita House as they transition back into long-term housing. To help address this, the county requests additional funding to hire peers and/or a former resident peer to provide support to the women as they leave the Carmelita House into long-term housing. These additional peers will also participate in weekly dinners and events, in addition to supporting the women into their next residence. The additional supportive resources will help strengthen the sense of community, and assist with transitioning to long-term housing with support, with the overarching goal of reducing recidivism and the cycling of homelessness and incarceration.

Community Program Planning Process (CPPP): (see pgs. 10-13 in original project; pg. 4 of extension request)

Local Level

The local CPPP for the extension request engaged community members who are currently or formerly experiencing homelessness and suffer from behavioral health challenges including Substance Use Disorders (SUD). A Human Centered Design approach was used to engage 22 community members who identified the following themes:

- People use drugs to relieve the pain of homelessness and/or previous trauma
- Those unhoused find safety in community at the encampment, both in tangible ways (Narcan taped to the pillars) and socially
- Those who are in recovery want to stay busy
- Many want to “give back” and find meaning through helping others

Marin County’s 30-day public comment period began on December 9, 2022, and concluded on February 21, 2023.

The following comments of support were submitted to the County through WebForm:

> ***“Greetings, I have read the information for the proposed Innovation Plan EXTENSION REQUEST for Marin County. The County is seeking to additional funding to***
>
> 1. ***Expand the number of women served in the house***
> 2. ***Increase the support for women who transition out of the house by adding a peer position who will receive a monthly stipend***
> 3. ***Expand the learning more widely throughout the behavioral health and homelessness systems of care by adding another peer position***
>
> ***I approve and concur with the outlined measures, so stated.”***
> ***Sharon Yates, Advocate Consultant Facilitator, MHSOAC Client Family Leadership Committee***
>
> ***“Nice job”***

> ***"Thank you for the emphasis on the value of peer support and community building. I believe it is the right direction in face of how our community is becoming more and more isolated."***

Commission Level
This extension request was initially shared with Community Partners on December 16, 2022, and the final version was again shared on March 9, 2023. Additionally, this project was shared with both the Client and Family Leadership and Cultural and Linguistic Competence Committees. ***No letters of support or opposition were received by Commission staff.***

Learning Objectives and Evaluation:

The County's original plan estimated serving six women in the first year and was successful in achieving that goal. The County's original first two learning goals remain the same and a new third goal was added:

1. Does centering the program on healing and addressing the trauma result in higher rates of successful stabilization, decreased recidivism, increased housing stability, and increased feelings of psychological wellbeing?
2. What somatic therapies are the most successful with this group of women.
   The County identified two additional learning goals for this funding extension:
3. How can we spread the learnings throughout the Behavioral Health and Homelessness systems of care?

The Budget:

The County is requesting authorization to spend up to $560,000 in MHSA innovation funding for this project. The new total Innovation funding for this project is $2,355,300 over a five (5) year project duration.

The Evaluation Budget will be increased by $20,000 to focus on the updated learning goals throughout the County's system of care through "Seeds of Hope" (a coalition of agencies that will share learnings throughout their system of care).

Originally Approved Innovation Funding	$1,795,000
Innovation Extension Funding Request	**$560,300**
Project Total	$2,355,300

MHSOAC

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

MARA MADRIGAL-WEISS
Chair
MAYRA E. ALVAREZ
Vice Chair
TOBY EWING
Executive Director

May 11, 2023

Dr. Todd Schirmer
Director, Behavioral Health & Recovery Services
20 North San Pedro Road, Suite 2021
San Rafael, CA 94903

Dear Dr. Schirmer,

Congratulations, the Commission has approved Marin County's *From Housing to Healing, A Re-Entry Community for Women's* Extension on May 11, 2023, up to an additional amount of $560,300 in Innovation funding.

You have indicated that the start date for the *From Housing to Healing, A Re-Entry Community for Women* was on January 15, 2022. With this extension of money, the *From Housing to Healing, A Re-Entry Community for Women* now has spending authority up to a total of $2,355,300, which shall not exceed five (5) years.

On behalf of the Commission, I would like to thank you for all the work you do in your community.

If you have additional questions or need further assistance, feel free to contact me sharmil.shah@mhsoac.ca.gov or your county liaison Vicque Kimmel vicque.kimmel@hsoac.ca.gov.

Sincerely,

Sharmil Shah, Psy.D
Chief-Program Operations

Copy: Galen Main, MHSA Coordinator

COUNTY OF MARIN

MENTAL HEALTH SERVICES ACT (MHSA)

INNOVATION PLANNING

MHSOAC Mental Health Services Oversight & Accountability Commission

INNOVATIVE PROJECT EXTENSION PLAN

County Name: **Marin**
Project Title: **From Housing to Healing, A Re-Entry Community for Women**
Public Hearing: **February 21, 2023**
Board of Supervisors: **March 21, 2023**

Original Plan

Date of Original Approval by the MHSOAC: **5/27/2021**
Project Start Date: **1/15/2022**
Project End Date: **1/14/2027**
Duration of Approved project: **5 years**
Original Approved budget: **$1,795,000**

Extension Plan

Request for additional funding: **$560,300** (average of **$140,075 per year** for the final 4 years of the project)
New total budget: **$2,355,300**
Request for additional time: **Not applicable**

LEARNING OBJECTIVES

Has the primary purpose changed? **No**

What is the added value in learning with the extension?

One of the key findings so far is that "*connection is the intervention*." With this expansion we are focused on developing out the objective around **how we can best spread the learnings from this project throughout the Behavioral Health and homelessness systems of care**. Instead of waiting until the end of the project to spread the learnings, we are valuing a process that looks to learn how we can best spread what is actively being learned while the project is still ongoing.

Learning objectives:

1. *Does centering the program on healing and addressing trauma result in higher rates of successful stabilization, decreased recidivism, increased housing stability, and increased feelings of psychological wellbeing?*
2. *What somatic therapies are the most successful with this group of women?*
3. ***How can we spread the learnings throughout the Behavioral Health and homelessness systems of care?***
4. *Cost effectiveness of the From Housing to Healing approach as compared to expected costs without this intervention*

Has the target population changed? **No**

OVERVIEW OF REQUESTS FOR ADDITIONAL FUNDING

What is the reason for the additional funds?

The reason we are requesting additional funding is twofold. First, the community being built at "Carmelita House" (the name for the *Housing to Healing* residence) in the first 9 months of the program is incredible. The women have built a sense of community that has far exceed expectations but is also leaving many of the women feeling fear or dread about the idea of leaving such a loving and supportive environment in their transition to long-term housing. In addition, there are many other women in the community still cycling through homelessness and incarceration who are eager to partake in this project.

Second, which is very closely tied to the first point, is that we are hoping to speed up the additional focus on the stated learning goal around how to spread the key learnings from this innovation project throughout our behavioral health and homelessness systems of care. This expansion will help reshape the systems into places these women—and everyone else—can get that desire for connection addressed, allowing them to feel confident in leaving Carmelita House to their next step.

How will the county be utilizing the new funding?

- **Expanding the number of women served in the house** (increasing from 6 to 8 residents at a time)
- **Increase the support for women to transition out of the house and retain that critical sense of community** (by adding a stipended alumnae peer position)
- **Expand learnings more widely throughout the behavioral health and homelessness systems of care** (*Seeds of Hope—1.0 FTE* peer specialist position)

With this additional funding we are looking to expand the number of residents at the house from 6 women to 8. The organization we selected to operate the housing component of the From Housing to

Healing project fortunately has capacity for additional bedrooms and there are a number of other women in the community ready for this healing centered intervention.

Currently we have a stipended peer resident ($750 per month in addition to housing). We are looking to establish through this expansion a second stipended peer position ($750/month) for a former resident to focus on supporting Carmelita alumnae in bringing them back for weekly dinners, events, and groups and building that support network for women who have transitioned to their next place of residence, helping alleviate the fear many women are expressing in leaving Carmelita House. These alumnae would also help share their success stories with the current residents helping them see opportunities for connection and community after leaving the house as well.

The third portion of funding for the expansion will be focused on expanding the learning throughout the systems of care through what we are calling "Seeds of Hope". This would involve funding one full-time or two-part time peer leader positions who would help build the pipeline of peer leaders/staff by reaching out to peers interested in giving back and mentoring them in peer leadership and potentially peer certification to help build and spread community building. In addition, the peer leaders would identify, publicize, and create opportunities for social connection based on the desires of this community. One of the focuses of these peers would be for building this social fabric and workforce pipeline to those in our recently established and upcoming supportive housing programs (where many of the Carmelita residents may eventually move), those living on the streets, those at Carmelita House, and those who have been homeless but are now housed independently Local data has shown that the first six months of independent housing for many individuals who have been chronically homeless can be the most vulnerable due to a loss of that sense of community that can be found in places like an encampment or Carmelita house.

By strengthening this support outside of Carmelita House, we are hoping to continue setting these women up for success where they can transition from Carmelita to other supportive environments, embracing the desire for connection and spreading those feelings of comradery and kinship to these other spaces—to set the system ablaze with a focus on connection.

Has the evaluation budget changed?

We have increased the evaluation budget by $20,000 to evaluate the more expansive focus on spreading the learnings throughout the system of care through "Seeds of Hope."

COMMUNITY PLANNING PROCESS

Public Comment Period: **December 9, 2022-February 21, 2023**
Public Hearing: **February 21, 2023** (pushed back from the January 10th due to lack of quorum at the January Behavioral Health Board due to massive power outages affecting our county)

The residents at Carmelita House helped design the strategies targeted toward easing their fears around leaving the house. The proposed addition of two part-time peer leaders—as part of a larger Seeds of Hope initiative—was inspired both by the early learnings from Carmelita House and developed through a Human Centered Design project incubated by the Center for Care Innovation's Catalyst program. The Seeds of Hope started as a coalition including Marin County Health and Human Services, the City of San Rafael, and two people with lived experience of behavioral health challenges and homelessness (one of whom lived at Carmelita House and the other in the community).

Using Human Centered Design as the basis for community planning, we interviewed 22 community members who are currently and formerly experiencing homelessness, in recovery and actively experiencing behavioral health challenges. They crave connection and want to give back. They also shared the following themes, which formed the basis of the Seeds of Hope aspects of this project.

- People use drugs to relieve the pain of homelessness and/or previous trauma
- Those unhoused find safety in community at the encampment, both in tangible ways (Narcan taped to the pillars) and socially
- Those who are in recovery want to stay busy
- Many want to "give back" and find meaning through helping others

The proposal expands upon this work by increasing social connection through programming co-designed with the community, while providing an opportunity for peers to give back and develop leadership capacity in order to spread the learnings from Carmelita house throughout our behavioral health and homelessness systems of care.

During the Public Comment period and Public Hearing, only comments of support were received such as *"thank you for the emphasis on the value of peer support and community building. I believe it is the right direction in face of how our community is becoming more and more isolated."*

The Behavioral Health Board voted unanimously in favor of supporting the expansion of this innovation project.

OTHER

- How did the county originally plan on sustaining a successful INN plan in the original proposal? *If shown to be successful and cost-effective we would demonstrate the cost-effectiveness to our Probation department to request some funds to help offset some of the costs in addition to funding the remainder out of CSS and Medi-Cal.*
- If the county is saying the original INN plan is going well, and requesting for an extension, the county will need to explain the additional value added to their successful program by seeking an extension. *We are not requesting a time extension, but the increased funds would expand the number of women served and enhance the learning around how to best spread what is being learned through this project throughout our systems of care.*

BUDGET

Expansion items are listed in red on the budget below.

COUNTY OF MARIN
MENTAL HEALTH SERVICES ACT (MHSA)
INNOVATION PLANNING

MHSOAC Mental Health Services Oversight & Accountability Commission

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY								
EXPENDITURES								
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21/22 (6 months)**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27 (6 months)**	**TOTAL**
1	Salaries							
	Trauma Therapist (1.0 FTE) LMHP	$51,339	$105,758	$108,931	$112,199	$115,564	$59,516	**$553,307**
	Benefits	$27,620	$56,898	$58,605	$60,363	$62,174	$32,019	**$297,679**
	FFP Revenue Offset	($45,796)	($94,340)	($97,171)	($100,086)	($103,088)	($53,090)	**($493,572)**
2	Direct Costs	$7,896	$16,266	$16,754	$17,256	$17,774	$9,154	**$85,099**
3	Indirect Costs	$6,159	$12,687	$13,068	$13,460	$13,864	$7,140	**$66,377**
4	Total Personnel Costs	$47,217	$97,268	$100,187	$103,192	$106,287	$54,738	**$508,890**
OPERATING COSTS		**FY 21/22 (6 months)**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27 (6 months)**	**TOTAL**
5	Direct Costs							
	Rent for the House	$34,800	$69,600	$71,688	$71,688	$71,688	$35,844	**$355,308**
	Utilities, repairs, and maintenance costs	$7,000	$14,000	$14,420	$14,420	$14,420	$7,210	**$71,470**
	House/Support Manager (.5 FTE)	$18,303	$36,608	$37,706	$37,706	$37,706	$18,853	**$186,883**
	Peer Stipend	$4,500	$9,000	$9,270	$9,548	$9,270	$4,635	**$46,223**
	Alumnae Peer Stipend		$4,500	$9,270	$9,548	$9,270	$4,635	**$37,223**
	Activity/Nutrition fund	$5,000	$10,000	$10,000	$10,000	$10,000	$5,087	**$50,087**
	Vehicle maintenance, gas costs	$1,500	$3,000	$3,090	$3,090	$3,090	$1,545	**$15,315**
	Increased costs for two additional residents		$20,000	$16,000	$16,000	$16,000	$12,000	**$80,000**
	Seeds of Hope (two .5FTE peer providers)			$100,000	$100,000	$100,000	$50,000	**$350,000**
6	Indirect Costs	$10,665	$21,331	$21,926	$21,968	$21,926	$10,976	**$108,793**
	Additional indirect	$0	$3,674	$18,790	$18,830	$18,790	$9,993	**$70,076**
7	Total Operating Costs	$81,768	$191,713	$312,160	$312,799	$312,160	$160,778	**$1,371,378**

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

	NON RECURRING COSTS (equipment, technology)	FY 21/22 (6 months)	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27 (6 months)	TOTAL
8	Program Van	$36,000						**$36,000**
9	Trauma Informed minor modifications to the house/furniture	$5,000						**$5,000**
10	Total Non-recurring costs	$41,000						**$41,000**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)	**FY 21/22 (6 months)**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27 (6 months)**	**TOTAL**
11	Evaluation Costs	$35,000	$20,000	$15,000	$15,000	$35,000	$50,000	**$170,000**
	Additional evaluation		$0	$10,000	$2,500	$2,500	$5,000	**$20,000**
	Somatic, Alternative, Wholistic, or Cultural therapy/activity contract	$15,000	$30,000	$30,000	$40,000	$40,000	$20,000	**$175,000**
12	Indirect Costs	$7,500	$7,500	$6,750	$8,250	$11,250	$10,500	**$51,750**
	Additional Indirect		$0	$1,500	$375	$375	$750	**$3,000**
13	Total Consultant Costs	$57,500	$57,500	$63,250	$66,125	$89,125	$86,250	**$419,750**
	OTHER EXPENDITURES (please explain in budget narrative)	**FY 21/22 (6 months)**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27 (6 months)**	**TOTAL**
14	Stipends for stakeholder representatives	$2,100	$2,520	$2,520	$2,520	$2,520	$2,100	**$14,280**
15								
16	Total Other Expenditures	$2,100	$2,520	$2,520	$2,520	$2,520	$2,100	**$14,280**

EXPANSION PROPOSAL TOTAL	FY 21/22 (6 months)	FY 22/23	FY 23/24	FY 24/25	FY 25/26	FY 26/27 (6 months)	TOTAL
Original Total	**$229,586**	**$320,828**	**$322,557**	**$337,382**	**$363,158**	**$221,489**	**$1,795,000**
Expansion Total (add lines 20, 23, 24, 26, 38)		**$28,174**	**$155,560**	**$147,253**	**$146,935**	**$82,378**	**$560,300**
BUDGET TOTALS (including expansion)	**FY 21/22 (6 months)**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**FY 26/27 (6 months)**	**TOTAL**
Personnel (line 1)	$33,163	$68,316	$70,365	$72,476	$74,650	$38,445	**$357,415**
Direct Costs (add lines 2, 5 and 11 from above)	$128,999	$232,974	$343,198	$346,756	$366,718	$223,963	**$1,642,608**
Indirect Costs (add lines 3, 6 and 12 from above)	$24,324	$45,192	$62,034	$62,883	$66,205	$39,359	**$299,997**
Non-recurring costs (line 10)	$41,000	$0	$0	$0	$0	$0	**$41,000**
Other Expenditures (line 16)	$2,100	$2,520	$2,520	$2,520	$2,520	$2,100	**$14,280**
TOTAL BUDGET	**$229,586**	**$349,002**	**$478,117**	**$484,635**	**$510,093**	**$303,867**	**$2,355,300**

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Summary of Updates

Contracts

New Contract: None

Total Contracts: 3

Funds Spent Since the April Commission Meeting

Contract Number	Amount
17MHSOAC073	$ 0.00
17MHSOAC074	$ 0.00
21MHSOAC023	$353,695.84
Total	**$353,695.84**

Contracts with Deliverable Changes

17MHSOAC073
17MHSOAC074
21MHSOAC023

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Regents of the University of California, Davis: Triage Evaluation (17MHSOAC073)

MHSOAC Staff: Kai LeMasson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $2,453,736.50

Total Spent: $**1,882,236.32**

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No No
Data Collection and Management Report	Complete	6/15/20	No

MHSOAC Evaluation Dashboard May 2023
(Updated May 15, 2023)

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Deliverable	Status	Due Date	Change
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports)	In Progress	1/15/21- 3/15/23	No
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	In Progress	1/15/21- 6/15/23	No
Co-host Statewide Conference and Workplan (a and b)	In Progress	9/15/21 Fall 2022	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Complete	7/15/21	No
Drafts Formative/Process Evaluation Final Report (a and b)	In Progress	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

MHSOAC
Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, Los Angeles: Triage Evaluation (17MHSOAC074)

MHSOAC Staff: Kai LeMasson

Active Dates: 01/16/19 - 12/31/23

Total Contract Amount: $2,453,736.50

Total Spent: 1,882,236.32

This project will result in an evaluation of both the processes and strategies county triage grant program projects have employed in those projects, funded separately to serve Adult, Transition Age Youth and child clients under the Investment in Mental Health Wellness Act in contracts issued by the Mental Health Services Oversight and Accountability Commission. This evaluation is intended to assess the feasibility, effectiveness and generalizability of pilot approaches for local responses to mental health crises in order to promote the implementation of best practices across the State.

Deliverable	Status	Due Date	Change
Workplan	Complete	4/15/19	No
Background Review	Complete	7/15/19	No
Draft Summative Evaluation Plan	Complete	2/12/20	No
Formative/Process Evaluation Plan Updated Formative/Process Evaluation Plan	Complete Complete	1/24/20 1/15/21	No No
Data Collection and Management Report	Complete	6/15/20	No
Final Summative Evaluation Plan	Complete	7/15/20	No
Data Collection for Formative/Process Evaluation Plan Progress Reports (10 quarterly reports)	In Progress	1/15/21- 3/15/23	No

MHSOAC Evaluation Dashboard May 2023
(Updated May 15, 2023)

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Deliverable	Status	Due Date	Change
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	In Progress	1/15/21- 6/15/23	No
Co-host Statewide Conference and Workplan (a and b)	In Progress	9/15/21 TBD	No
Midpoint Progress Report for Formative/Process Evaluation Plan	Complete	7/15/21	No
Drafts Formative/Process Evaluation Final Report (a and b)	In progress	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

MHSOAC
Mental Health Services
Oversight & Accountability Commission

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:$ 2,475,870.88

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.

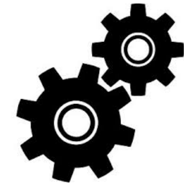
Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Complete	09/30/21	No
Quarterly Progress Reports	Complete	12/31/21	No
Quarterly Progress Reports	Complete	03/31/2022	No
Quarterly Progress Reports	Complete	06/30/2022	No
Quarterly Progress Reports	Complete	09/30/2022	No
Quarterly Progress Reports	Complete	12/31/2022	No
Quarterly Progress Reports	Complete	03/31/2023	Yes
Quarterly Progress Reports	In Progress	06/30/2023	No

MHSOAC
Mental Health Services
Oversight & Accountability Commission

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

INNOVATION DASHBOARD

MAY 2023



UNDER REVIEW	Final Proposals Received	Draft Proposals Received	**TOTALS**
Number of Projects	5	3	**8**
Participating Counties (unduplicated)	5	3	**8**
Dollars Requested	$256,044,610.86	$4,568,935	**$260,613,545.86**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2017-2018	34	33	$149,548,570	19 (32%)
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%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
2022-2023	26	26	$98,403,817	21

INNOVATION PROJECT DETAILS

DRAFT PROPOSALS

Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	Santa Clara	TGE Center	$17,298,034	54 Months	10/4/2022	Pending
Under Review	Yolo	Crisis Now	$3,584,357	3 Years	6/1/2022	Pending
Under Review	San Luis Obispo	Behavioral Health for Residential Care Facilities: Older Adult Mental Health Care & Education Project (BRACE)	$984,578	3 Years	3/24/2023	Pending

FINAL PROPOSALS

Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Tuolumne	Family Ties: Youth and Family Wellness	$925,892	5 Years	8/22/2022	12/7/2022
Under Final Review	Los Angeles	Interim Housing Multidisciplinary Assessment & Treatment Teams	$155,927,580	5 Years	3/7/2023	4/6/2023
Under Final Review	Monterey	Rainbow Connection	$7,883,562.86	5 Years	1/6/2023	5/8/2023
Under Final Review	San Bernardino	Progressive Integrated Care Collaborative	$16,557,576	5 Years	3/24/2023	5/11/2023
Under Final Review	San Diego	Public Behavioral Health Workforce Development and Retention Program	$75,000,000	5 Years	3/17/2023	5/8/2023

APPROVED PROJECTS (FY 22-23)			
County	Project Name	Funding Amount	Approval Date
Napa	FSP Multi-County Collaborative	$844,750	10/11/2022
Sonoma	Semi-Statewide Enterprise Health Record	$4,420,447.54	11/17/2022
Tulare	Semi-Statewide Enterprise Health Record	$6,281,021	11/17/2022
Humboldt	Semi-Statewide Enterprise Health Record	$608,678	11/17/2022
Colusa	Social Determinants of Rural Mental Health (Extension)	$983,124	11/18/2022
Sacramento	Behavioral Health Crisis Services Collaborative	$1,000,000	1/4/2023
Alameda	Peer-led Continuum for Forensics and Reentry Services	$8,692,893	1/25/2023
Alameda	Alternatives to Confinement	$13,432,651	1/25/2023
Santa Barbara	Housing Assistance and Retention Team	$7,552,606	1/25/2023
Kings	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$3,203,101.78	1/25/2023
Imperial	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$2,974,849	1/25/2023
Mono	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$986,403	1/25/2023
Placer	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$4,562,393	1/25/2023
San Benito	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$4,940,202	1/25/2023
San Joaquin	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$8,478,140	1/25/2023
Siskiyou	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$1,073,106	1/25/2023
Ventura	Semi-Statewide Enterprise Health Record (EHR) Multi-County INN Project	$3,514,910	1/25/2023
San Mateo	Mobile Behavioral Health Services for Farmworkers	$1,815,000	2/23/2023

APPROVED PROJECTS (FY 22-23)			
County	Project Name	Funding Amount	Approval Date
San Mateo	Music Therapy for Asian Americans	$940,000	2/23/2023
San Mateo	Recovery Connection Drop-in-Center	$2,840,000	2/23/2023
San Mateo	Adult Residential In-Home Support Element (ARISE)	$1,240,000	2/23/2023
Contra Costa	Supporting Equity through Community Defined Practices	$6,119,182	3/23/2023
Fresno	The Lodge (EXTENSION)	$3,160,000	4/27/2023
Fresno	Participatory Action Research with Justice-Involved Youth using an Adverse Childhood Experiences (ACEs) Framework	$3,000,000	4/27/2023
Stanislaus	Embedded Neighborhood Mental Health Team	$5,185,000	4/27/2023
Marin	From Housing to Healing, Re-Entry Community for Women (EXTENSION)	$560,300	5/11/2023

DHCS Status Chart of County RERs Received
May 25, 2023, 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 May 15, 2023. This Status Report covers FY 2019 -2020 through FY 2021-2022, 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 2021-2022 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.

DHCS Status Chart of County RERs Received
May 25, 2023, Commission Meeting

DCHS MHSA Annual Revenue and Expenditure Report Status Update

There is one RER not finalized for FY 19-20, Inyo.

County	FY 20-21 Electronic Copy Submission	FY 20-21 Return to County	FY 20-21 Final Review Completion	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion
Alameda	1/26/2022	2/3/2022	2/8/2022	1/31/2023	2/6/2023	2/7/2023
Alpine	1/26/2022	2/3/2022	2/15/2022	4/14/2023		4/17/2023
Amador	1/27/2022	2/3/2022	2/10/2022	1/31/2023	2/7/2023	2/17/2023
Berkeley City	2/1/2022	2/3/2022	3/1/2022	1/31/2023	2/2/2023	2/7/2023
Butte	8/11/2022	8/12/2022	8/15/2022			
Calaveras	1/31/2022	2/4/2022	2/8/2022	1/27/2023		2/7/2023
Colusa	2/1/2022	2/4/2022	2/15/2022	4/3/2023	4/4/2023	5/11/2023
Contra Costa	1/31/2022	2/4/2022	3/11/2022	1/30/2023		2/1/2023
Del Norte	1/28/2022	2/7/2022	2/23/2022	1/30/2023		2/7/2023
El Dorado	1/28/2022	2/4/2022	2/9/2022	2/24/2023		2/28/2023
Fresno	1/26/2022	2/7/2022	2/16/2022	1/31/2023	2/2/2023	2/10/2023
Glenn	3/21/2022	3/22/2022	4/6/2022			
Humboldt	8/15/2022	8/16/2022	8/24/2022	1/31/2023		2/2/2023
Imperial	1/31/2022	2/4/2022	2/15/2022	1/20/2023	1/23/2023	2/1/2023
Inyo	4/1/2022	4/12/2022				
Kern	2/3/2022	2/7/2022	2/17/2022	1/31/2023	2/1/2023	2/15/2023
Kings	2/22/2022	2/22/2022	3/11/2022	1/10/2023	1/19/2023	2/14/2023
Lake	2/1/2022	2/8/2022	2/23/2022	1/31/2023		2/1/2023
Lassen	2/2/2022	2/8/2022	2/17/2022	2/8/2023	2/9/2023	2/14/2023
Los Angeles	2/1/2022	2/7/2022	2/22/2022	1/31/2023	2/2/2023	2/17/2023
Madera	3/25/2022	3/29/2022	5/19/2022	2/8/2023	2/9/2023	2/14/2023
Marin	1/31/2022	2/7/2022	2/9/2022	1/30/2023	1/31/2023	2/3/2023
Mariposa	1/31/2022	2/7/2022	2/25/2022	4/19/2023	4/20/2023	4/21/2023

DHCS Status Chart of County RERs Received
May 25, 2023, Commission Meeting

County	FY 20-21 Electronic Copy Submission	FY 20-21 Return to County	FY 20-21 Final Review Completion	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion
Mendocino	2/1/2022	2/7/2022	2/24/2022	1/31/2023		2/2/2023
Merced	1/27/2022	2/7/2022	2/8/2022	1/19/2023		1/23/2023
Modoc	4/27/2022	4/28/2022	4/28/2022	3/23/23	4/4/2023	4/5/2023
Mono	1/18/2022	2/7/2022	2/17/2022	1/31/2023		2/2/2023
Monterey	2/2/2022	2/7/2022	2/9/2022	1/31/2023	2/2/2023	2/2/2023
Napa	2/7/2022	2/8/2022	3/3/2022	1/31/2023	2/1/2023	2/13/2023
Nevada	1/31/2022	2/2/2022	2/3/2022	1/31/2023	2/1/2023	2/2/2023
Orange	1/31/2022	2/3/2022	2/17/2022	1/31/2023		2/1/2023
Placer	1/31/2022	3/17/2022	4/13/2022	1/31/2023	2/1/2023	2/14/2023
Plumas	7/14/2022	7/14/2022	11/29/2022	2/14/2023	2/15/2023	2/21/2023
Riverside	1/31/2022	2/4/2022	3/11/2022	1/31/2023	2/1/2023	2/15/2023
Sacramento	1/31/2022	2/3/2022	3/11/2022	1/25/2023	1/26/2023	1/27/2023
San Benito	2/13/2023	2/13/2023	2/27/2023	5/10/2023	5/11/2023	
San Bernardino	3/23/2022	3/23/2022	3/29/2022	1/31/2023		2/6/2023
San Diego	1/31/2022	2/3/2022	2/18/2022	1/31/2023	1/31/2023	2/14/2023
San Francisco	1/31/2022		2/4/2022	1/31/2023	2/1/2023	2/16/2023
San Joaquin	3/22/2022	3/23/2022	3/25/2022	1/31/2023		2/1/2023
San Luis Obispo	1/26/2022	2/2/2022	2/7/2022	12/30/2023	1/6/2023	1/19/2023
San Mateo	1/31/2022	8/3/2022	8/4/2022	3/6/2023	3/24/2023	4/3/2023
Santa Barbara	1/26/2022	1/26/2022	2/10/2022	12/23/2023	2/7/2023	2/15/2023
Santa Clara	1/31/2022	2/15/20222	2/18/2022	1/31/2023	1/31/2023	2/16/2023
Santa Cruz	3/25/2022	3/25/2022	4/4/2022	4/6/2023	4/14/2023	
Shasta	1/25/2022	1/26/2022	2/10/2022	1/31/2023	2/2/2023	2/16/2023
Sierra	1/31/2022	2/2/2022	2/28/2022	1/27/2023	1/30/2023	2/16/2023
Siskiyou	7/18/2022	7/18/2022	8/10/2022	2/6/2023	2/7/2023	2/9/2023
Solano	1/31/2022	2/2/2022	2/8/2022	1/31/2023	1/31/2023	2/15/2023

DHCS Status Chart of County RERs Received
May 25, 2023, Commission Meeting

County	FY 20-21 Electronic Copy Submission	FY 20-21 Return to County	FY 20-21 Final Review Completion	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion
Sonoma	1/31/2022	2/3/2022	2/22/2022	1/31/2023	2/2/2023	3/6/2023
Stanislaus	1/31/2022	2/2/2022	2/15/2022	1/31/2023	2/2/2023	2/3/2023
Sutter-Yuba	2/9/2022	2/10/2022	2/15/2022	1/31/2023	2/2/2023	3/6/2023
Tehama	4/12/2023	4/12/2023	4/13/2023			
Tri-City	1/31/2022	2/2/2022	5/25/2022	1/25/2023	1/25/2023	2/16/2023
Trinity	7/5/2022	7/5/2022	7/27/2022			
Tulare	1/31/2022	2/2/2022	2/10/2022	1/31/2023	1/31/2023	2/15/2023
Tuolumne	1/31/2022		2/4/2022	3/29/2023	3/30/2023	4/5/2023
Ventura	1/28/2022	2/2/2022	2/14/2022	1/30/2023	1/30/2023	1/31/2023
Yolo	1/31/2022	2/2/2022	2/2/2022	1/31/2023	2/2/203	3/15/2023
Total	**59**	**56**	**58**	**54**	**40**	**53**