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Mental Health Services
Oversight & Accountability Commission

Meeting Materials Packet

Commission Teleconference Meeting
September 28, 2023
9:00 AM – 3:00 PM

MHSOAC
Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING NOTICE & AGENDA

SEPTEMBER 28, 2023

NOTICE IS HEREBY GIVEN that the Commission will conduct a Regular Meeting on **September 28, 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: September 28, 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/88331142995
Meeting ID: 883 3114 2995

FOR PHONE DIAL IN
Dial-in Number: 1-408-638-0968
Meeting ID: 883 3114 2995

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 the Commission will honor former Research Supervisor Ashley Mills for her dedication and service to the Commission.

9:50 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.

10:15 AM

4. August 24 and September 5, 2023 Meeting Minutes
Action
The Commission will consider approval of the minutes from the August 24 and September 5, 2023 Commission Meetings.

- Public Comment
- Vote

10:25 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.

- Santa Cruz County Innovation Project: Approval of $4,544,656 in innovation funding over 3 years for their Multi-County Crisis Now innovation project.

- San Luis Obispo Innovation Project: Approval of $860,000 in innovation funding over 4 years for their Embracing Mental & Behavioral Health for Residential Adult Care & Education (EMBRACE) innovation project.
  - Public Comment
  - Vote

10:35 AM

6. Substance Use Disorder Panel

Action

The Commission will hear a panel presentation on opportunities to allocate Mental Health Wellness Act funds to expand promising practices and/or evidence-based practices for substance use disorder treatment; *presented by Tom Orrock, Deputy Director and the following panelists:*

- *Tyler Sadwith, Deputy Director, Behavioral Health, California Department of Health Care Services*
- *Tommie Trevino, UC Davis Peer SUD Navigator*
- *Dr. Gary Tsai, Los Angeles County Department of Public Health, Director of Substance Abuse Prevention and Control*
- *Dr. Rebecca Trotzky-Sirr, Los Angeles General Hospital; USC Clinical Assistant Professor of Psychiatry and the Behavioral Sciences*
- *Dr. Aimee Moulin, UC Davis Emergency Addiction Medicine*
  - Public Comment
  - Vote

12:30 PM

7. Lunch

1:30 PM

8. Amador County Innovation Project

Action

The Commission will consider approval of $1,995,129 in innovation funding over 5 years for their Workforce Recruitment & Retention Strategies innovation project; *presented by Stephanie Hess, MHSA Coordinator, Amador County Behavioral Health.*

- Public Comment
- Vote

2:10 PM

9. Request for Proposal Outline for Advocacy Contracts

Action

The Commission will hear a presentation on feedback received during recent community listening sessions and will consider approval of the Request for Proposal Outlines for advocacy, training, and outreach on behalf of six underserved populations; *presented by Tom Orrock, Deputy Director and Lester Robancho, Health Program Specialist.*

- Public Comment
- Vote

3:00 PM

10. Adjournment

Mental Health Services
Oversight & Accountability Commission

Our Commitment to Transparency	Our Commitment to Those with Disabilities
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	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

September 28, 2023 Commission Meeting

Approve August 24, 2023 and September 5, 2023 MHSOAC Teleconference Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the August 24, 2023 and September 5, 2023 Commission teleconference meetings. 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 (4): (1) August 24, 2023 Meeting Minutes; (2) September 5, 2023 Meeting Minutes; (3) August 24, 2023 Motions Summary; (4) September 5, 2023 Motions Summary;

Handouts: None.

Proposed Motions:

- The Commission approves the August 24, 2023 Meeting Minutes
- The Commission approves the September 5, 2023 Meeting Minutes

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date August 24, 2023

Time 9:00 a.m.

Location MHSOAC
1812 9th Street
Sacramento, California 95811

Additional Public Locations

UC Berkeley SCET, 1923 Gridiron Way, CMS 122, MC# 1768, Berkeley, CA 94720
20151 Nordhoff Street, Chatsworth, CA 91311
700 S Flower Street, Suite 1000, Los Angeles, CA 90017

Members Participating:

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

*Participated remotely
[1] a.m. only

Members Absent:

Sheriff Bill Brown
Steve Carnevale
Assemblymember Wendy Carrillo
Senator Dave Cortese
Itai Danovitch, M.D.

MHSOAC Meeting Staff Present:

Geoff Margolis, Chief Counsel
Tom Orrock, Deputy Director of Operations
Norma Pate, Deputy Director, Administration and Performance Management
Kendra Zoller, Deputy Director, Legislation
Melissa Martin-Mollard, Ph.D., Chief, Research and Evaluation
Kali Patterson, Policy Research Supervisor
Amariani Martinez, Administrative Support
Lester Robancho, Health Program Specialist
Cody Scott, Meeting Logistics Technician

[Note: Agenda Item 7 was taken out of order. These minutes reflect this Agenda Item as listed on the agenda and not as taken in chronological order.]

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 9:06 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.

Amariani Martinez, Commission staff, reviewed the meeting protocols.

2: Announcements and Updates

Chair Madrigal-Weiss gave the announcements as follows:

Commission Meetings

- The July 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 September 28th in Los Angeles. The meeting will focus on substance use disorder (SUD) programs and highlight opportunities for the Commission to expand promising programs. The day before the Commission meeting, on Wednesday the 27th, there will be a site visit for Commissioners to interact with consumers and program staff who are serving individuals with substance use disorders. More information is forthcoming.

CYBHI Announcement

- The Request for Applications (RFA) has been released for the Children and Youth Behavioral Health Initiative (CYBHI) Round 4, which will provide grants to youth-driven programs.
- The RFA for Round 5, which will provide grants to early intervention programs, will soon be released.
- These grant projects are a part of the $4.7 billion investment in the mental health of the most vulnerable children and youth. Vice Chair Alvarez has been designated by the Commission to work with staff on this process.

Chair Madrigal-Weiss asked Vice Chair Alvarez to say a few words about the Round 5 RFA for early intervention services.

Vice Chair Alvarez stated that Round 5 is intended to increase the number of coordinated specialty care clinics that address first episode psychosis and can support things like youth mobile crisis response teams and school-based programs.

Vice Chair Alvarez stated that Rounds 4 and 5 together will distribute up to $150 million to support programs for children and young people across the state. She stated appreciation for the effective collaboration between Commission staff, under the leadership of Tom Orrock, Deputy Director, and the Department of Health Care Services (DHCS), under the leadership of Autumn Boylan, Deputy Director, which has happened throughout this process.

Vice Chair Alvarez stated that the Round 5 RFA reflects the input received during workgroups and listening sessions conducted by the DHCS, as well as community feedback heard during Commission meetings over the past few months. Each of the six rounds of funding through the CYBHI has an equity focus and calls for programs that reduce health disparities by including equitable access to services for parents, caregivers, and children in California that are culturally and linguistically responsive to the needs of the populations of focus.

Transformational Change Report

- The Commission's Transformational Change Report covering the Commission's work for the first half of 2023, including updates and status reports on all initiatives and in-depth features on community engagement, innovation, Full-Service Partnerships (FSPs), Early Psychosis Intervention Plus (EPI Plus), new advocacy grantees, the strategic planning process, and the Governor's proposed modernization of the Mental Health Services Act (MHSA), has been posted on the website and included in the meeting materials.

Research and Evaluation Workgroup Announcement

- The Research and Evaluation team will be holding a Mental Health Student Services Act (MHSSA) Research and Evaluation Committee Workgroup meeting on Friday, September 22, 2023, from 10:00 a.m. to 11:30 a.m. This Workgroup provides expert guidance to Commission staff regarding MHSSA evaluation planning and implementation.
- At the September Committee meeting, the Workgroup will hear from WestEd, the Commission's MHSSA evaluation partner. WestEd will present a plan for conducting robust community engagement to ensure that community partners and especially youth are involved in guiding the planning of this evaluation. Commissioners and members of the public are invited to attend.

Brian Sala's Recognition

Chair Madrigal-Weiss thanked former Deputy Director of Research and Evaluation Brian Sala for his contributions during his time at the Commission. On behalf of the Commission, Chair Madrigal-Weiss presented Brian Sala with a resolution in appreciation for his years of service with the Commission.

Commissioners, presenters, and members of the public expressed their thanks, appreciation, and gratitude for Brian Sala and his work over the years.

3: General Public Comment

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), reminded the Commission that community-defined evidence practices (CDEPs) are eligible to apply for every grant round and should be given equal consideration as evidence-based practices for awards. She asked the Commission to ensure that at least some organizations that utilize CDEPs will be awarded in the rounds the Commission is responsible for administering. She stated that, if no programs that utilize CDEPs apply by the deadline, the Commission should reopen the Request for

Proposals (RFP) and recruit organizations utilizing CDEPs. Finally, if no organizations apply that utilize CDEPs for the program for the CYBHI, she asked that the Commission be concerned and ask itself why no such programs applied, make an investigation, and discuss this at a regular Commission meeting.

Stacie Hiramoto stated that the California Health and Human Services Agency (CalHHS) and the DHCS have indicated to communities that they are committed to CDEPs and want to see them awarded in every grant round. She stated the hope that the Commission has a similar commitment to these practices that reduce disparities and are often preferred by Black and indigenous people of color (BIPOC) and LGBTQ communities.

Mark Karmatz, consumer and advocate, stated that Project Return Peer Support Network (PRPSN) will be doing a training on Certified Peer Support Specialists from September 5th through October 16th.

Mark Karmatz stated that Doors to Wellbeing will be holding a Webinar next Tuesday, August 29, 2023, at 2:00 p.m., on the Substance Abuse and Mental Health Services Administration (SAMHSA) National Model Standards for Peer Support Certification.

Mark Karmatz thanked the Commission for informing the public that the next Commission meeting will be held in Los Angeles. The speaker asked about the location so they can spread the word.

Mark Karmatz stated that the California Technical Assistance Center in Florida will be holding webinars on Peer-Run Crisis Support Centers.

Steve McNally, family member and Member, Orange County Behavioral Health Advisory Board, speaking as an individual, asked the Commission to invite the California Mental Health Services Authority (CalMHSA) to present or provide a single-page report on their Peer Support Specialist Certification process, the number of scholarships that have been awarded out of the 5,000 provided by the DHCS, and the number that have been implemented. If using peers who can bill Medi-Cal is a big part of Senate Bill (SB) 326, it is important to monitor how peers will be included and how to include peers who have a mission and focus to help other people in their recovery journey who maybe do not bill Medi-Cal.

4: <u>July 27, 2023, Meeting Minutes</u>

Chair Madrigal-Weiss stated that the Commission will consider approval of the minutes from the July 27, 2023, Commission meeting. She stated that meeting minutes and recordings are posted on the Commission's website.

There were no questions from Commissioners and no public comment.

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

- *The Commission approves the July 27, 2023, Meeting Minutes.*

The Motion passed with 9 ayes, 0 noes, and 2 abstentions, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Bontrager, Chambers, Chen, Gordon, Robinson, Rowlett, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioners abstained: Commissioners Bunch and Mitchell.

5: <u>Data and Transformational Change</u>

Panelists:

- Sameer Chowdhary, Partner, McKinsey & Company
- Emily Putnam-Hornstein, Ph.D., Director, Children's Data Network, and Advisor to the California Cradle-to-Career Data System
- Daniel Webster, Ph.D., Principal Investigator, California Child Welfare Indicators Project, UC Berkeley
- Serene Olin, Ph.D., Principal, Health Management Associates, Former Assistant Vice President of Research and Analysis at the National Committee for Quality Assurance, and co-author of "Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care"
- Marlies Perez, Chief, Community Services Division, Behavioral Health Services, DHCS

Chair Madrigal-Weiss stated that the Commission will hear a panel presentation and discuss the use of data as a lever for transformational change. Chair Madrigal-Weiss asked staff to present this agenda item.

Melissa Martin-Mollard, Ph.D., Chief of Research and Evaluation, stated that the purpose of this agenda item on data and metrics is to discuss opportunities and challenges related to using data for decision-making, transparency, and accountability with an emphasis on accountability for public systems. She stated that each of the panelists will share their unique and specific perspectives on using data for public governance.

Melissa Martin-Mollard introduced the members of the panel and asked them to give their presentations.

<u>Emily Putnam-Hornstein, Ph.D.</u>

Emily Putnam-Hornstein, Ph.D., Director, Children's Data Network (CDN), and Advisor to the California Cradle-to-Career Data System, stated that, because most of her research is focused on the Child Protection System, almost all her examples focus on child welfare, but she noted that she tried to bring a mental health lens to those examples.

Emily Putnam-Hornstein stated that the CDN is a project housed at the University of Southern California in partnership with the California Child Welfare Indicators Project (CCWIP) at UC Berkeley and the School of Social Work at the University of North Carolina (UNC) and, for the last 10 years, it has been working closely to demonstrate that there is much one can learn from individual data systems that serve children and families but much more can be learned when connecting those different data systems.

Emily Putnam-Hornstein stated that the Record Reconciliation Project is a multiyear effort that the CDN did in partnership with the CalHHS using a census of clients CalHHS served in calendar years 2018 through 2023. The CDN used probabilistic algorithms to match up those clients to see how many clients had open child welfare cases and were also receiving developmental service supports. The CDN is closely partnering with the Center for Data Insights and Innovation within CalHHS to transfer the linkage work back to CalHHS. The Record Reconciliation Project was treated as a

demonstration project of what is possible when creating a huge Venn diagram that helps in understanding the different public benefits and systems that individual clients are interacting with.

Emily Putnam-Hornstein presented four examples of how data has been used to generate new insights and drive important policy and practice conversations:

- The first example was a study about the percentage of child clients receiving benefits who were eligible for services from a given CalHHS program in 2017 and interacting with other CalHHS programs between 2015 and 2018.
- The second example was a study linking Medicaid or Medi-Cal records for children throughout the state to determine the number of those children who have both a diagnosed mental health disorder and some child protection or child welfare involvement using records as far back as the late 1990s.
- The third example was a study about discrepancies between what is being maintained in one case management system versus another. This leads to the importance of continuing to link data as opposed to simply thinking that adding fields to existing data systems will produce the information needed. The study showed that relying on one data system and not studying these discrepancies misrepresented the extent of mental health challenges and the extent to which mental health supports were needed.
- The fourth example was a study demonstrating that real-time data can be used to improve practice. Harvesting information from the case management system in real-time presents supervisors with information as to the risk and protective factors that may be operating so they can better tailor and target their time to ensure they are connecting children and families with preventative resources and interventions, when warranted.

Emily Putnam-Hornstein stated that there are tremendous opportunities to continue to promote accountability and transparency through linked data and administrative data, but there are also opportunities to start thinking about cost-effective tools that can be used as overlays to case management systems to help front-line staff better serve children, families, and others throughout the state.

Daniel Webster, Ph.D.

Daniel Webster, Ph.D., Principal Investigator, CCWIP, UC Berkeley, stated that the CCWIP provides data and technical assistance to promote child welfare system improvement. He stated that the project is a collaborative venture between UC Berkeley and the California Department of Social Services (CDSS). The project is housed in the School of Social Welfare, and provides agency staff, policymakers, researchers, and the public with access to critical outcome information on California's child welfare system. He discussed key foundational pieces for ongoing use of data for system accountability and transparency and provided an overview, with a slide presentation, of the challenges and barriers to transparency and developing core metrics, system reform in child welfare, and promising models.

Daniel Webster stated that, for almost two decades, the CCWIP has received quarterly extracts of the California Administrative Data System and child welfare data, which is then posted on the website as part of the California Child Welfare Outcomes and Accountability System. He stated that the necessary pre-condition for transformational change using data is a change in mindset.

Daniel Webster stated that the mindset for individuals in human services is that they came into this work to help people and that they are a people person, not a data or a math person. Using data to look for areas that need improvement oftentimes elicits reactions from the human services workforce, anywhere from complete dismissal to using whatever data they come up with to support their pre-conceived positions. He stated that data is not another component or something that only data-quality or data-assurance people do but it is something that the entire agency and the entire system do in order to improve their work in helping the clients they are charged to help. This requires a different mindset.

Serene Olin, Ph.D.

Serene Olin, Ph.D., Principal, Health Management Associates, Former Assistant Vice President of Research and Analysis at the National Committee for Quality Assurance (NCQA), and co-author of "Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care," provided an overview, with a slide presentation, of the challenges to behavioral health quality accountability, the Behavioral Health Quality Framework, and the Roadmap for Joint Accountability to Whole Person Care. She noted that the Quality Framework document is available on the NCQA and California Health Care Foundation (CHCF) websites.

Serene Olin stated that behavioral health is a key driver of overall health. Quality measures are needed to guide value-based payment models to support high quality care that is equitable and coordinated. She stated that one cannot improve what one does not measure. Communities at different levels of the delivery system have unique and unmet quality measurement needs. The Quality Framework is a measurement framework that focuses on reporting what matters at each of those levels. The goal of the Quality Framework is not to replicate measures across levels of the system, but is intentional coordination focused on a bundle of prudent measures that collectively drive population outcomes.

Serene Olin stated that the Roadmap applies the measurements in the Quality Framework to identify population goals and priority populations, choose the right tools and strategies, and align policies and payment to support and sustain. She provided an illustrative example of how quality measures might be used. She began her example by selecting a population health goal and priority populations. The next step in her example was to bring the community together to develop bundles of meaningful quality measures at each level of the system.

Serene Olin highlighted the larger system supports that are needed to facilitate the use of quality measures for driving outcomes, such as updated policies around behavioral health financing to support adequate evidence-based care, data infrastructure to support the use of metrics to track outcomes, policies that focus on coordination and information exchange across the system, and workforce capacity and training in evidence-based practices and culturally competent care.

Serene Olin ended her presentation by asking everyone to think about how to contribute to the larger behavioral health transformation efforts in California, clarify missions and visions, choose the right tools and strategies, leverage resources, and coordinate and collaborate with key partners.

Marlies Perez

Marlies Perez, Chief, Community Services Division (CSD), Behavioral Health Services, DHCS, stated that the DHCS oversees several behavioral health funding sources with various data systems. Federal

and state grant data includes project outcomes on grant investments – for example, the Behavioral Health Continuum Infrastructure Program (BHCIP) Data Dashboard includes highlights, facility capacity, regional capacity, and facility type. Behavioral Health Medi-Cal services data includes patient outcomes, core measure, and service data – for example, the Behavioral Health Dashboard includes specialty mental health services performance measures, mental health services demographics for child and adult, and CMS mental health measures. She provided examples of the BHCIP grant data collected for Rounds 1 through 5 and the Behavioral Health Medi-Cal Services dashboard. She noted that, along with the various funding streams, there are various data requirements. She provided a link to the slide for further review.

Marlies Perez provided an overview, with a slide presentation, of the potential additional behavioral health data changes from the AB 529 Behavioral Health Reform and the County Behavioral Health Outcomes, Accountability, and Transparency Report. She noted that SB 326 contains information on data on behavioral health funding, metrics to be aligned across funding sources, and quality metrics.

Sameer Chowdhary

Sameer Chowdhary, Partner, McKinsey & Company, provided an overview, with a slide presentation, of the key components of the Influence Model, implications for underlying data infrastructure to enable transformational change, examples of data-based initiatives within the Influence Model, and the example of safe and secure use of data to drive effective public sector change across the globe in Singapore's behavioral interventions.

Kana Enomoto

Kana Enomoto, Director of Brain Health, McKinsey Health Institute, continued the slide presentation and discussed examples of Vibrant's 988 operational readiness and Rhode Island's health equity surveillance system as safe and secure use of data to drive effective public sector change across the globe. She highlighted Rhode Island's system to guide policy. She stated that project raised $10.4 million to invest in their Health Equity Zone Initiative, saw a 163 percent increase in community engagement, and saw decreases in health outcomes for communities that were traditionally underserved or marginalized, such as a decrease of 44 percent in childhood lead poisoning, which has long-term social, health, and financial implications.

Kana Enomoto stated that key learnings about tracking this information at a granular geographic level allowed for targeting of specific local concerns, having clear consensus on health equity measures allows for an apples-to-applies comparison, and providing evidence of specific disparities and quantifying their magnitudes to drive funding, engagement, and legislation for improved impacts.

Commissioner Comments & Questions

Commissioner Tamplen referred to Serene Olin's presentation about aligning across systems to drive improvement in population goals and asked Serene Olin and Marlies Perez about state and provider collaboration with the counties and how these collaborations can be increased.

Marlies Perez stated that she loved Serene Olin's Framework and the levels of data. She stated that not all counties have county-operated providers of behavioral health services. Every level needs a different type of data but they are all interconnected. Collaboration is extremely important not only with counties but with providers. Without it there would be a missing link.

Marlies Perez suggested considering how this can be streamlined since providers in counties are busy with the provision of services. It is important to make that data and/or performance measures meaningful to them. There are counties in California with incredible data systems already developed with their own performance measures and providers. She asked how to then draw that up with what is being done at the state level and how to also mirror that and mesh it with what some federal partners are asking counties to do. Without all those collaborative partners at the table, performance measures and data systems will not be successful.

Serene Olin stated that the NCQA interviewed five states across the nation. What was striking about the county system in California was that the counties have multiple roles – they manage care and may also be the providers. Clarifying roles and understanding who is responsible for what may be helpful in thinking about what metrics may be most relevant given the hat the county is currently wearing and ensuring that they are in alignment and not conflicting. At the provider level, individuals were so overwhelmed with the reporting requirements that there was no room to consider why they were measuring what they were measuring.

Serene Olin agreed with Marlies Perez that having a deliberate connection is critical. California is particularly tricky because of that dual hat that county behavioral health agencies wear. What this means in terms of the performance metrics that might be relevant to the county in those instances needs to be considered.

Commissioner Mitchell stated that data and outcomes are important, but it is also important to coordinate what is being reported on. She stated that she appreciated Daniel Webster's presentation because standardization of quality measures is needed in order to get better health outcomes. She asked how to get this standardization of reporting and what to report to get the outcomes needed or to address outcomes that are known to be poor in counties, the state, and the federal government. She noted that what is predictable is preventable.

Daniel Webster stated that the Family First Prevention Services Act (FFPSA) is a good anchor point for mobilizing individuals' responsibility and efforts by putting people on the hook for a shared enterprise. If everyone can measure what they want, everyone will end up with measure fatigue because invariably it will be measured and reported in a way that may cast them in a bad light. Having shared responsibilities and consensus on system goals anchors everyone towards going in a similar direction.

Daniel Webster suggested looking at AB 636 and the Federal Child and Family Services Review (CFSR), which is like FFPSA but is a federal initiative that says that all states must be measured on certain metrics. There are seven system indicators that they look at and the methodology for what to look at is specified. From that flowed AB 636. California is a state-run but county-administered system where all counties must use the same measurement and methodology when ranking core system outcomes. This is a great way to bring unification to counties and communities. Individuals with lived experience are needed to be part of the conversation while these measures are being developed to identify gaps and provide input on how to look at things.

Daniel Webster stated that AB 636 has been helpful. Progress has been made in the measures that that system has implemented, but counter-balance measures need to be built in because, as certain areas are improving, there will be other areas that may not have been part of the initial system but need to be included. That continuous quality improvement needs to be monitored while building in the capacity to track these new areas of concern.

Commissioner Rowlett stated that he is a provider of services and often felt referenced when the presenters were talking about service provision. He stated that his organization wants the individuals it is privileged to serve to get optimal care and to be a part of not only the genesis of measures that determine whether the care they are receiving is effective, but the development of measures that make sense to them. He provided the example of not needing to know everything his cardiologist knows, but needing to know if his heart is healthy. He noted that this, fundamentally, is one of the unique challenges of the behavioral health community.

Commissioner Rowlett referred to one of the points on Serene Olin's slide on the behavioral health quality landscape that stated that few behavioral health measures are consistently used and that 35 standardized measures were found. He asked if those standardized measures were used across California or other states, and if specific providers or managed care organizations that are counties or government that is providing services included services that were not evidence-based or community-defined practices, and if the entities that were advocating and effectively utilizing community-defined practices had measures that were standardized.

Serene Olin acknowledged that her sample was limited. She referred to Commissioner Rowlett's question asking if there were standardized measures for community-defined practices across the nation, and stated that the programs reviewed were at the federal level. A push for standardization is expected at the federal level because they are looking at an apples-to-apples comparison. They are pushing to set benchmarks that will allow for fair comparisons.

Serene Olin stated that there was quite a bit of variation when trickling down from the federal, to the state, to the community level. Community providers on the ground do not have the same level of resources that health plans, managed care entities, or states may have to support the level of standardization that is required. Providers on the ground have the primary responsibility of service delivery and oftentimes measurement comes as an afterthought. The lack of standardization often comes at the micro level on the Behavioral Health Quality Framework.

Serene Olin provided an example from California, where the local entity worked together with their partners to come up with a set of standardized measures that they all agreed to report on. She stated that the presentation she gave today was part of a national webinar hosted by the NCQA a couple of years ago. The webinar highlighted eight communities in California that were proactive. They reached out to community partners to come up with six measures that they all agreed to get behind to guide how they delivered care for a targeted population. Although this has been done, it has not been a consistent practice across the country.

Commissioner Rowlett asked if there were specific set-asides for infrastructure across California and other states where there is a funding mechanism for community-based services. He stated that his experience is that community-based organizations develop infrastructure themselves to measure effectiveness because they will be asked about that, and yet there is not standardization and not even a standard funding mechanism associated with infrastructure.

Commissioner Rowlett asked if set-asides should be prioritized or if there should be a standardized way to go about advising organizations that provide services to set aside dollars for infrastructure. He noted that he knows of only one county in California that sets aside dollars for infrastructure for the entities they contract with. He asked if this is a practice that the Commission should support because outcomes are needed to inform service delivery.

Serene Olin suggested considering opportunities to support providers in developing the much-needed infrastructure within the California landscape, given some of the innovation funds that may be available to counties.

Serene Olin stated that, unfortunately, behavioral health did not participate in the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009. As a result, it continues to play catch-up in many ways. She stated that California has historic investments. She suggested considering how those investments can be used in infrastructure funding mechanisms to begin to build up the infrastructure. She stated that she has seen people do an Excel Spreadsheet; it does not need to be fancy. Everyone must start somewhere and laying a foundation is critical.

Commissioner Gordon stated that so much is focused on treatment rather than prevention in the current system. When many young people reach 4, 5, or 6 years of age, they have deep-rooted deficiencies which do not stem from the child alone, but, in many cases, stem from the fact that the young people have not had the benefit of the medical system working with them from birth on. That seems to be a large indicator of trouble down the line when they get to school and beyond.

Commissioner Gordon stated that approximately 30 percent of young people do not get the requisite well-baby examinations at the prescribed age levels. That speaks not just to deficiencies in the children, which are undetected, but to the fact that no one is bringing them in for those services, even though they have access to medical care. He asked if there are leading indicators of things that portend problems down the road. It is important to focus on those early age levels where, although school-based screenings are fine, it is awfully late for many young people. He asked if anything like this has been seen on a major scale either in California or elsewhere.

Serene Olin stated that one of the core-set measures across the nation is to track well-child visits. There is data at national and state levels on the percentages of children who receive well-child visits at any given time point. The data is there, but the question is how to use that data to raise awareness of the services, inform strategies, or apply incentives to support and encourage caregivers to bring their babies in for treatment at the prescribed age levels.

Chair Madrigal-Weiss stated that definitions must be exact. Measurements cannot be truly accurate until everyone is on the same page. She stated concern that definitions for terms such as “prevention” and “early intervention” vary greatly among California’s 58 counties, which creates a barrier for data comparison. Meaningful measurements cannot be considered without first developing standardized definitions.

Commissioner Mitchell asked about next steps.

Melissa Martin-Mollard stated that one of the areas that staff would like to focus on with the guidance and direction of the Commission is to engage in community outreach and engagement to bring these frameworks, ideas, and mindsets to help identify metrics and quality measures that community partners would like to see the Commission focus on.

Commissioner Rowlett stated the hope that the Commission would consider making a bold statement about data and the implications to inform not only policy but also service delivery. He suggested identifying the ideal way to incorporate all the uniqueness that is California, being mindful that evidence-based practices are typically federally-funded and standardized by the federal government. In some ways, community-defined practices are instilled in many different organizations and managed care entities, and are appreciated by the people who receive the service.

Commissioner Rowlett stated the need to ensure that this bold statement about what data should look like and how to operationalize a plan that results in the Commission endorsing something that robustly says "this is how the Commission thinks you should collect data, California," includes the perspective of every person who is a recipient of service and wants to be involved in the development of such a plan or policy statement.

Chair Madrigal-Weiss agreed and asked Melissa Martin-Mollard and the Data and Research team to work with Commissioners to begin to develop a bold statement.

Commissioner Gordon agreed but also urged that there is an opportunity to dive into that space with data, work with managed care plans, and capitalize on California Advancing and Innovating Medi-Cal (CalAIM) and the great relationships being developed with behavioral health at the state level and with the Governor's initiatives. It does not need to be a total change of the data system but picking and choosing. There is a wonderful opportunity and much to be gained.

Commissioner Mitchell agreed with the need to get families involved. She suggested doing a study on the number of families who are involved and what it looks like when families are not included in the behavioral health system, particularly when children come from child welfare where oftentimes families are considered the problem. Children do better when at least involved with natural supports. She asked if this can be incorporated into the data discussion. The family is essential to health outcomes – it must be connected to the data conversation.

Public Comment

Mark Karmatz asked if peer support will be available and a part of the data process.

Steve Leoni, consumer and advocate, stated that there has always been an interest in data and understanding things better. A panel member who was a supervisor in the county of Santa Cruz in yesterday's discussion on the Governor's proposal stated the opinion that if a person is doing the reporting, they are not providing services. The panel member was saying that Santa Cruz County cannot afford to do the reporting.

Steve Leoni stated that every new data system can only collect what is already being collected, but there needs to be a much better data system for the counties and the state that does not use 40-year-old data programming language. There are ways of setting up data warehouses, web tools, etc., with productivity gains that allow more efficiency in recording the data. The speaker stated the need to stop processing shovelfuls of data repeatedly but to have the system set up to put the data in one time. Far more data can be collected with far less effort. The speaker asked the Commission to investigate this.

Steve McNally referred to the presentation about the integration of social services and welfare relative to mental health and asked how to replicate that in another county. The speaker asked, if a county was willing to do it, if it could be done by assigning a dollar amount to it. Los Angeles County has great data with the MHSA and Debbie Innes-Gomberg. The speaker stated that they have asked how to replicate this in their county but it goes nowhere.

Steve McNally stated that they liked the presentation on the framework for organizational development. It is difficult to break out of silos with matrix management because there are no leaders. How to leverage First 5 to MHSA has been looked at many times. The speaker suggested paying someone extra to be the lead case manager over all the services individuals interact with throughout their lives. A mind-shift needed in the state and the Commission is the most influential of

the mental health subgroups. It is difficult to believe that all these services can be provided without two-way communication.

6: Lunch

[Note: Agenda Item 7 was taken out of order and was heard before the lunch break.]

7: Universal Mental Health Screening for Children and Youth Project

Chair Madrigal-Weiss stated that Commission staff will provide an overview of the universal mental health screening for children and youth project, including a plan to use the $200,000 provided in the 2023-24 State Budget to accomplish the goals of the project. She asked staff to present this agenda item.

Kali Patterson, M.A., Policy Research Supervisor, provided an overview, with a slide presentation, of the state of emergency for youth mental health, early detection and intervention, the Universal Mental Health Screening of Children and Youth Project, project goals, activities, and timeline. She noted that school is a strategic setting for mental health screening. Public health models endorse universal screening, where all students are assessed for risk. Screening is seen as a key component of the comprehensive school-based mental health approach.

Kali Patterson stated that the Legislature has requested that the Commission report information and recommendations for expanding universal mental health screening for children and youth in California to inform future budget and policy considerations around universal screening.

Commissioner Comments & Questions

Commissioner Gordon asked for more detail on the proposed outreach and engagement process. He stated that schools will expect an update on the findings of the screenings. If the Commission is not able to provide follow-up, the screening will not only be ineffective but it will be discredited.

Commissioner Gordon stated that Sacramento County decided to place a mental health clinician in each of its schools sustainably funded by the Medi-Cal system. Mental health clinicians work onsite in almost 40 schools in Sacramento County. He stated that what is being found is that young people are coming to that person to report concerns about their mental health but they are also coming to report that stigma is very much in place.

Kali Patterson stated that there are key community members that need to be considered. It is not just screening but it is building out that continuum of care that ensures that screening results, services and supports, infrastructure, and provider staffing are in place to meet the need. There is concern that casting a wider net will identify more needs. It is important to understand the barriers being faced and what it would take to support this extra load in terms of incentives, capacity, and billing mechanisms from the provider, school, parent, and student perspectives. This will look very different, depending on the community.

Commissioner Robinson asked about the planned outreach to children who are homeschooled.

Kali Patterson agreed that the homeschool population needs to be considered but thus far has not been.

Commissioner Rowlett stated that Sergio Aguilar-Gaxiola presented at the last Commission meeting on engagement and engagement strategies that specifically result in the kind of outcomes that

Commissioner Gordon discussed. He thanked Commissioner Robinson for bringing up children who are homeschooled or utilizing an educational method that is different from the traditional public school system.

Commissioner Rowlett stated that all the strategies presented today would be highly effective in engaging families and children and ensuring that school systems and educators do not feel alienated in the process. Also important is that all of those methods take into consideration the Social Determinants of Health that often prohibit participation or result in individuals thinking that there is too much stigma associated with behavioral health who will not go there and will certainly not go downtown to get services because that clearly identifies them as participants in behavioral health. Going downtown also includes the barriers of time and money for gas.

Commissioner Rowlett stated that the program that Commissioner Gordon is implementing in Sacramento helps individuals overcome those barriers. The homeschool population has a whole different set of variables that need to be taken into consideration in order to effectively engage them. It is important to include individuals who are going through or who have gone through a homeschool experience and their educators.

Chair Madrigal-Weiss stated that universal screenings have been considered and a couple of things have come up, especially as it relates to schools. She agreed with Commissioner Gordon that one cannot ask what one is not going to address. That is the biggest tension. She stated that this especially became an issue coming out of the COVID-19 pandemic when everyone was asking about mental health issues but having nothing in place to address them.

Chair Madrigal-Weiss stated that some districts say they are doing universal mental health screenings when they are socioemotional learning screening tools, which are very different and set students and families up to fail because they do not measure mental health issues. The Commission needs to get this right because the recommendations will change lives and systems.

Public Comment

Stacie Hiramoto thanked Commissioner Rowlett for his comments and for bringing things that are relevant to the communities she serves. She stated that she personally is in favor of mental health trainings in schools. She shared that her son's school had a mental health screening for the children at a young age and that because of the screening she was able to get her son the help he needed. She noted that, while schools are logical places for mental health screenings and programs, schools and campuses are not the refuge or welcoming safe place that they are for many. This is especially true for some students and families from BIPOC communities and for some LGBTQ students, especially in rural communities.

Stacie Hiramoto stated that, while she strongly supports mental health screenings in schools, she urged the Commission to remember that treatments and programs may be better placed at community-based organizations or other places off campuses. She stated the hope that, as this project moves forward, communities of color and LGBTQ communities will be invited to advise on this project.

Kit Wall, Project Director, Words to Deeds, stated that the state of Nevada in 2013 began exploring the opportunity of universal screening for all middle school students as they entered middle school. At the same time, students are required to have a certain number of vaccines, medical examinations, etc., before they enter middle school.

Kit Wall stated that Christie McGill, Director, Office for a Safe and Respectful Learning Environment, Nevada Office of Education, has offered to speak or meet with Commission staff to share information and learnings on the state of Nevada's program. The speaker offered to follow up with staff offline or to introduce Christie McGill to staff.

Chair Madrigal-Weiss asked staff to reach out to Kit Wall with contact information.

8: Commissioner 2023-2024 Spending Plan

Chair Madrigal-Weiss stated that the Commission will consider approval of the 2023-24 Fiscal Year (FY) Spending Plan and associated contracts. She asked staff to present this agenda item.

Norma Pate, Deputy Director, stated that the Commission is presented with the budget three times per year, the goal of which is to support fiscal transparency and to ensure that the Commission's expenditures are in line with the Commission's priorities. She provided an overview, with a slide presentation, of the current year budget expenditure plan, FY 2023-24 procurements, and expenditure authorization. She noted that last year's budget included one-time funds that will be spent over multiple years for the Schools and Mental Health Grant Program. This year's budget is approximately $50 million less than last year because of those one-time funds but there was no reduction in the baseline budget.

Commissioner Comments & Questions

Commissioner Mitchell asked if the conferences have been identified.

Deputy Director Pate stated that only two conferences have been identified to date: the Words to Deeds Conference and the Science Summit at the 78 Global United Nations General Assembly. Throughout the year, the Commission sometimes receives requests to provide stipends for youth and other individuals who would otherwise be unable to attend conferences and events.

Commissioner Mitchell suggested adding the 2024 Wraparound Conference to the list.

Public Comment.

There was no public comment.

Commissioner Discussion

Action: Chair Madrigal-Weiss asked for a motion to approve the Fiscal Year 2023-24 expenditure plan and associated contracts. Commissioner Tamplen moved, and Commissioner Rowlett seconded, that:

- *The Commission approves the Fiscal Year 2023-24 expenditure plan and associated contracts.*

The Motion passed with 9 ayes, 0 noes, and 0 abstentions, per roll call vote as follows:

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

9: Legislative Priorities for 2023

Chair Madrigal-Weiss stated that the Commission will consider legislative priorities for the current 2023-24 legislative session, including:

- Assembly Bill 599 (Ward) relating to public health approaches for addressing student drug, alcohol, and tobacco possession and use in schools.
- Senate Bill 10 (Cortese) relating to opioid overdose prevention and treatment in schools.
- Senate Bill 326 (Eggman) relating to modernization of the Mental Health Services Act.

Chair Madrigal-Weiss asked staff to present this agenda item.

Kendra Zoller, Deputy Director of Legislation, stated that the Commission has prioritized an active role in policy-making related to mental health policy and practices and is routinely asked to provide guidance on legislative proposals that would impact the Commission's operations or result in new duties for the Commission. There are three weeks left of this legislative session; however, there is still time to take action and make an impact. She stated that today Commissioners will hear about three bills.

Deputy Director Zoller introduced the speakers for this agenda item and asked them to give their presentations.

Assembly Bill 599 (Ward)

Caleb Beaver, Legislative Aide to Assembly Member Christopher Ward, provided an overview of Assembly Bill (AB) 599, which would amend the Education Code to remove possession of or being under the use of tobacco products as a sole basis of suspension or expulsion. This policy also requires the California Department of Education (CDE) to give further guidance to administrators and school districts to address substance possession and use. The CDE would be required to collaborate with treatment providers, public health resources, location education agencies, and youth in community-based organizations in the development of a model policy on supporting students that would be available by July 1, 2025.

Caleb Beaver stated that, while drug possession and use on school campuses is an infraction that requires school involvement, suspensions and expulsions do little to aid a student in understanding the risks and dangers of drug abuse and addiction. According to the data from the CDE, over 60 percent of drug-related suspensions and expulsions are boys, over 80 percent are socioeconomically disadvantaged students, and 80 percent are youth of color.

Caleb Beaver stated that AB 599 is about supporting students struggling with substance use and giving administrators more options and tools that are non-punitive. He noted that, at its core, this bill is about supporting students to address the youth behavioral health crisis. AB 599 is co-sponsored by the California Alliance of Child and Family Services, the California Youth Empowerment Network (CAYEN), Children Now, and the California Academy of Children and Adolescent Psychiatrists.

Commissioner Comments & Questions on AB 599

Commissioner Gordon asked how AB 599 has been amended. He stated that the bill originally spoke of taking a public health approach but did not specify what that consisted of.

Caleb Beaver stated that originally the bill was much larger in its scope. The requirement for the CDE to create model policy with youth involvement and public health approaches has stayed in the bill. However, by doing that, the CDE will need to reach out to local and statewide organizations to

develop the model policy in addition to speaking with local education agencies to find best practices and uses.

Chair Madrigal-Weiss stated appreciation for the bill language around designing the model policy with youth involvement, adding more options, including language such as substance use, and trying to address substance use in non-punitive ways.

Senate Bill 10 (Cortese)

Tara Sreekrishnan, Legislative Director to Commissioner Senator Dave Cortese, provided an overview of Senate Bill (SB) 10, which is also known as Melanie's Law. The bill is named in honor of Melanie Ramos, a teenager who died of fentanyl poisoning in her school bathroom. SB 10 is focused on youth in schools and is a bill that will expand statewide prevention and education efforts to combat the skyrocketing overdoses and fentanyl-related deaths that have plagued youth statewide. She stated that SB 10 seeks to provide necessary intervention, increase accessibility to resources, and provide valuable education and training to protect youth from fentanyl poisoning and overdoses.

Tara Sreekrishnan stated that SB 10 was, in part, inspired by the Santa Clara County Fentanyl Working Group, led by the Santa Clara Office of Education in the Senator's home district. The bill requires local education agencies to embed opioid prevention and treatment in school safety plans, CDE to work with CalHHS to develop and distribute opioid antagonist training and school resource guides to all local education agencies, and local education agencies to distribute safety advice to families regarding opioid overdose prevention, including through student orientation materials and posting online information.

Tara Sreekrishnan stated that SB 10 establishes a state working group on fentanyl and provides $3.5 million of ongoing Proposition 98 General Fund dollars for middle schools, high schools, and adult schools to maintain at least two doses of Naloxone on their campuses.

Tara Sreekrishnan stated that the bill has no registered opposition and has received full bipartisan support, including the county of Santa Clara, the Santa Clara Office of Education, the State Superintendent of Public Instruction, the California Teachers Association, the California School Nurses Association, the California Association of Student Councils, and many more.

Commissioner Comments & Questions on SB 10

Commissioner Gordon stated that this issue is very important. The Sacramento Opioid Coalition has done tremendous work and is providing information to schools, teachers, parents, and adults, widely distributing Narcan.

Commissioner Tamplen agreed that this is an important issue and that prevention interventions and treatment need to be throughout all schools in California.

Chair Madrigal-Weiss stated the need to include not only high schools but middle and elementary school students who are siblings of older students. Getting educational information out there is critically important.

Senate Bill 326 (Eggman)

Stephanie Welch, Deputy Secretary of Behavioral Health, California Health and Human Services Agency (CalHHS), reviewed the August 15th and August 24th amendments and provided a sneak peek into the next round of amendments that will soon be coming out.

August 15th Amendments to SB 326:

Ms. Welch summarized the key policy changes that were reflected in the August 15th amendments. She noted that this information is included in more detail in slide format on the CalHHS website:

Changes to Local Services Categories

» Housing Interventions – 30%.

» Full Services Partnerships (FSP) – 35%.

» Behavioral Health Services and Supports (BHSS) – Now 35% (up from 30%).

- Added "outreach and engagement" as allowable service.
- At least 51% of BHSS shall be used for Early Intervention.
- New: At least 51% of Early Intervention shall be used to serve individuals who are 25 years of age or younger.

Flexibility for Local Services

» Added flexibility to move up to 5-7% funding from one service category to another with a maximum shift of 10-14% across all categories. Funding changes can only be made during the 3-year plan cycle.

» Flexibility aligns with the transition to implementation and is ongoing.

- Shift 7% from any one service to another; 14% max – 2026-27 through 2028-29.
- Shift 6% from any one service to another; 12% max – 2029-30 through 2031-32.
- Shift 5% from any one service to another; 10% max – 2032 forward.

Changes to Population-Based Prevention

» Shifted population-based prevention to state-directed administration.

» The California Department of Public Health (CDPH) will be lead in consultation with DHCS and BHSOAC.

» No less than 4% of the MHSA, which will now be known as the Behavioral Health Services Act (BHSA), total funds will be dedicated to these efforts.

- 51% must be dedicated to individuals 25 years of age and younger.

Changes to State-Directed Funding Amounts

» 10% of Total Funds.

- 4% for Population-Based Prevention.
- 3% for Statewide Workforce.
- 3% for State Administration (reduced from 5%).

Behavioral Health Services & Supports – Now 35% (up from 30%)

» BHSS funds Early Intervention, Workforce, Education, and Training, Capital Facilities and Technology Needs, Innovative Behavioral Health Pilots and Projects, and Prudent Reserve.

» New:

- Adds Outreach and Engagement Services.
- For Early Intervention – Identifies that the biennial list of evidence-based practices may include practices identified pursuant to the Children and Youth Behavioral Health Initiative (CYBHI).
- For Early Intervention – Directs half to people 25 years and younger.

Full-Service Partnerships – 35%

» Added Individual Placement and Support model of Supported Employment, High-Fidelity Wraparound, and provides authority to the DHCS to identify other evidence-based services and treatment models.

» Included assertive field-based initiation for substance use disorder treatment services, including the provision of medications for addiction treatment, as specified by the DHCS.

» Added language to address concerns that small/rural counties may not be able to implement to fidelity certain evidence-based practice (EBP) models like Assertive Community Treatment or Forensic Assertive Community Treatment.

- Counties with a population of less than 200,000 may request an exemption from these requirements. An exemption shall be justified by the requesting county and approved by the DHCS.

» Added supported employment and psychosocial rehabilitation as part of the definition of "supportive services."

» FSPs shall have an established standard of care with levels based on an individual's acuity and criteria for step-down into the least intensive level of care. The DHCS may develop and revise documentation standards for service planning to be consistent with the standards developed. Documentation of the service planning process in the client's clinical record may fulfill the documentation requirements for both the Medi-Cal program and this section.

Housing Interventions – 30%

» Funding could be used for rental subsidies, operating subsidies (including for behavioral health settings built through the general obligation bond), shared and family housing, capital, and non-federal share for transitional rent.

» New:

- Adds clarifying language for housing supports, defined by DHCS, including but not limited to the community supports policy guide.
- Allows small county exemption process beginning with 2026-29 planning cycle.
- Provides flexibility commencing with the 2032-35 planning cycle on the 30% requirement, based on DHCS criteria for exemptions.

- Clarifies that a county can use BHSA for housing supports for non-Medi-Cal and where plans have not elected to cover housing.
- Updates definition of chronically homeless throughout language as defined by the DHCS.
- Housing interventions are not limited to persons in FSPs or individuals enrolled in Medi-Cal.
- Removes the requirement that capital funds be spent in the same fiscal year as allocated; requires the funds to be spent within a reasonable time frame, as specified by the DHCS.

Behavioral Health Planning and Reporting

» Clarifies the relevant data counties must consider includes local data.

» Adds a requirement for counties to describe the system it has in place to facilitate transitions of care between County Mental Health Plans (MHPs) and Medi-Cal Managed Care Plans (MCPs).

» Requires counties to include a budget that includes all funding sources in the Integrated Plan and adds language that expenditures must align with the Integrated Plan.

» Adds language to the expenditure enforcement requirements to account for funding volatility prior to enforcement action if counties' expenditures are off from their three-year plan by a small percentage.

» Aligns due process with the Community Assistance, Recovery, and Empowerment (CARE) Court program and requires funds withheld to remain with the county.

Alignment with CalAIM

» Updated eligibility criteria to align with CalAIM, as defined in Welfare and Institutions (W&I) Code section 14184.402. This amendment removes the requirement for children to have a formal diagnosis, for example.

» Removed edits to Bronzan-McCorquodale Act (W&I Code section 5600.3).

Behavioral Health Services Act Oversight and Accountability Commission (BHSOAC)

» Supports a BHSOAC that is a strong and unique asset, leveraging its capacity and expertise to achieve the goals of overarching behavioral health transformation.

» Shall receive the data necessary to fulfill its obligations.

» Aligned number of peers and family members, with one additional seat for a transition age youth (TAY) behavioral health peer.

» Adds a seat for a disability/aging perspective.

» Commission selects their own Executive Director.

» Provides technical assistance to support quality change management including implementation planning, training, and capacity-building investments.

» Provides technical assistance on innovation; compiles list of innovative approaches across each of the program buckets.

» The DHCS will consult with the BHSOAC on:

- Developing biennial list of early intervention evidence-based practices.

- Building FSP levels of care.
- Developing statewide outcome metrics.
- Determining statewide behavioral health goals and outcome measures.

August 24th Amendments to SB 326:

Stephanie Welch summarized the key policy changes that were reflected in the August 24th amendments:

» Require the California State Auditor, no later than December 31, 2029, to issue a comprehensive audit on the progress and effectiveness of the BHSA implementation.

» Require two subsequent audits with the final audit being due to the Legislature December 31, 2035.

» The DHCS will consult with the BHSOAC on:

- Development of priorities for the use of early intervention funds.
- Tracking spending on children and youth services.
- Drafting errors, typos, etc.

» Under the Housing Intervention Bucket, making sure that master leasing is included in project-based housing.

» Ensure that local areas of education are represented in the local planning process.

» Public safety partners are inclusive of county juvenile justice agencies.

» Ensure that local emergency medical services partners are included in the local planning process.

» Clarify, in the Population-Based Prevention bucket, that work can be done statewide, countywide, or focused on a particular community.

Next Round of Amendments to SB 326:

» Clarify how community-defined practices are described and how they fit into the Prevention and Early Intervention bucket.

» Ensure that the term "children and youth" in the Early Intervention bucket is inclusive of pre-K children and TAY who may not be in school.

Public Comment on AB 599 and SB 10

Danny Thirakul, Public Policy Coordinator, CAYEN, and Mental Health America of California (MHAC), stated that CAYEN and MHAC are co-sponsors of AB 599. He asked the Commission to support AB 599.

Adrienne Shilton, Director of Public Policy and Strategy, California Alliance of Child and Family Services (CACFS), stated that the CACFS is a co-sponsor of AB 599. The speaker asked the Commission to support AB 599.

Stacie Hiramoto stated that REMHDCO is in strong support of AB 599 and SB 10. She thanked the sponsors and the author for carrying these important bills. She asked the Commission to support AB 599 and SB 10.

John Drebinger, Senior Advocate, Policy and Legislative Affairs, California Council of Community Behavioral Health Agencies (CBHA), stated that the CBHA is in strong support of AB 599 and SB 10. He thanked the author and the sponsors for their leadership on these issues.

Commissioner Discussion on AB 599 and SB 10

Action: Chair Madrigal-Weiss asked for a motion to support AB 599 and direct staff to communicate the Commission's position to the Governor and the Legislature. Commissioner Mitchell moved, and Chair Alvarez seconded, that:

- *The Commission supports AB 599 and directs staff to communicate its position to the Governor and the Legislature.*

The Motion passed with 9 ayes, 0 noes, and 0 abstentions, per roll call vote as follows:

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

Action: Chair Madrigal-Weiss asked for a motion to support SB 10 and direct staff to communicate the Commission's position to the Governor and the Legislature. Chair Madrigal-Weiss moved, and Commissioner Gordon seconded, that:

- *The Commission supports SB 10 and directs staff to communicate its position to the Governor and the Legislature.*

The Motion passed with 8 ayes, 0 noes, and 0 abstentions, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Chambers, Gordon, Mitchell, Robinson, Rowlett, and Tamplen, Vice Chair Alvarez, and Chair Madrigal-Weiss.

Commissioner Comments & Questions on SB 326

Commissioner Chambers stated that peers went to the Capital to express their concerns and needs for amendments. She stated that she is happy that the Administration has listened, particularly about the CDEPs and culturally-defined practices and the need to include peer services. One of the issues that has not been addressed by the Administration relative to the implementation of SB 803 in its relevance to the current legislation is that, currently with this proposal, even though peer services are included, many peer organizations will be unable to participate, particularly the small BIPOC community-based organizations because currently they do not bill Medi-Cal. There are no amendments relative to providing technical assistance to community-based organizations, particularly small BIPOC organizations, to include them in this new system that will heavily rely on Medi-Cal billing.

Commissioner Chambers stated that, as it stands and if nothing is done to CalAIM to bring Medi-Cal peer support specialists into the fold like community health workers, they will not be included in this. The workforce is in threat of expansion because it is limited to specialty mental health. Peers have been referred to as community health workers on several occasions, but peers are not community health workers – they have a certification process. She asked why peer support specialists are not included in CalAIM and why is there not a promise of technical assistance to be a part of the fold and address the mental health crisis and the workforce shortage.

Commissioner Tamplen stated the importance of reviewing the slides that outline the SB 326 amendments on the CalHHS website, as noted by Ms. Welch. Commissioner Tamplen agreed that peer support specialists are not under the umbrella of community health workers. Peer support specialists have unique roles and should be separate from community health workers. This process emphasizes having lived experience and prioritizes that. She suggested emphasizing that certified Medi-Cal peer support specialists have a unique role and should have a unique classification.

Commissioner Tamplen stated that the state would benefit from the establishment of a lived experience advisory board that consults on behavioral health policy. She stated that the community feels that individuals with lived experience are at the end of the decision-making process and are informing the process after decisions have been made.

Commissioner Tamplen stated the need for more state support around peer respites and including the peer respite centers in the resources to help prevent crises. There should be a peer respite center in every city since they are more accessible, welcoming, and warm than locked psychiatric facilities.

Ms. Welch stated that CalHHS is especially interested in hearing from partners at the MHSOAC about its work in bringing lived-experience voice to forums. She stated that CalHHS agrees that supporting smaller community-based organizations is critical. She noted that this is not just a behavioral health issue. She asked for feedback on how to make the most of the Medi-Cal dollars while not medicalizing the great work that some community-based organizations do.

Public Comment on SB 326

Danny Thirakul stated that CAYEN stands in opposition to SB 326. The state should find other means of funding housing interventions without diverting funds from mental health services.

Danny Thirakul suggested that SB 326 include a set-aside for TAY in all funding buckets, including the FSP and housing buckets. Data has shown that set-asides for TAY result in significantly reducing the homeless population for the TAY population.

Danny Thirakul stated that SB 326 should include a minimum spending requirement to ensure community engagement at the local level.

Steve Leoni referred to the part of SB 326 dealing with W&I Code section 5806, which originated in 1999 and is used within the current MHSA for defining the nature and the running of FSPs. It includes education and support for family members. The speaker stated that the new version has added that family members shall be involved with treatment and service planning. This section of SB 326 is not dealing with 5150 hold situations; it is dealing with individuals who presumably are already voluntarily in an FSP and, as such, the mandated intervention of family members is not appropriate and may even be disruptive to some individuals.

Steve Leoni stated that Dave Pilon, Ph.D., Mental Health America, who was part of The Village, made the comment that the Clubhouse Model has recently been made fundable under Medi-Cal. He suggested adding the Clubhouse Model in the new section about FSPs as well as the Assertive Community Treatment (ACT) as part of the models to follow.

John Drebinger stated that the CBHA previously submitted a letter to CalHHS with members' concerns and recommendations to the relevant legislative committees. He stated appreciation for the August 15th amendments, which address some of the CBHA's concerns and specifically for the update to FSP implementation. The CBHA looks forward to continuing to work with the

Administration to refine the Governor's proposal to ensure that it is impactful and mindful of community needs.

Stacie Hiramoto stated that REMHDCO had a good meeting less than a week ago with the Governor's administrative staff and provided extensive amendments on Monday to them after this meeting. REMHDCO was grateful for this meeting and felt that its concerns were heard. REMHDCO hopes its recommended amendments are accepted as they ensure, among other things, that it clarifies that CDEPs are eligible for funding in the population prevention component as well as the early intervention component under the BHSS bucket.

Stacie Hiramoto stated that she was happy to hear in today's presentation that SB 326 will be amended to make it clear that an individual would not be required to have a diagnosis to receive early intervention services, as this removes confusion.

Stacie Hiramoto stated that REMHDCO looks forward to seeing the next set of amendments and thanked CalHHS for their willingness to collaborate. She stated that, unfortunately, REMHDCO must still retain its oppose unless amended position. She stated that REMHDCO is compelled to say that the way this broad initiative has been introduced and rushed through the legislative process is a travesty and an insult to the spirit of the MHSA. While REMHDCO has worked primarily on saving CDEPs, there are many serious issues with this bill – for example, the issues highlighted by Commissioners Chambers and Tamplen regarding problems with CalAIM and Medi-Cal. Many issues can be worked out in compromise; however, the way in which this entire initiative has been handled has broken trust with the behavioral health community at large and it will take a long time to mend this relationship.

Steve McNally stated concern that the individuals looked to for leadership at state agencies are talking more like elected officials. There is a possibility of a liability of the Medi-Cal claims process for federal funds participation. Payment reform started on July 1st, but it is discussed as it if is completely operational and going smoothly. The speaker asked, if it takes 10 years to ensure that both state and federal claims are cleared, what will be done for the liabilities for FY 2015-16 and forward in this plan.

Steve McNally discussed the unintended consequences of the Governor's proposition. The No Place Like Home Initiative lost $800 million of future direct mental health services in order to have access to money – $2.8 billion was taken out but only $2 billion was awarded. The speaker recommended, rather than talking about awards, considering instead the speed of implementation as loved ones get sicker each day. The speaker suggested presenting the business case – if the state has a homeless problem, a budget problem, or a mental health budget problem, determine the amount of money needed to solve the problem and then ask voters if they want to solve it that way.

Steve McNally stated that all of this requires silo-breaking and presenting the information across the boards. If safety cannot be found where individuals can speak in public without fear of retribution or fear of speaking in public, it will never work in California.

Avery Hulog-Vicente, Advocacy Coordinator, California Association of Mental Health Peer-Run Organizations (CAMHPRO), echoed the comments from Commissioners Chambers and Tamplen about Medi-Cal billing. She stated that the peer support workforce needs to be provided support and technical assistance to sustain their work and have equitable access to opportunities to expand and build upon the great work that they are already providing to service communities.

Avery Hulog-Vicente agreed with Commissioner Tamplen's suggestion to include a lived-experience advisory board that consists of mental health peer consumers with lived experience, defining what "lived experience" means from the many peer consumer perspectives. To include that language and to create a lived-experience advisory board would be an opportunity for the Administration to show respect and uplift voices with intention.

Avery Hulog-Vicente stated that CAMHPRO remains in opposition of SB 326 despite these amendments. This bill has been moving incredibly fast and CAMHPRO, along with many allied organizations, have been organizing and advocating within the limiting structures of public comment in commission meetings, legislative hearings, and meetings with legislators. It should not be this way.

Avery Hulog-Vicente stated that the community should be at the table working hand-in-hand to address the needs of the community, which is how the MHSA was created from the beginning. This expedited process contradicts the intent and the structure of the MHSA, which was designed for communities by communities. She stated that CAMHPRO asks that the process slow down and delay putting this proposal on the ballot in March. Much more needs to be addressed beyond the confines of Commission public comment periods.

Tara Gamboa-Eastman, Senior Advocate, Steinberg Institute, spoke in support of SB 326, which provides clarity in terms of setting statewide priorities and strengthens outcomes and the accountability framework so everyone is rowing in the same direction and able to achieve the original vision of the MHSA.

Tiffany Elliott, Project Manager, Painted Brain, speaking as an individual, echoed the comments of Commissioners Chambers and Tamplen and Avery Hulog-Vicente. She stated that this is going fast and peers have not been brought to the table in a way that would be beneficial to the entire process. There should be intentionality in reaching out to the individuals who will be directly impacted by this bill and who have specific experiences with the kinds of conditions mentioned within this bill. More time should be allotted for everyone to come together to discuss changes and solutions that will be impactful and not something that will harm peer support. "Nothing about us without us" is an important tenet to peer support and the laws that impact peers. She asked that the timeline be extended to give more of an opportunity for voices to be heard and not be silenced by the speed in which it is being pushed through.

Chair Madrigal-Weiss thanked Ms. Welch and Secretary Ghaly for listening to everyone's thoughts and concerns both before the Commission and in separate ongoing conversations. She stated appreciation for the time Ms. Welch has spent coming to multiple Commission meetings to provide updates.

Chair Madrigal-Weiss stated that the Commission is still working through the amendments, but they address many of the concerns that have been raised by the Commission. The proposal highlights areas where not enough has been done and where there are opportunities to do more, such as housing, addiction, early intervention, prevention, early psychosis intervention, and leveraging the opportunities to tailor care through FSPs.

Chair Madrigal-Weiss stated that the Commission continues to have concerns and has not yet been able to clarify how they may have been addressed by the amendments:

- Behavioral Health Reform is not tackling the opportunity to ensure California's commitment to school mental health is sustained when the CYBHI sunsets.
- It is unclear how the state will ensure that innovation will happen without a fiscal mandate.
- It is unclear how the refocus and restatement of a commitment to accountability will be implemented.
- The fiscal categories for state operations may not be sufficiently flexible over time to address evolving needs, especially considering the amount of technical assistance this proposal will require to be successful.
- It is crucial that the Governor and the Legislature can amend and adjust the language over time to account for unanticipated challenges rather than going back to the ballot.
- The details matter; how the state and the counties implement these reforms will determine if more Californians can access care and achieve recovery.
    - It is important to ensure that the state has an implementation plan that matches the scale of this statutory reform.
    - It is even more important to ensure that that implementation sufficiently engages the clients and families served by the behavioral health system.
- One of the goals of this reform should be to eliminate disparities in behavioral health outcomes. The best way to do this is to improve how California's diverse communities are engaged with and listened to.

Chair Madrigal-Weiss suggested that the Commission not take a vote on a position for SB 326 today, considering these outstanding concerns that require clarification. She asked to call a special virtual Commission meeting within the next ten days before the end of the legislative session to provide additional time for the Administration to respond to the Commission's concerns and to allow the Commission to vote on the final product after the amendment process is complete.

Chair Madrigal-Weiss again thanked Secretary Ghaly and his team for the time they have spent with the Commission to understand the concerns and thanked the speakers for their presentations. She stated that the Commission is excited to continue working on these important issues.

10: <u>Commission's 2024-2027 Strategic Plan</u>

Chair Madrigal-Weiss stated that the Commission will hear an update on recent community engagement efforts and draft plan components for the Commission's 2024-27 Strategic Plan. She asked the representative from the Boston Consulting Group (BCG) to give their presentation.

Anna Silk, Principal, BCG, stated that the BCG has been engaged by the Commission to help support the strategic planning process, particularly to help collect community input, which will be reflected in the strategic plan. She provided an overview, with a slide presentation, of the background, building blocks of the Commission's strategic direction and change model, and key insights heard from input collected.

Commissioners provided feedback, updates, and changes on today's topics for discussion:

<u>The Commission's Mission and Guiding Principles</u>

- Add “in California” so the Mission Statement will read “... changes across services systems so that everyone in California who needs mental health care ....”
- Add “changes within” to “changes across” so the Mission Statement will read “... transformational changes within and across service systems ....”
- Due to current legislation, possibly change “mental health care” to “behavioral health care” so the Mission Statement will read “... everyone in California who needs behavioral health care ....”
- Add “that supports an individual in their recovery and/resiliency journey” at the end of the Mission Statement so it will read “... receives effective and culturally competent care that supports an individual in their recovery and/resiliency journey.”
- Include “recovery” and “resiliency” in every area of the Commission’s work.
- Include “prevention” somewhere in the Mission Statement.
- Not only emphasize care but “services and supports.”
- Include the focus on disparities and health equity at large and the need to protect vulnerable communities.
- Include the need to be data- and metrics-driven in decision-making in the role the Commission plays in advancing that effort across the state.
- Add “including family and natural support involvement” so the Guiding Principle will read “transparent data-driven decision-making, including family and natural support involvement.”
- Include the need for agility and responsiveness in how the Commission makes decisions.

<u>The Commission’s Roles</u>

- Add “prevention, early intervention, and” under the Commission’s role of Catalyzing Innovation Across the Landscape so it will read “... adopt a culture of prevention, early intervention, and innovation in their approach ....”
- Prevention, early intervention, and innovation need to support individuals in their recovery and resiliency journey.
- All categories should be seen through the lens of cultural competency, equity, inclusion, resiliency, and including of families and natural supports. These should be a natural part of the process in everything the Commission does.
- Shared understanding, buy-in, and commitment. Consider how to merge interested systems not just by saying who oversees what, but to where the people who they serve get common messages and the people who serve others have common messages about what is important to support their physical and mental wellbeing in schools and the workplace.
- Advance a unified message. Individuals in schools must be well in order to promote wellness. It is not just whole-person, it is whole-community. Common messages must be sent across all systems.
- The lens should always be towards getting better. Getting better is a goal.

The Decision-Making Framework

- Policy project activities always need to include the Commission's Committees – the Client and Family Leadership Committee (CFLC), and the Cultural and Linguistic Competency Committee (CLCC).
- Priority-setting should focus on what should be done differently or in addition to what the Commission is currently doing.
- Review program outcomes to identify change and consider how outcomes can be measured, whether from program to program or from zero to start-up. It is important to demonstrate outcomes.
- The work that is being done can be missed if only data is considered. Site visits show tangible progress and success, yet the biggest impacts are being made by mom-and-pop programs. There is a gap that needs to be closed but money is not the answer.
- The Commission does not have control over certain pieces but it can shine a light on what needs to change.

Anna Silk deferred to Commission staff to discuss next steps.

Deputy Director Pate provided an overview, with a slide presentation, of the purpose and progress of engaging the community in the strategic planning process, opportunities to gather more feedback on the themes in the Decision-Making Framework, phases of the community engagement process, and next steps of the Commission's 2024-27 Strategic Plan. She stated that community partners are valuable experts; collaborating with partners will help to gain different perspectives on mental health issues to better understand the needs and priorities of different groups in the community. The draft strategic plan incorporating the feedback heard from the community will be presented at the November Commission meeting with a goal to adopt the final draft of the strategic plan in January of 2024.

Commissioner Comments & Questions

Commissioner Tamplen invited Deputy Director Pate and the team working on the strategic plan to provide an update at the next CFLC meeting.

Public Comment

Stacie Hiramoto stated appreciation for the individuals facilitating this process. She stated that they listen to the community and present in a way that is more meaningful. She stated that she attended a meeting on August 3rd for racial and ethnic communities, which she thought was for the community advocacy grants but it was listed during this presentation. She stated that the only people who seemed to be in attendance were people connected with the current providers. This is problematic. If the meeting was meant to collect information on the strategic plan, it should be separate from the community advocacy grants.

Steve McNally stated that the Commission is modeling the behavior everyone is hoping for in state agencies. The speaker commended the Commission for having a safe space where everyone can talk freely and information can be collected with easy access to online videos and information. The speaker noted that some of the concerns shared in today's meeting are things that cannot be controlled. Openness, transparency, and wanting community engagement are not part of

California's make up for state agencies. Until this changes, it will continue to be difficult. It should not be this way with all the resources and funding available in California.

Steve McNally stated the hope that, while continuing to fight silos in its own areas of work, the Commission will model those behaviors to help the public break down silos at other levels. Advocates can effect change when they are all on the same page.

Vattana Peong, Executive Director, The Cambodian Family Community Center, stated that The Cambodian Family Community Center has had success in engaging and empowering community members to make changes around language justice in Orange County. The measure of success does not have to be quantitative data to prove success. The qualitative data – the narrative from the community themselves – will prove that the Commission's work is making an impact in local communities.

11: <u>Anti-Bullying Social Media Report</u>

Chair Madrigal-Weiss stated that the Commission will hear a report out on the youth-driven social media strategy to address race-based bullying, including a demonstration of some of the digital features that provide peer-to-peer support for youth and share successes and future opportunities for youth-designed digital platforms. She stated that Commissioner Chen has chaired this effort and asked her to introduce this agenda item.

Commissioner Chen stated that, according to AB 1134, the Legislature has allocated $5 million to create and support a peer social media network project for children and youth, with an emphasis on students in kindergarten and grades 1 to 12 who have experienced bullying or who are at risk of bullying based on race, ethnicity, language, or country of origin. The project began in 2020, during the COVID-19 pandemic, as a response to increased levels of race-based bullying, especially directed towards the Asian Pacific Islander (API) community.

Commissioner Chen stated that a youth-driven advisory committee was formed that identified key priorities for the social media strategy. Since then, Media Cause, the contractor who developed and executed the youth-driven social media strategy to address race-based bullying, has worked with youth to build a digital peer-support network through social media. She stated that Media Cause has been invited to present the social media strategy and lessons learned from this project. She introduced the Media Cause representatives and asked them to give their presentations.

Melvin Karsenti, Senior Account Director, Media Cause, and lead on this project, provided an overview, with a slide presentation, of the background of the Right Our Story campaign. He stated that the team has been collecting stories since the campaign was launched last February.

Clara Campbell, Senior Director of Advocacy, Media Cause, continued the slide presentation and discussed the importance of hearing from the individuals being served. She discussed why stories are important and central to this campaign. She shared intimate and powerful stories gathered from young people in the community about being called names, shoved, ignored, and left out, being told to go back to where they came from, and daily being accused of being a terrorist – being alone and no one did anything about it.

Clara Campbell stated that the pain is lasting; the solution needs to be lasting, too. Bullying is more pervasive than ever, and the modern life school spectrum of being always online means that bullying

behavior is all the easier to practice and is widespread. It is surprising how serious these things are that young people are experiencing and at such young ages.

Clara Campbell stated that Right Our Story is a unique campaign and community that brings up the topics of race-based bullying, bullying, and mental health that holds discussions that are informed and led by youth and for youth. Right Our Story often hears from young people that these topics are not something they have had a space to talk about or share safely and connected on this topic, or that the only time or place that young people can remember seeing bullying campaigns or anyone trying to do anything about it is posters that go up in the hallways and then fade away.

Clara Campbell stated that it is important not to treat young people like that or to break their faith in this movement. Young people trust Right Our Story and Right Our Story is accountable to them. The Right Our Story campaign has over 8,000 members to date and is growing every day. She stated the need to continue and to build on this important work.

Clara Campbell showed a video of one of the Youth Advisory Committee (YAC) members advocating for the Right Our Story campaign. She showed several news articles and noted that the urgency and need for programs like Right Our Story has grown.

Melvin Karsenti provided an overview of how Media Cause began addressing this issue by building the Right Our Story ecosystem. Media Cause began by creating a home for the campaign, RightOurStory.com. The website provides viewers with the purpose of the campaign and invites them to share their stories and experiences of bullying in a safe and anonymous way.

Melvin Karsenti stated that the Right Our Story website includes a Community tab where young people can access the full library of stories and experiences of bullying, provide support to one another, have meaningful conversations, and share ideas on how to have a positive impact in their own community.

Melvin Karsenti stated the need to meet the audience where they are to get them to the website and to the community. This meant creating a social media presence, leveraging partnerships and advertising, both online and offline, via different tactics and platforms ranging from paid social media to influencer marketing to out-of-home advertising in community centers, malls, and major league baseball stadiums across the state.

Melvin Karsenti stated that this was done to create what is known as a “surround sound effect” around young people to catch their attention. He stated that, once Media Cause had young people’s attention, it offered them multiple ways to get involved, such as through sharing their story and community features on the website, as has already been discussed.

Melvin Karsenti stated that Media Cause hosted a virtual, statewide Week of Action during May’s Mental Health Awareness Month and Asian American and Pacific Islander (AAPI) Heritage Month, with multiple panels featuring inspiring young people and partners, such as the Youth Leadership Institute (YLI), AAPI Youth Rising, and other partners. The panel members shared ways to cope with bullying and some of the mental health effects and discussed solutions to race-based bullying.

Melvin Karsenti stated that Media Cause launched the “Bullied Button” tab on the website at the end of the Week of Action. It is an online tool where someone can log a bullying incident quickly, safety, and anonymously. This feature will help Media Cause understand and get the data about where and when bullying is happening in the state in order to develop future solutions to bullying. It is also another opportunity for young people to share their voice.

Melvin Karsenti discussed the central role that was played by the YAC and the YLI in the creation of this campaign. All these elements of the Week of Action were workshopped, proposed in some instances, or proven by the YAC. He showed a video of a member of the YAC speaking about the benefits of the Bullied Button and the importance of the Advisory Committee.

Melvin Karsenti provided an overview of the campaign progress from February 7th to July 31st, as follows:

- Total impressions: over 207 million
- Total social media engagements: over 147,000
- Website sessions: 432,000
- Paid ad clicks: over 1.6 million
- Right Our Story Members (social followers plus community members): 8,770
- Stories submitted: 298
- Bullied Button incidents: 467
- Partners engaged: 14

Melvin Karsenti stated that Media Cause's efforts have been noticed. More and more organizations have begun to reach out directly to ask how they can help spread the word or how to be involved in the campaign. He shared the story of the San Diego Padres, a major league baseball team in San Diego. They reached out to Media Cause after seeing one of the advertisements in the San Francisco Giants stadium while they were playing a baseball game there. Media Cause is now working with the San Diego Padres on a few Right Our Story brand activation on-sites in their stadium and also at multiple family events that they host.

Melvin Karsenti stated that Media Cause is also working on Right Our Story brand activations for Bullying Prevention Month in October. Media Cause is working with CAYEN and the California Association of Student Councils (CASC) on new content and new resources that can be shared with young people. The goal is to double the numbers highlighted earlier by the end of 2023. He asked the Commission to look further into the future and to imagine what could be done if this campaign continued through 2024.

Clara Campbell stated that Media Cause has built momentum and a strong foundation for growth, but noted that changing behavior and impacting society does take time. Behavioral change takes roots, consistent care, trust, relationship building, and dedication. In order to be serious in writing the story about race-based bullying and its impacts on young people's mental health, programs like Right Our Story need to be sustainable in order prove to young people that these programs are serious about allying with them to create change.

Melvin Karsenti stated that it is about young people and the future. Young people will set the next standards of how individuals treat one another. The team at Media Cause has hope from what was heard during the Week of Action panels. Young people are the people who will choose to support and give to some causes and not to others. They are the people who will age with the repercussions of the choices that they make. It is known that Generation Z cares and acts on a higher rate than other generations. Action-takers today who want to have a lasting impact know that lasting change deeply involves young people. Media Cause can give young people tools and commit to change alongside

them. By continuing this campaign into 2024, Media Cause can help young people build a better world not only for themselves, but also for the generations that follow.

Clara Campbell provided an overview of next steps for 2024 and beyond. She stated Media Cause would like to study young people's mental health and forms of bullying in video gaming, the world of technology, and how that intersects with the Right Our Story campaign. Video gaming is one of the social media platforms where cyberbullying happens most. Young people go to games to enjoy, entertain, and be creative. They sometimes play to compete and form connections and sometimes to escape the things that are happening in their lives. Video games are often thought of distinctly from social media but that is not the case. It is an important space that Media Cause needs to be in. One of the best places to address mental health and bullying, including race-based bullying, is in the gaming sphere.

Melvin Karsenti stated that Media Cause has learned that it is difficult to build trust and earn trust with audiences. Earning trust is an indicator of the success of campaigns. Building trust takes a long time; however, breaking trust is quick. Building trust is important in making inroads with the young people who were the audience during this campaign. This is about the young people who are feeling like outcasts, down, desperate, and alone as they face these issues today. This campaign is an investment but it is an investment that pays off richly both now and in the future.

Commissioner Comments & Questions

Chair Madrigal-Weiss stated that this is an important topic. She thanked the speakers for their work. She agreed that it will be young people who flip the script.

Commissioner Mitchell asked about the website and if the campaign includes dealing with anti-hate and respect.

Melvin Karsenti stated that the website is RightOurStory.com. The website includes links to the social media platforms.

Clara Campbell stated that Community tab on the website is primarily for young people and was created as a separate space distinct from social media. She asked Commissioners to contact Media Cause staff if they would like to explore the Community tab.

Clara Campbell stated one of the things learned is that there is a huge deficit in terms of acknowledging a definition to bullying. Media Cause researched and began to define the bullying experience as part of this campaign. The lack of a definition is one of the reasons Media Cause leads with stories that show what is included in the anti-bullying, race-based bullying umbrella, such as active hate, using offensive words to address someone, being hostile, being aggressive, and isolating someone. The stories shown as part of the fundamental components of the campaign help to define bullying. Media Cause staff classify and tag stories submitted to the website into different categories to demonstrate the different facets of bullying.

Commissioner Tamplen stated that this program is greatly needed. She stated that she appreciated the way the messages are framed to let young people know that they are not alone and appreciated that bullying is being defined by showing versus telling. She asked what the Commission can do or advocate for in order to grow this important project.

Melvin Karsenti stated that change and building trust take time. Media Cause needs more time and funding to continue this work, to engage with other partners, and expand the work to be embedded

in schools, and to include the gaming industry and the social network. He noted that Media Cause reached out to schools in the beginning of the project but it had nothing to show at that point – no momentum, no members. This is no longer the case. Media Cause would like the opportunity to build on the momentum they created to reach out to different communities to build on this work.

Clara Campbell stated that another important component of this effort is that it is being built through young people and is not just happening from the top down. Young people can find ways to bring this effort into schools in partnership with educators, but it is important to protect the core tenet of being youth-led and youth-driven. Young people have the greatest impact and influence on their peers. She noted that young people have thanked Media Cause for the Right Our Story campaign and stated that this is the first time they have been able to process and share their stories, because there is no other place like this.

Public Comment

Laurel Benhamida, Ph.D., Muslim American Society – Social Services Foundation and REMHDCO Steering Committee, stated that she was happy to hear about this project. She stated the presentation included reasons why a person might be bullied, but religion was not mentioned. It is important to be clear that religious bullying is a big problem. The Council on American Islamic Relations (CARE) California has reported over the years and done reports on bullying and other issues that affect children that note that bullying also comes from teachers. She encouraged Media Cause to share the feedback received from children who have been bullied based on their religion, and asked if children whose first language is not English can be included on the Right Our Story websites. This is also of great importance.

Stacie Hiramoto stated that this was a fine presentation and that she has many questions. She stated that she is not surprised to see that this presentation was the last item on the agenda – things that have to do with race and ethnicity often get put to the very end. She stated that she will reach out to Commissioner Chen offline because there are only a couple of Commissioners left in the meeting. She stated she would like to see this campaign continue but that she was interested in hearing what Commissioner Chen has to say.

Commissioner Chen stated the Commission's Anti-Bullying Advisory Committee has discussed wanting to engage more community members beyond youth from the beginning of the project, including teachers, parents, and others, but wanted youth to be at the core. She stated that the Advisory Committee was unable to discuss materials to put in front of parents and teachers to help facilitate these conversations, due to time constraints.

Commissioner Chen agreed with Laurel Benhamida's comment that expanding conversations around issues such as religion is important. She stated the hope that today's presentation will be the beginning of what can turn into a much longer and larger project. It is important to have this conversation, particularly in today's landscape. The data presented by Media Cause has shown early success. She stated the hope that it will provide a solid foundation to continue the conversation. She stated that the Advisory Committee has talked internally about being able to showcase better data for further support in expanding the scope of the project. She asked for everyone's support in doing that.

12: <u>Adjournment</u>

Chair Madrigal-Weiss thanked everyone for participating in today's meeting to continue the work and discussions around mental health. She especially thanked members of the public for their valuable input and participation. She stated that the next Commission meeting will take place on September 28th in Los Angeles. There being no further business, the meeting was adjourned at 4:25 p.m.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date September 5, 2023

Time 2:00 p.m.

Location MHSOAC
1812 9th Street
Sacramento, California 95811

Additional Public Locations

UC Berkeley SCET, 1923 Gridiron Way, CMS 122, MC# 1768, Berkeley, CA 94720
20151 Nordhoff St, Chatsworth, CA 91311
4665 Business Center Drive, Fairfield, CA 94534
700 S Flower St, Suite 1000, Los Angeles, CA 90017
8700 Beverly Blvd, Los Angeles, CA 90048
3551 Trousdale Parkway, Los Angeles, CA 90089
2000 Embarcadero Cove, Suite 400, Oakland, CA 94523
10474 Mather Blvd, Rancho Cordova, CA 95655
10850 Gold Center Drive, Suite 325, Rancho Cordova, CA 95670
6600 Bruceville Road, Sacramento, CA 95823
UCSF Sandler Building, 675 Nelson Rising Lane, San Francisco, CA 94158
6401 Linda Vista Rd, San Diego, CA 92111
2495 W March Lane, Stockton, CA 95207

Members Participating:

Mara Madrigal-Weiss, Chair*
Mayra Alvarez, Vice Chair*
Mark Bontrager*
Sheriff Bill Brown*
Keyondria Bunch, Ph.D.*
Steve Carnevale*
Assembly Member Wendy Carrillo*
Rayshell Chambers*
Shuo Chen*
Itai Danovitch, M.D.*
David Gordon*
Gladys Mitchell*
Jay Robinson, Psy.D.*
Alfred Rowlett*
Khatera Tamplen*

*Participated remotely

Members Absent:

Senator Dave Cortese

MHSOAC Meeting Staff Present:

Toby Ewing, Ph.D., Executive Director
Geoff Margolis, Chief Counsel
Tom Orrock, Deputy Director of Operations
Norma Pate, Deputy Director, Administration and Performance Management
Kendra Zoller, Deputy Director, Legislation
Melissa Martin-Mollard, Ph.D., Chief, Research and Evaluation
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 2:01 p.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.

Amariani Martinez, Commission staff, reviewed the meeting protocols.

2: General Public Comment

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), thanked the Commission for calling this meeting for another opportunity for comment on the Governor's proposal. She stated that she had hoped that the Client and Family Leadership Committee (CFLC) and the Cultural and Linguistic Competency Committee (CLCC) could have reviewed and provided feedback on the Governor's Proposal.

Richard Gallo, consumer and advocate and Volunteer State Ambassador, ACCESS California, a program of Cal Voices, stated concern that emails sent to Commission staff are not acknowledged or followed up. The speaker asked if their emails are shared with Commissioners since they are not included in Commission meeting packets as part of public feedback.

Emily Wu Truong, former CFLC Member, and National Speaker for the National Alliance on Mental Illness (NAMI) FaithNet Conference, stated concern about the mental health care system. She stated that she has been a mental health advocate for the past ten years but has suffered compassion fatigue and burnout for the past year and a half. She stated that she

does not have trust in the system and is even more traumatized due to being accidentally 5150'd one month ago. She shared her experience about feeling violated and no longer being able to go inside a hospital alone because she is in fear for her life. The police did not know what to do during the 5150. The hospital staff refused to communicate with her and kept her confined for several days with no outside contact, and now health care agencies are charging her $12,000. 5150 experiences are harmful and traumatizing, not helpful.

John Drebinger, Senior Advocate, Policy & Legislative Affairs, California Council of Community Behavioral Health Agencies (CBHA), a Member of the California Reducing Disparities Project (CRDP), stated that the CBHA has registered a neutral position on Senate Bill 326, noting concerns both to the author and administration. He stated appreciation for the fruitful conversations and amendments made to date, especially the inclusion of Community-Defined Evidence Practices (CDEPs). He thanked the Commission for its work, for providing a platform for stories like what was shared today, and for the community-based advocacy that has been working on refining practices for the work ahead.

Hector Ramirez, consumer, Los Angeles County Department of Mental Health, stated that Los Angeles County is one of the major beneficiaries of the Mental Health Services Act (MHSA) funding. Some of the concerns, particularly for equity-seeking populations, about the Governor's proposal are that Los Angeles County has begun its MHSA community process again but is doing it without providing materials in Spanish for Spanish-speaking Los Angeles County residents and without supplying disability accommodations, even though these were requested and multiple complaints were filed.

Hector Ramirez highlighted the inequities in Los Angeles County and stated that the Spanish-speaking population in Los Angeles County cannot equitably participate and benefit because of the lack of oversight that the Department of Mental Health or the county is not able to do. The speaker asked the Commission to remediate these issues.

Susan Gallagher, Executive Director, Cal Voices, thanked the Commission for hosting this forum. The speaker stated that the changes to the community advocacy grants during the last round moved the statewide focus for advocacy back to local communities. The speaker stated that this indiscretion is connected to bad legislation in the last few years, including the Community Assistance, Recovery, and Empowerment (CARE) Court. It may not have been so easy to pass if there was advocacy at the statewide level. The Governor's modernization proposal will change the mental health system without community input. The speaker encouraged the Commission to include statewide advocacy in the community advocacy contracts.

3: <u>The Governor's Modernization Proposal – Senate Bill 326 (Eggman)</u>

Chair Madrigal-Weiss stated that, over the last few months, the Commission has received several briefings on the Governor's modernization proposal and the language in Senate Bill (SB) 326, the implementing legislation carried by Senator Susan Eggman. The Administration has been generous with their time and has presented their proposal to the Commission as it has been modified, including just eight days ago.

Chair Madrigal-Weiss stated that the Commission will hear an update on the status of SB 326, with a focus on recent amendments, and consider taking a position on the bill. She stated that the bill recently passed out of the Assembly Appropriations Committee and will next head to the full Assembly for a vote before it returns to the Senate for concurrence.

Chair Madrigal-Weiss stated that the Commission has held off taking a position on the legislation as the Administration has shared along the way that major amendments were planned. It is now close to the end of the legislative process and the bill is in or near its final version. She asked staff to provide a brief summary of the status of the bill and the recent amendments.

Kendra Zoller, Deputy Director, Legislation, noted that there has been a series of amendments to SB 326, including amendments published today. She stated that staff did a cursory review of today's amendments for this presentation. A deeper analysis will be forthcoming. She provided an overview, with a slide presentation, of the tentative timeline, allocation comparison between the MHSA and the Behavioral Health Services Act (BHSA), major recent amendments, and impacts to the Commission. She stated that the BHSA has three funding buckets: 30 percent Housing Interventions, 35 percent Full-Service Partnerships (FSPs), and 35 percent Behavioral Health Services and Supports (BHSS) bucket, which serves as a catch-all.

Deputy Director Zoller noted that there is a new Innovation Partnership Fund component for $20 million annually under the 35 percent BHSS catch-all bucket. The Commission will provide technical assistance to counties and award grants under the Innovation Partnership Fund to private, public, and nonprofit partners to promote development of innovative mental health and substance use disorder programs and services.

Deputy Director Zoller stated that today's amendments included language that community-based organizations and CDEPs would be under Early Intervention in the BHSS bucket and added the goal to reduce disparities.

Deputy Director Zoller stated that the bill includes adding 11 new Commissioners for a total of 27. New language in print today includes that the Commission may establish a reducing disparities committee focusing on demographic, geographic, and other communities.

Deputy Director Zoller stated that the Commission will be required to publish recommendations for the state in collaboration with the Department of Health Care Services (DHCS), based on data from technical assistance and a robust community engagement process focused on priority populations and diverse communities, and to publish a report that includes recommendations for improving and standardizing promising practices for BHSA programs in collaboration with the DHCS, the California Behavioral Health Planning Council (CBHPC), and the County Behavioral Health Directors Association (CBHDA).

Commissioner Comments & Questions

Chair Madrigal-Weiss stated that the Commission has made considerable progress in its work for transformational change over the years:

- School mental health has been embraced across the state in ways it could not have been imagined five years ago.
- Public awareness of the need for suicide prevention is increasing, and the Commission's suicide prevention efforts are continually improving.
- Stigma is down, and community support for mental health is up.
- The Commission has made gains in early psychosis, youth drop-in, criminal justice diversion, and community engagement.

Chair Madrigal-Weiss stated that, at the same time, California has an addiction crisis, a housing crisis, and a workforce crisis, and it continues to be difficult to access care when needed. Too many families must resort to calling law enforcement as a first response to unmet mental health needs. Also, disparities are not yet trending toward equity. California needs to do something differently. She noted that, although she does not agree with everything in SB 326, it brings a renewed commitment to getting the job done and it preserves the Commission's authority and capacity to ensuring that that happens.

Commissioner Brown asked about amendments for the circumstances where the Legislature can amend the MHSA.

Chief Counsel Margolis stated that, because this is an initiative, to the degree that any of these provisions are part of the new initiative that will go on the ballot, they need to go back to the voters for approval. The MHSA, under Proposition 63, has a special provision that the Legislature by a two-thirds vote can pass legislation if it furthers the purpose of the Act or makes technical or minor changes. It depends on whether the language comes out of the existing Proposition 63 because, even though the BHSA is large and encompassing, it does not take away everything. There are still provisions in the law that come out of the MHSA. It depends on the circumstances of each situation as to whether the Legislature can modify the language and then by what standard going forward. Generally, it must go back to the voters if it was on this ballot and this initiative is passed this spring.

Commissioner Brown stated that he was struck by the number of additional Commissioners being proposed in these amendments. 27 individuals on a Commission is exceptionally large, which will make it difficult for discussion and agreement and for business to be done efficiently. He asked if there is another state Commission with this number of Commissioners.

Executive Director Ewing stated that there are other larger Commissions such as the CBHPC. The makeup of the new seats at the Commission show areas of interest that the Governor and Legislature are encouraging the Commission to include, such as housing, reducing disparities, and substance use disorder (SUD) seats. He agreed with Commissioner Brown's concern about the complicating nature of scheduling and achieving a quorum with 27

Commissioners. Although staff has brought this to the Administration's attention, they felt strongly that more seats at the table were important.

Commissioner Chambers asked if the workforce amendment includes anything to resolve the number of peer support services that are potentially lost with the reduction in the community supports and services (CSS) bucket. Most peer support organizations have funding under the MHSA and do not currently bill Medi-Cal. She asked about solutions addressed in these amendments. If there are no proposed solutions, the whole workforce and services will be completely wiped out.

Deputy Director Zoller stated that she is still reviewing the amendments but has seen nothing about solutions for CSS yet. The workforce initiative language has no additional language to what was on her presentation slide – that a portion of the workforce initiative may focus on providing technical assistance and support to county and contracted providers to maximize the use of peer support specialists.

Commissioner Chambers asked for verification that there are no amendments to address how peer support services will operate outside of MHSA funding.

Executive Director Ewing stated that the Governor's proposed behavioral health reform is massive and there are several initiatives that lay out an agenda and call for the state, through various departments, to push in those areas where the specific policy or practice changes that need to be put in place would come later. For example, this proposal is tied to California Advancing and Innovating Medi-Cal (CalAIM) and other reforms that the state is working towards.

Executive Director Ewing stated that the conversation staff has had with the Administration is that the details matter moving forward. The first step is to put this policy change forward, but it must be followed up with intensive community engagement and conversations to ensure that the day-to-day work results in the outcomes the Commission wants to achieve, including considering how to ensure that workforce needs are met with heavy emphasis on peer strategies.

Executive Director Ewing stated that not everything is being addressed in the statute. It is meant to lay the foundation for conversations moving forward as reflected in several instances where there is significant discretion on the part of the DHCS or, in the case of workforce, the Department of Health Care Access and Information (HCAI). The good news is that the state is embracing the workforce challenge as evidenced by the fact that the funds are being allocated at the state level, but there is more work to do to ensure that peer strategies are reflected in fiscal policy, training, and practice implementation across the state so that, when individuals walk in for services, they know what to expect and that there is consistency including respecting peer roles.

Executive Director Ewing stated that the intent is that enhancing access for federal funding and commercial coverage, improving utilization of Medi-Cal Managed Care dollars, and clarifying how these funds can be used for that broader array of services would result in a net gain, but it is unclear how this will happen. The policy piece must first be put into place to

tackle the changes that have long been unaddressed. The follow-through on implementation will be important.

Commissioner Tamplen stated that the challenge that has remained is that California is in a housing crisis. She stated that she wished there would have been additional, consistent resources to support the services needed and to continue growing the services versus chopping MHSA dollars up, moving them around, and restricting access to the funding that is necessary for services to happen. She stated that the prevention piece is missing. Prevention needs to be done locally.

Commissioner Tamplen stated that it is difficult to be here to see something that was originally well thought through with the community and advocated by many individuals across the state but now has so many individuals advocating against it. She asked what the population-based prevention is.

Deputy Director Zoller stated that population-based prevention was moved to the state level to the California Department of Public Health (CDPH) to provide population-based mental health and substance use disorder prevention programs.

Commissioner Tamplen stated concern that prevention is decreased to 4 percent and that local counties will be unable to meet the needs of prevention necessary to help keep individuals out of hospitals and get the support they need before it turns into crisis.

Commissioner Bunch stated that the Commission already faces scheduling challenges. She noted that adding 11 more members to the Commission will add to that logistical concern.

Commissioner Bunch asked if the Governor's proposal includes an evaluation period to at least see if there are unintended consequences of the housing set-aside on mental health services.

Deputy Director Zoller stated that implementation and the effectiveness of programs and services in the housing bucket will be evaluated through the county planning process, the data counties are required to send annually to the DHCS, and the state audit every three years.

Commissioner Bunch asked about the timeline for the first evaluation.

Deputy Director Zoller stated that the evaluation will begin after the effective date for the funding bucket section, which is July 1, 2026.

Executive Director Ewing added that the language preserves the Commission's independent authority to review the implementation process at any time on top of regularly-scheduled audits. He noted that the audit contains a component to verify that a high level of collaboration between the Commission, DHCS, HCAI, and other participating departments is maintained.

Commissioner Rowlett acknowledged that there is a crisis as it relates to unhoused individuals in California but stated that he does not believe that a disproportionate number of those individuals are homeless due to untreated mental illness. There is a unique housing

challenge in California that must also be addressed, including for individuals without symptoms associated with mental illness.

Commissioner Rowlett stated that the MHSOAC is an independent Commission with oversight responsibilities. He stated that it does not make sense that the oversight and accountability commission will not have an oversight role, especially as it relates to the list of bullets under the no oversight role statement.

Executive Director Ewing stated that the latest round of amendments, while it did not recreate the existing statutory language, reaffirmed the Commission's oversight role in anything related to behavioral health in more expansive statements through the Commission's capacity to promote transformational change, undertake reviews, and recommend progress.

Commissioner Rowlett stated that the MHSA funds important outpatient services in many counties. Funding for existing outpatient services will now be under the category of General Systems Development or GS funding. He stated concern that the impact on the existing outpatient system will be harmful and is not being talked about.

Executive Director Ewing stated that impacts to traditional outpatient care are uncertain because of the package of reforms, including the new Medicaid waivers, access to commercial insurance, the standards that the DHCS will put in place for care, and the language around early interventions. There is no program-by-program analysis showing what that would look like in terms of revenues available to cover care.

Commissioner Rowlett asked staff to get clarification on the intent of the language on the specific oversight role of the Commission, and to project or illustrate possible impacts on existing services.

Commissioner Mitchell asked if there is conversation regarding making access to care simpler for families to obtain when they are in crisis.

Executive Director Ewing stated that part of the conversation with the Administration is around the importance of the implementation strategy being aligned where the community is.

Commissioner Carnevale stated that, although this proposal is challenging and still has many issues to work through, the Governor's office is aware of the issues, committed to working through them, and taking the input of the Commission into consideration. This Administration is more aligned to the goals and values of the MHSA than any previous Administrations. The Commission is a platform for the voices of all constituencies to be heard; he stated the hope that the entities making these decisions would choose to help instead of harm, and, in the meantime, encouraged the Commission to continue promoting the voices it protects.

Vice Chair Alvarez stated that modernizing the MHSA is a tremendous opportunity. The Commission has made positive changes with limited resources in the past. She encouraged the Commission to use its experience and wisdom in this opportunity to make greater

changes. It is because of the work of the Commission, advocates, and communities that the amended language has significantly changed. It has greater attention on children and young people, it strengthens the role of this Commission, and it gives attention to innovation. She stated appreciation for the work and advocacy that went into evolving this language and for the commitment to partnerships from this Administration and California Health and Human Services Agency (CalHHS) to find ways to evolve the language to give credit to the incredible amount of work that the MHSA has done in these two decades.

Vice Chair Alvarez stated the need to continue to focus on upstream prevention activities that do not require a diagnosis for children but that allow services to be given to children at the county level.

Vice Chair Alvarez stated that she wanted to give attention to the ongoing role of the Commission and the commitment to partnership with the DHCS that has evolved over her time on this Commission. She stated the need for it to further evolve while trying to create one system of care for California so that, whatever door an individual comes in, they will get the services they need to support their mental health and wellbeing.

Vice Chair Alvarez asked staff to report on those shifts, particularly about the Commission's role and the partnership between the DHCS and the Commission and the work the Commission is already doing with community engagement projects such as Schools and Mental Health, Gun Violence, and peers. This is critical work and the Commission can bring an incredible amount of partnership and leadership to the work ahead. She asked for more information about that role and opportunity as a result of these changes at a future meeting to help inform decisions moving forward.

Executive Director Ewing suggested inviting Secretary Mark Ghaly, M.D., MPH, to present at a future Commission meeting to create clear expectations and to ensure that the lines of communication that have been established through this process remain open.

Commissioner Gordon agreed with Chair Madrigal-Weiss and Commissioner Carnevale that the efforts of the Administration have been extraordinary. He stated that the Commission is full of knowledgeable, astute leaders. Much of the innovation work that was done, proposed, carried through, and carried on has also been extraordinary. Times change. It is not smart to let the perfect become the enemy of the good because it is a work in progress. He stated that he has had the opportunity to work closely with many of the Governor's staff people. They care and are in this for the right reasons - they want to make changes that will enhance opportunities for health care for every individual in California.

Commissioner Gordon stated concern about prevention and early intervention in the Governor's proposal. Catching individuals early enough, between ages zero to five, keeps them from ending up in the criminal justice system. Opportunities have now been taken to do screenings and treatment and to sell the notion of wellness and prevention at schools, where children spend a part of every day. There is still a long way to go, but the efforts of the Commission have made extraordinary changes. This momentum must be kept going by working with the Governor's initiatives.

Commissioner Gordon stated that the Commission needs to remain independent and not chained to the Administration or the system. The Commission still has an opportunity to comment on the state of change and of progress so that, if housing is taking out too large a proportion of funding that is needed to move the system, that gets called out and the state has an opportunity to make that right in the spirit of the original Commission mission. He asked for assurance that the Administration will be open to the criticisms of the Commission, not as criticisms to put things aside, but to make it better.

Executive Director Ewing reassured Commissioners that the amended language preserves the Commission as an independent voice that is advisory to the Governor and the Legislature. The authorizing statute explicitly directs the Commission to call out whether sufficient progress is being made in the goals that the Commission determines are important.

Commissioner Robinson stated that he is proud to be in a state that recognizes mental health and has a level of commitment to address mental health needs. He stated that he shares Commissioner Rowlett's concerns about the oversight Commission having no oversight role. He stated the need to better understand that.

Executive Director Ewing stated that the Administration has used language that it is less about compliance and more about driving quality improvements in terms of the kinds of work the Commission has been doing. He stated that, while the words have changed, the ability of the Commission to render an opinion remains. There is no functional difference between the two.

Commissioner Robinson stated that the Governor's proposal names the Commission as a member of the BHSA Revenue Stability Workgroup. He asked if that means the Commission has a voice among many other voices, and if the Commission has an oversight or leadership role in that because revenue stability is key to effectiveness.

Executive Director Ewing stated that one of the issues that has challenged the MHSA for several years is the Prudent Reserve Standards. The tension is between putting a percentage of resources into a prudent reserve to weather a downturn in revenues at any point in time versus having those revenues available for use. The language calls for the formation of a workgroup to help determine how to balance those tensions.

Executive Director Ewing stated that, although the Commission is one voice on that workgroup, it has that independent authority to express itself should whatever resolution come out of that be inconsistent with the Commission's perspective.

Commissioner Robinson stated that innovation is one of the most compelling aspects of the Commission, but the proposal changes the role of the Commission from overseeing innovative programs to administering innovation in partnership. He asked for additional details about this change.

Executive Director Ewing stated that the innovation component of the MHSA has evolved to where, although the dollars were held by the counties, the Commission was increasingly identifying investment opportunities while working with counties. The Commission often

funded the development of innovation proposals, but the work was funded by the counties. He stated that the Administration envisions that, between the $20 million SB 82 Investment in Mental Health Wellness Act grants, which the Commission has been using as incentive funds to encourage local partners to adopt effective practices, and the $20 million in innovation funds, the Commission will learn what is effective and how to incentivize it.

Executive Director Ewing stated that the amended language reflects the conversations the Commission has been having with the Administration about the importance of innovation and the opportunities to leverage the collective voice of what will be 27 Commissioners.

Executive Director Ewing stated that the push to leverage the private sector and others outside of the behavioral health sector to support innovation in ways that can drive quality at a systems level is somewhat new. The Governor's proposal is an expansion of the opportunity that the innovation dollars represent with direction that the Commission will decide how best to use that investment.

Commissioner Brown added clarification to his statement at the beginning of this discussion where he asked questions and voiced concerns, particularly about the size of the Commission as amended. He stated that the Governor's proposal is bold and, in some ways, risky to fundamentally change the MHSA. It proposes significant change. Change, in and of itself, is usually painful for organizations and individuals, but great accomplishments are not achieved without change, without some risk, and oftentimes without some grievance.

Commissioner Brown stated that there are many organizations, individuals, and advocates who are concerned about the Governor's proposal. He stated that he appreciates those concerns and that he has concerns himself about the significant expansion of the Commission size and, as a result, its ability to efficiently conduct business. However, he stated that, on balance, he gives great credit to the Governor for a bold approach to address two of California's most vexing problems – homelessness and substance abuse – each of which exists in concert with and exacerbates mental illness. California is in the midst of a crisis and something other than the status quo must be done.

Commissioner Brown stated that the Governor's proposal provides the opportunity to modernize the system and address the extraordinary size and scope of the perplexing problems of homelessness and substance use. Just like any other proposal to solve difficult problems, the plan is not perfect. He agreed with Commissioner Gordon's statement about perfection being the enemy of the good, and ended his comment with a quote from General Omar Bradley, who once said, "A good plan enacted swiftly is better than a perfect plan enacted too late." The time has come for the Commission to embrace the boldness of the proposal at hand.

Commissioner Danovitch stated appreciation for the Commissioner discussion. The range of concerns, the grappling with complexity, and the perspectives articulated demonstrate the strength of this Commission. He stated that he also appreciates the concerns raised by the members of the community, and the real and legitimate fears and worries about how so much of what has been achieved will be maintained. He stated appreciation for Commission

staff who have worked closely with the Administration and the DHCS to significantly alter, modify, and improve the legislation that is now before the Commission.

Commissioner Danovitch stated that, for the Commission to fulfill its ultimate mission, one of the areas of struggle has been improving the alignment and cooperation with the DHCS. This is more written into this version of the legislation and it is being manifested more by the leadership of the DHCS communicating with the Commission and expressing commitments to continue to do that. That cooperation is necessary to manifest the systemic change that everyone wants and that continues to need to be done. Notwithstanding the many concerns and risks, he stated that he is ultimately in support of the Commission moving forward with the Governor's proposal.

Commissioner Rowlett stated appreciation for a diversity of opinions. He recognized that, as it pertains to the existing service array, his questions and concerns about the implications there were noted by staff. He stated that, while staff has not had an opportunity to look at what some of the implications might be as it pertains to the expansion of services to include people with SUD issues, he agrees with Commissioner comments about the importance of that.

Commissioner Rowlett stated that he also recognizes that, even now, community members are expressing concerns about existing services not being included in the Governor's proposal. He stated that many of these services include engagement strategies that work particularly well in communities of color, especially in the Black community, which, in Sacramento County, is overrepresented in the unhoused count. He agreed with Commissioner Brown that California has a horrific problem that must be solved. He stated appreciation for the attention this problem has been given without disparaging the people who are experiencing the blunt end of the problem. Community-defined practices have done amazing things to engage and ameliorate some of those challenges.

Commissioner Rowlett stated the hope that staff will provide the Commission with potential illustrations that look at some of the downsides because there is always a cost and a benefit when expanding the individuals being served. He stated that he looks forward to hearing more about that from staff at a future meeting.

Public Comment

Sean Kelson stated that many have shared that the potential of defunding the safety net that exists, due to the many MHSA-funded peer support programs, will likely be devastating. The robustly choiceful no-wait-list services are lifesaving for many, help keep individuals out of higher levels of service, and help support them with connection and community to get into higher levels of services that offer a full continuum of care. So many of these services are what is right with the system. Defunding them, as another peer has stated at a different meeting, is like selling off the fence at the top of a cliff to pay for more ambulances down below.

Sean Kelson stated that many individuals have shared that, if this proposal passes, the loss of hope, trust, community, and connection is of great concern. Pretending that Medi-Cal billable

peer support can or will replace these services is unrealistic. There is a place for Medi-Cal billable peer support but not instead of these more choiceful services that are working and that are the safety net. The speaker stated the hope that communities across the state can recover from this erosion of trust should this come to pass.

Tiffany Elliott, Project Manager, Painted Brain, speaking as an individual, stated concern about how there is much more to do in this late hour. The housing portion of this proposal and what the proposal will do to peer support within California are still unknown, although there are already locations that are talking about defunding peer support positions. She questioned the lack of response to the many concerns expressed about the speed with which this proposal is going through. The peer community talks about "nothing about us without us." This should not be an afterthought; peers should be at the front of the table in these discussions. The peer voice needs to be heard from the beginning of the process. She asked for additional time to gather robust peer input.

Patricia Wentzel, Mental Health Advocate and Member, Sacramento County Mental Health Board, speaking as an individual, stated that the Sacramento County Behavioral Health Services Department has advised that they expect to see a 65 percent reduction in the funding available for outpatient and crisis services in Sacramento County, if this bill passes as currently amended. She noted that, even if the 7 percent flex option is used, it would mean that the FSP would drop from 38 percent of funding to 28 percent of funding. Even if 7 percent was taken from the housing bucket as well, it would still only increase the behavioral health services bucket from 17 percent to 24 percent. It will not solve the problem with defunding current services, including non-billable Medi-Cal services such as case management services that help individuals to maintain their housing. She stated that the potential for there to be a new wave of individuals with severe mental illness becoming homeless because they have lost the services that help them maintain that housing is real, based on conversations with local Behavioral Health Services Department.

Patricia Wentzel agreed with the concerns brought up by Commissioner Rowlett. She stated that the current requirement in Sacramento County for only 25 percent of the housing bucket to be spent on capital development is an issue because Sacramento County is already spending that much money in capital development now from FSP funding. Sacramento will not be able to build anything more than it is already building and there is no property to rent or lease. She urged the Commission to oppose the Governor's proposal.

Karen Vicari, Mental Health America of California (MHAC), stated that MHAC is opposed to SB 326 for many reasons. She highlighted two concerns:

- While SB 326 does not specifically cut programs, a loss of funding from mental health services absolutely will result in a reduction of services. She stated that she has heard the Administration and today she heard the Executive Director saying that, with all the new programs the state is coming out with, such as CalAIM, the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) waiver, the Children and Youth Behavioral Health Initiative (CYBHI),

etc., there will be plenty of funding for community-based services, but no one knows what the state's landscape will look like once those programs are implemented. The MHSA was intended to fill gaps in the system, and until those programs take effect, the gaps will remain unknown. An effective modernization of the MHSA cannot be written without knowing what the system will look like.

- The community engagement process is another big concern. The California Code of Regulations, Title 9, Section 3300 requires training of county staff and community members. SB 326 makes this optional. The Welfare and Institutions Code Section 5892 requires counties to pay for the costs of consumers and other community members to participate in the planning process. This has been entirely removed from the MHSA. The planning process has also been changed to every three years instead of every year. The planning process is essential to the success of the MHSA. It is essential to know the needs of the local community.

Karen Vicari stated that it saddens her to have heard words from Commissioners such as "half-baked," "risky," and "work in progress." Something this substantial should not be rushed through the process. She urged the Commission to oppose SB 326 or, at the least, remain neutral.

Susan Gallagher stated that many individuals got concessions in the amendments but consumers did not. Consumers look to the Commission to stand in the gap for them. The Governor's proposal will disrupt services for at least 250,000 individuals in California by shifting funding away from the CSS bucket into housing. The state of California has spent $20 billion on housing over the past three years and the state auditor is currently in the process of auditing that funding. The speaker stated that, until that audit determines where that funding went and if it was spent well, it is not prudent to hand the MHSA funding over to them.

Susan Gallagher stated that the community has been requesting mandated peer support throughout the continuum of care – that individuals would be eligible to receive mandated peer support services, whether they are Medi-Cal certified or not, but that throughout the continuum of care peer support should be part of the equity lens, including individuals who have been disabled with mental health conditions. This is vitally important. The state of California has a bad reputation for employing peers. California needs to do a better job at employing peers and expanding the peer workforce, but peers have been left out of the discussion. The speaker stated that for the Commission to make deals with the Administration without peers at the table is heartbreaking. The MHSA will go away and peers relied on the Commission to stand up for it. The speaker urged the Commission to oppose SB 326.

Susan Gallagher stated that bringing in commercial insurers such as Medi-Cal Managed Care into the specialty mental health system is problematic. They do not come under the MHSA guidelines or under the mental health board. Their authority is only to insurance companies. The speaker noted that this needs to be thought through. It is a bad plan.

Stacie Hiramoto acknowledged that the Administration did make many suggested amendments regarding reducing disparities. REMHDCO is grateful. She thanked Vice Chair Alvarez for talking about up-stream prevention because this is one of the issues that REMHDCO wanted to focus on because, although the MHSA was not only for individuals with serious mental illness, it was also for up-stream prevention. She stated that REMHDCO tried to make it clear that CDEPs could be utilized in both prevention and early intervention. She stated that, although the Administration is working toward that, REMHDCO wanted them to say that, for early intervention, a diagnosis is not required.

Stacie Hiramoto thanked Commissioner Rowlett for acknowledging the value of CDEPs because the community was successful in getting that into the bill. She stated that it is difficult for the Commission to take a support position when the amendment only just came out and there are so many issues.

Tara Gamboa-Eastman, Senior Advocate, Steinberg Institute, thanked everyone for the rich discussion. She spoke in support of SB 326.

Clare Cortright, Policy Director, Cal Voices, stated that they are a consumer and a person who benefited from and whose life was saved and changed by the MHSA, which provided them services when they did not have insurance. The speaker stated that no one is truly in favor of this bill as it stands. The Commission should come out in an unequivocal opposition today. Cal Voices is disappointed that the Commission has not done so already but is sympathetic to the fact that there is a great deal to digest in order to comment on the amendments intelligently.

Clare Cortright stated that the Administration has yet to respond to any of the points raised by the Legislative Analyst's Office (LAO), counties, or members of the public. The speaker noted that it is mathematically impossible that services will not be cut. The Administration has not offered an analysis, data, or a plausible argument as to why this massive cut to services and moving from MHSA as it currently exists to SB 326 is an improvement. The speaker questioned how and why SB 326 would result in better services, more satisfied clients, or better outcomes. The human toll of cutting services is entirely foreseeable and it ranges from destabilization to loss of life.

Le Ondra Clark Harvey, Ph.D., Chief Executive Officer, California Council of Community Behavioral Health Agencies (CBHA), stated that the CBHA is hopeful to continue dialogue with the Governor's Administration and the Legislature in these final weeks and appreciated the amendments made thus far. The speaker thanked Commission staff for the overview of the new amendments.

Le Ondra Clark Harvey stated that the CBHA members would like to see the following areas addressed in the Governor's proposal:

- Accountability for managed care plans.
- Clarification around the division of prevention and early intervention.

- Consideration around combining prevention and early intervention to allow counties to utilize the funding in that bucket as needed based on the needs of the Medi-Cal recipients in their various counties.
- Flexibility to be restored as much as possible to FSPs.

Le Ondra Clark Harvey stated the need to stay true to the tenets of FSPs. Some of the accountability that was built into the amendments for providers was restrictive.

Danny Thirakul, Public Policy Coordinator, California Youth Empowerment Network (CAYEN), stated that CAYEN vehemently opposes SB 326. He stated that homelessness is primarily an affordable housing issue and not a mental health issue. The state oversees multiple programs for reducing homelessness and has spent billions of dollars trying to solve a housing crisis and it is still no closer to the intended outcomes. All other means of addressing these issues have not been exhausted, such as rent control, holding municipalities accountable for building the required housing, or focusing on the high cost of living in California.

Danny Thirakul stated that the Administration should be having those conversations and looking at those possible solutions, but only then should the discussion of using MHSA funding be had. SB 326 bypasses this process of engagement, discussion, and planning and rushes a proposal that may not reduce the number of unhoused but instead may reduce mental health services. The MHSA should not be reallocated. He stated that the funds to continue to serve the most vulnerable populations with serious mental illness so that they may receive the supports and services they need, including the housing interventions, which are already allowed and available in FSPs.

Danny Thirakul asked the Commission to vote against supporting SB 326.

Sharon Jennings, consumer and advocate, and former legislative employee in the Senate, stated that this process has not been transparent. When the county introduces a proposal, it is posted for public review for a period of 30 days. The speaker noted that the efforts of the Administration are noble but their approach is incorrect.

Sharon Jennings suggested asking the Federal Emergency Management Agency (FEMA) for assistance, given that homelessness is a nationwide disaster and that 30 percent of this population is in California. The speaker asked Commissioners to use their collective voice to shout loudly by voting no to SB 326.

Steve Leoni, consumer and advocate, stated that, at the table 20 years ago when the MHSA was being crafted, the speaker spoke about the core of what makes the MHSA the MHSA. Many people were concerned 20 years ago to take more people into the communities instead of in Institutions for Mental Diseases (IMDs), which alienated people. Counties generally did not have enough money or they did not understand how to support those people. The speaker stated that the MHSA was meant to provide a program and money to bring people into the community, which was much more effective, and to reduce the overall use of involuntary care.

Steve Leoni stated that the Governor's proposal will now make modifications to this. FSPs will be standardized with levels of care and step-downs. The step-downs are based on acuity. The speaker stated the need to talk about severe and persistent mental illness. Now, if a person is less acute, they can step down to lesser services when maybe the greater services were helping to keep the person well.

Steve Leoni stated concern that the most intensive level of the FSPs might be voluntary. The speaker stated the hope that they were wrong. The language as it is written leaves it open. The speaker asked the Commission to look into this.

Holly Tan, Community Advocacy Manager, California Pan-Ethnic Health Network, (CPEHN), stated that CPEHN holds an oppose unless amended position on SB 326. CPEHN is in the process of reviewing the amendments that recently went into print. She stated that, while CPEHN appreciates the changes to consistently apply the use of CDEPs, particularly for early intervention services and the expansion to include a Commissioner who is knowledgeable on CDEPs, CPEHN remains concerned about the lack of specific and actionable focus on racial disparities in SB 326.

Holly Tan stated that the lack of specific and explicit benchmarks pertaining to racial equity will risk leaving thousands of communities of color behind and further exacerbate the behavioral health crisis for underserved communities. She stated that CPEHN would like to uplift the following additional concerns:

- Substance use disorder treatment and housing interventions are now optional for counties, which contradicts the vision to encompass behavioral health more holistically under the MHSA. This is discriminatory and will invite implicit bias when determining who receives services.
- The proposal fails to leverage resources across the continuum of care and will stretch limited resources to a breaking point. Health plans have an obligation to provide behavioral health services. SB 326 fails to account for their mandated responsibilities and instead places continued burden on local health care providers.

Holly Tan asked the Commission to take these concerns into consideration.

Lauren Rettagliata, family member of a loved one who has lived on the streets and has a serious mental illness and an addiction, implored the Commission to listen to the wisdom of modernizing the MHSA. A good bill is made better by modernizing it. That is what is needed. The speaker stated that they met many parents and family members who marched the streets asking to pass the MHSA. Loved ones are the ones who are not getting the care that they need. Legislators have worked hard on modernizing the MHSA and have been listening to communities who contact their offices.

Laurel Benhamida, Ph.D., Muslim American Society – Social Services Foundation and REMHDCO Steering Committee, agreed with individuals who are unhappy with this bill and who were not at the table during the drafting of the bill. She stated that this bill is being legislated at such a speed that unwise decisions are being made. Despite some of the

amendments mentioned by Stacie Hiramoto and others, there are large problems. For example, California is short one million units of housing. To solve that, all mental health services would need to be cut to give to housing.

Laurel Benhamida stated that CalMatters has a good article about what Karen Bass is trying to do in Los Angeles on this issue. They can get people off the street and in houses but they have no services. They do not have the staff to solve the problem. There are no bilingual clinicians to provide clinical services. There are many problems. For example, people on the street will have a better chance of receiving mental health services if they first become addicted. She stated that she sees California being left with a large mess to clean up while the politicians move along in their careers.

Hector Ramirez stated that modernization needs to happen. In California, one out of three Latino youth are considering suicide, even though billions of dollars have been spent. The speaker stated that, although the Latino community represents the largest ethnic population in California, it remains grossly underserved by the MHSA in counties because populations are not prioritized or served correctly. The peer certification movement in Los Angeles County, in a very racist and discriminatory way, completely disenfranchised Latino community members and promotoras.

Hector Ramirez stated the hope that this modernization act will focus on consumers who try to attend Commission meetings and must deal with hostility from the Commission. The speaker stated that, as communities attend Commission meetings seeking help because they cannot get help from their mental health commissions and boards of supervisors, the speaker stated the hope that they will not only be able to share concerns but that the Commission will listen and take action or direct them to the right resources. This Commission became a wrong place for communities to try to seek help. This is one of the reasons the modernization should happen. The Hispanic community is underserved and grossly inappropriately served by this Commission. The speaker stated the hope that this Commission will elevate and advocate for the Hispanic community.

Commissioner Discussion

Chair Madrigal-Weiss asked for a motion on SB 326. She stated that when the Commission takes a position on legislation, staff communicates the position to the Governor and Legislation in the form of a letter. She asked, due to the significance of this legislation and the tight timeframe for taking a position, that the motion include direction for staff to prepare the letter to reflect the Commission's position and to be signed off by the Chair before it is submitted.

Chair Madrigal-Weiss recommended that the Commission take a support position, with the following concerns:

- Community engagement – the language of SB 326 was not developed through a community engagement process. That needs to be remedied with a robust commitment to engagement with peers and families on implementation, particularly for any accountability strategy.

School mental health – as a follow-up to SB 326, the state needs to establish or at least clarify leadership and accountability for sustaining attention on school mental health after the CYBHI sunsets.

Disparities – all behavioral health reform efforts need to focus on addressing disparities and achieving equity for the communities most impacted by unmet mental health needs, including native communities, Black, Latino, LGBTQ, veterans, and others.

Prevention – the Governor's proposal emphasizes care delivery and early intervention. Although necessary, the proposal should also emphasize prevention. More work is needed to lead with prevention in everything done in the behavioral health space.

Chair Madrigal-Weiss asked Commissioners for feedback.

Commissioner Carnevale moved to support SB 326 and direct staff to write a letter to the Governor and Legislature outlining the concerns discussed.

Commissioner Chambers asked to add the concern about peer support and the need to mandate peer support services or at least to ensure that peer support services are preserved.

Commissioner Carnevale agreed to add Commissioner Chambers's friendly amendment.

Vice Chair Alvarez seconded.

Commissioner Rowlett asked to add the concern about the existing effective service array.

Chair Madrigal-Weiss asked staff to include Commissioner Rowlett's friendly amendment to the letter to the Governor and Legislature.

Commissioner Bontrager asked about timing. He stated that this bill is not static but is being amended with a flurry of amendments over the next few days. He stated that he is uneasy about supporting a bill that is still in progress and not knowing what the final draft will be in the next few days. He asked if the Commission is voting based on what is known today.

Executive Director Ewing stated that typically, when the Commission takes a position on a bill, it is the bill that is currently in print. He stated the need to recognize that legislation often evolves, even after positions are taken. Staff monitors the bill, assesses if modifications are consistent with the position the Commission took, and works closely with the Chair to determine if the Commission's position should change.

Executive Director Ewing reviewed the motion as it stands, including the friendly amendments made by Commissioners Chambers and Rowlett.

Action: Commissioner Carnevale moved, and Vice Chair Alvarez seconded, that:

- *The Commission supports SB 326, and directs staff to draft a letter, to be approved by the Chair, to the Governor and Legislature outlining the concerns discussed, including community engagement, school mental health, disparities, prevention, mandating peer support services, and ensuring that the existing service array is not inappropriately impacted in the modernization process.*

The Motion passed with 8 ayes, 2 noes, and 2 abstentions, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Bontrager, Brown, Bunch, Carnevale, Chen, and Gordon, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioners voted “No”: Commissioners Chambers and Tamplen

The following Commissioners abstained: Commissioners Robinson and Rowlett.

4: Adjournment

Chair Madrigal-Weiss thanked everyone for their participation and stated that the next Commission meeting will take place on September 28th in Los Angeles. There being no further business, the meeting was adjourned at 4:29 p.m.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
August 24, 2023

Motion #: 1

Date: August 24, 2023

Proposed Motion:

The Commission approves the July 27, 2023 Meeting Minutes

Commissioner making motion: Commissioner Robinson

Commissioner seconding motion: Vice Chair Alvarez

Motion carried 9 yes, 0 no, and 2 abstain, per roll call vote as follows:

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

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
August 24, 2023

Motion #: 2

Date: August 24, 2023

Proposed Motion:

The Commission approves the Fiscal Year 2023-24 expenditure plan and associated contracts.

Commissioner making motion: Commissioner Tamplen

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	Not Voting
1. Commissioner Bontrager	☐	☐	☐	☐	☒
2. Commissioner Brown	☐	☐	☐	☒	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☐	☐	☐	☒	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☐	☐	☐	☐	☒
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☐	☐	☐	☒	☐
10. Commissioner Gordon	☒	☐	☐	☐	☐
11. Commissioner Mitchell	☒	☐	☐	☐	☐
12. Commissioner Robinson	☒	☐	☐	☐	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. Commissioner Tamplen	☒	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary
Commission Meeting
August 24, 2023

Motion #: 3

Date: August 24, 2023

Proposed Motion:

The Commission supports AB 599 and directs staff to communicate its position to the Governor and the Legislature

Commissioner making motion: Commissioner Mitchell

Commissioner seconding motion: Vice Chair Alvarez

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

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

Motions Summary
Commission Meeting
August 24, 2023

Motion #: 4

Date: August 24, 2023

Proposed Motion:

The Commission supports SB 10 and directs staff to communicate its position to the Governor and the Legislature.

Commissioner making motion: Chair Madrigal-Weiss

Commissioner seconding motion: Commissioner Gordon

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

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

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
September 5, 2023

Motion #: 1

Date: September 5, 2023

Proposed Motion:

The Commission supports SB 326, and directs staff to draft a letter, to be approved by the Chair, to the Governor and Legislature outlining the concerns discussed, including community engagement, school mental health, disparities, prevention, mandating peer support services, and ensuring that the existing service array is not inappropriately impacted in the modernization process.

Commissioner making motion: Commissioner Carnevale

Commissioner seconding motion: Vice Chair Alvarez

Motion carried 8 yes, 2 no, and 2 abstain, per roll call vote as follows:

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

AGENDA ITEM 5

Action

September 28, 2023 Commission Meeting

Consent Calendar

Summary: The Mental Health Services Oversight and Accountability Commission will consider approval of the Consent Calendar which contains 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.

San Luis Obispo and Santa Cruz Counties are requesting that the Commission authorize up to $5,404,656 in Mental Health Services Act Innovation (INN) funds for the following two projects:

Project Name	Total Innovation Funding Requested	Duration of Project (years)
Embracing Mental & Behavioral Health for Residential Adult Care & Education (San Luis Obispo)	$860,000	4
Crisis Now Multi-County Innovation (Santa Cruz County)	$4,544,656	3
Total:	**$5,404,656**	

<u>Embracing Mental & Behavioral Health for Residential Adult Care & Education (San Luis Obispo):</u>

The County is experiencing limited housing options for adults 60 years of age and older who require both physical and behavioral health services. RCFE staff are not required to be trained to care for older adults who have mental health care issues, and when mental health symptoms are present, older adults are often turned away, increasing their risk for becoming unhoused.

San Luis Obispo County would like to test and pilot the use of a Multi-Disciplinary Behavioral Health Team (EMBRACE Team) who will work in partnership with participating Residential Care Facilities for the Elderly (RCFE). These teams will consist of a Behavioral Health Clinician, a Peer Advocate, and a Program Coordinator.

RCFEs are licensed through Department of Social Services; however, there are no requirements for staff to be trained to recognize mental health symptoms in older adults. Only recognizing signs of dementia are required of RCFE staff.

The EMBRACE Team will provide on-call support, early intervention consultations, system navigation, and education and training for facility staff so that older adults living in these RCFEs can receive proper care and treatment.

The Community Program Planning Process:

Local Level

In 2019, the idea for this project was brought forward by Wilshire Community Services (WCS), a local non-profit provider of mental health services for older adults, and the idea was further developed with input from the community and in collaboration with the County's Long Term Ombudsman's Office. Although this project received support from the Innovation Stakeholder Committee in 2020, it was put on hold due to the pandemic. This project is now being resurrected with more support from the community as part of a new round of innovation projects presented at the County's Innovation Stakeholder meeting held on January 11, 2023. This meeting included individuals with lived experience, educators, providers, community-based organizations and collaborators, as well as mental health partners. The County has provided input and technical assistance to WCS in the development of this project, ensuring that this project aligns with community needs and priorities.

Community partners will continue to provide feedback during all stages of this project, including implementation and evaluation. The project will comply with MHSA standards to be culturally competent, involve community collaboration, be client and family driven and focused on wellness, recovery and resilience.

San Luis Obispo's CPP process included the following:

- 30-day Public Comment Period: July 14, 2023-August 15, 2023
- Local Mental Health Board Hearing: August 16, 2023
- Board of Supervisor Approval: Scheduled for October 10, 2023

Commission Level

This project was initially shared with Community Partners on July 17, 2023, and the final version was again shared on August 22, 2023.

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

Crisis Now Multi-County Innovation (Santa Cruz County):

The Crisis Now Multi-County Innovation project presents Santa Cruz County and subsequent participant counties with an innovative opportunity to complement and strengthen their crisis response systems in a manner aligned to the Crisis Now Model, while allowing for flexibility in the context of competing priorities and challenges. This project aims to construct a model that is tailored to the unique needs of California, offering both fidelity to the Crisis Now Model and flexibility.

The Crisis Now model, in alignment with the Substance Abuse and Mental Health Services Administration (SAMHSA) National Guidelines for Behavioral Health Crisis Care, identifies four key guidelines that every crisis system of care should include:

1. High-tech Crisis Call Centers that coordinate all aspects of an immediate crisis response in real time.
2. 24/7/365 Mobile Crisis Outreach Teams that work in the community with those at risk and reduce the need for uniformed officers to provide mental health triage in the streets.
3. Facility-based, 23-hour crisis receiving centers that divert away from hospital emergency departments and arrest, booking, and detention, while providing crisis-specific interventions in safe and secure environments; and
4. Commitment to evidence-based safe care practices, such as Trauma-Informed Care, Zero Suicide principles, and a multidisciplinary approach to crisis resolution.

Participating counties will receive technical assistance throughout the project from RI International (RI), a national and international consultant and operator for the Crisis Now Model with over 30 years of experience as a provider in the behavioral health space.

The success of the project will be examined through an evaluation that will assess the project's impact toward the following goals:

- Improve and increase access to ongoing behavioral health crisis response services
- Divert individuals experiencing a behavioral health crisis from jail/carceral settings
- Reduce emergency department behavioral health admissions
- Increase the number of clients who voluntarily use crisis response services
- Improve long-term outcomes for service recipients

<u>The Community Program Planning Process:</u>

Local Level

The County's integrated community planning process identified a need for a stronger crisis response system. In addition, state level mandates regarding mobile crisis created another opportunity for the county to look at the whole crisis system of care. Joining the Crisis Now Multi-County Collaborative was identified as a timely solution.

Beginning in February 2023, RI supported Santa Cruz to facilitate additional engagements with key community partners to determine the specific needs of diverse communities in the County. Engagements included surveys, open meetings, listening sessions and focus groups where feedback informed the development of this proposal. Participants supported the need to improve crisis care and identified BH crisis response services and suicide prevention as a priority.

Santa Cruz's CPP process included the following:

- 30-day Public Comment Period: July 14, 2023 through August 17, 2023
- Local Mental Health Board Hearing: August 17, 2023
- Board of Supervisor Approval: Pending Commission Approval

Commission Level

This project was initially shared with Community Partners on August 20, 2023, and the final version was again shared on September 11, 2023.

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

Enclosures (3): (1) Commission Community Engagement Process; (2) San Luis Obispo Analysis: Embracing Mental & Behavioral Health for Residential Adult Care & Education; (3) Santa Cruz Analysis: Crisis Now Multi-County Innovation

Additional Materials (2):

Final Innovation projects are available on the Commission website at the following URLs:

Embracing Mental & Behavioral Health for Residential Adult Care & Education
https://mhsoac.ca.gov/wp-content/uploads/San-Luis-Obispo_INN-Project_EMBRACE_09122023_Final.pdf

Crisis Now Multi-County Collaborative
https://mhsoac.ca.gov/wp-content/uploads/Santa-Cruz_INNPlan_Crisis-Now.pdf

Proposed Motion:

That the Commission approves the Consent calendar which includes funding for San Luis Obispo County's Embracing Mental & Behavioral Health for Residential Adult Care & Education (EMBRACE) Innovation Project for up to $860,000 over four (4) years, and Santa Cruz County's Crisis Now Multi-County Innovation Project for up to $4,544,656 over three (3) years.

Mental Health Services
Oversight & Accountability Commission

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**
  i. Innovation project is initially shared while County is in their public comment period
  ii. County will submit a link to their plan to Commission staff
  iii. 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)**
  iv. Comments received while County is in public comment period will go directly to the County
  v. Any substantive comments must be addressed by the County during public comment period
- **Procedure – Final Sharing of INN Projects**
  i. 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)**
  ii. 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**
  i. Comments received during the final sharing of the INN project will be incorporated into the Community Planning Process section of the Staff Analysis.
  ii. Staff will contact community partners to determine if comments received wish to remain anonymous
  iii. Received comments during the final sharing of INN project will be included in Commissioner packets
  iv. Any comments received after final sharing cut-off date will be included as handouts

STAFF ANALYSIS – SAN LUIS OBISPO COUNTY

Innovation (INN) Project Name:	**Embracing Mental & Behavioral Health for Residential Adult Care & Education (EMBRACE)**
Total INN Funding Requested:	**$860,000**
Duration of INN Project:	**4 Years**
MHSOAC consideration of INN Project:	**September 28, 2023**

Review History:

Approved by the County Board of Supervisors:	Pending Commission Approval
Mental Health Board Hearing:	August 16, 2023
Public Comment Period:	July 14, 2023-August 15, 2023
County submitted INN Project:	September 8, 2023
Date Project Shared with Stakeholders:	July 17, 2023 and August 22, 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.*

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:

San Luis Obispo County would like to test and pilot the use of a Multi-Disciplinary Behavioral Health Team (EMBRACE Team) who will work in partnership with participating Residential Care Facilities for the Elderly (RCFE). These teams will consist of a Behavioral Health Clinician, a Peer Advocate, and a Program Coordinator.

RCFEs are licensed through Department of Social Services; however, there are no requirements for staff to be trained to recognize mental health symptoms in older adults. Only recognizing signs of dementia are required of RCFE staff.

The EMBRACE Team will provide on-call support, early intervention consultations, system navigation, and education and training for facility staff so that older adults living in these RCFEs can receive proper care and treatment.

What is the Problem:

San Luis Obispo is bringing forward a project to address the needs of older adults who reside in Residential Care Facilities for the Elderly (RCFE). By definition, Department of Social Services states RCFEs "are a housing arrangement chose voluntarily by the resident, or the resident's responsible person, where 75% of the residents are 60 years of age and older, and where varying levels of care and supervision are provided, as agreed to at the time of admission, or as determined necessary at subsequent assessments. Residents under age 60 must have needs compatible with the needs of other residents.[i]" (California.pdf (ahcancal.org))

The County is experiencing limited housing options for adults 60 years of age and older who require both physical and behavioral health services. RCFE staff are not required to be trained to care for older adults who have mental health care issues, and when mental health symptoms are present, older adults are often turned away, increasing their risk for becoming unhoused.

Licensing and admittance requirements for RCFEs indicate the following: **Individuals with the following conditions may also not be admitted or retained:** (1) a need for assistance to perform all activities of daily living (ADLs); (2) a communicable disease; (3) unable to get out of bed; **(4) mental disorders that result in ongoing behaviors that would upset other residents;** and (5) dementia, unless certain requirements for specialized care are met.[ii]

The County cites a report written by The Steinberg Institution and in collaboration with the County Behavioral Health Directors Association of California (CBHDA), titled *Loss of Board and Care Facilities is at Crisis Level.*[iii] In this report, there is recognition that mental health supports and education provided to RCFE staff will assist in reducing the risk of these older adults becoming unhoused.

The County is trying to address this issue through this innovation project and hopes to bring much-needed mental health services and awareness to RCFEs for this vulnerable population. These learnings can be shared more broadly, bringing overall change to the mental health system.

How this Innovation project addresses this problem (see pgs 4-6 of project):

The County would like to create a multi-disciplinary behavioral health team and provide training to RCFE staff so that older adults living in these facilities can receive appropriate physical and mental health services. The team will employ a Behavioral Health Clinician, a Peer Advocate and a Program Coordinator who will be responsible for the following activities:

- Behavioral Health Clinician – will provide assessments, consultations with facility staff, and crisis interventions for residents who are at risk of-or are displaying symptoms of-mental illness
- Peer Advocate – will work closely with older adult residents, family members and staff to ensure adequate resources are available
- Program Coordinator – will be responsible for development of the training and consultation component of this project

The County indicates there are several RCFE facilities that have shown interest in participating in this project and that hope to benefit from the training and consultation this program would provide. The EMBRACE team and RCFE staff will identify appropriate clients and develop a care plan that fits their individual needs. If it is determined that a resident requires services beyond what the EMBRACE team can provide, a referral will be made for applicable programs offered by the County.

Training Curriculum

The learning of this innovation project places a large emphasis on training and the opportunity to transform the care provided for older adults living in an RCFE facility. It is important to reiterate that there are currently no licensing requirements for RCFE staff to complete trainings related to mental health services or recognizing symptoms of mental health illness.

This project will provide mental health education and training for RCFE staff in the areas of:

- Identifying red flags
- De-escalation techniques
- Addressing crisis situations
- Recognizing mental health symptoms and providing treatment to reduce symptoms
- Mental Health First Aid
- Older Adult Depression
- Suicide Prevention

Training curriculums will be identified for use and developed as needed, and individual facilities will be able to select those that would most benefit the needs of their specific residents.

EMBRACE Call Center

The RCFE facilities participating in this project will have access to a call center to reach the EMBRACE team for any situations that may arise (i.e., consultations or general questions) and will establish available office hours to be able to provide guidance and consultation.

The Community Program Planning Process (see pgs 9-11 of project):

Local Level

In 2019, the idea for this project was brought forward by Wilshire Community Services (WCS), a local non-profit provider of mental health services for older adults, and the idea was further developed with input from the community and in collaboration with the County's Long Term Ombudsman's Office. Although this project received support from the Innovation Stakeholder Committee in 2020, it was put on hold due to the pandemic. This project is now being revived with more support from the community as part of a new round of innovation projects presented at the County's Innovation Stakeholder meeting held on January 11, 2023. This meeting included individuals with lived experience, educators, providers, community-based organizations and collaborators, as well as mental health partners. The County has provided input and technical assistance to WCS in the development of this project, ensuring that this project aligns with community needs and priorities.

Community partners will continue to provide feedback during all stages of this project, including implementation and evaluation. The project will comply with MHSA standards to be culturally competent, involve community collaboration, be client and family driven, and focus on wellness, recovery and resilience.

The County held their public comment period between July 14, 2023 and August 15, 2023, followed by their Mental Health Board Hearing on August 16, 2023. San Luis Obispo is calendared to appear before their County Board of Supervisors on September 26, 2023.

Commission Level

This project was initially shared with Community Partners on July 17, 2023, and the final version was again shared on August 22, 2023.

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

Learning Objectives and Evaluation (see pgs 7-8 of project):

The County hopes this project will serve approximately 300-400 older adults (ages 60 and over) annually, which is approximately 20% of the County's entire RCFE population.

The County has established the following four learning questions for this project:

1. Will the utilization of a multi-disciplinary team-based approach to mental health assessment, support, and education in Residential Care Facilities for the Elderly (RCFEs) promote better health and wellness outcomes for the participants?

2. Will increased community collaboration between County Behavioral Health Department and RCFEs result in an increase of placement options for Older Adults with a mental illness?

3. Will the use of a multi-disciplinary team-based approach to mental health assessment, support, and education in RCFEs create a more sustainable housing and treatment option for Older Adults with a mental illness?

4. Will the testing of this model of support have an impact on RCFE staff and administration as it pertains to stigma reduction and improved confidence in providing care for residents with mental illness?

Measurement of these established learning questions will be both qualitative and quantitative, with metrics as follows:

- Pre and post assessments of residents related to wellness outcomes, quality of care provided by staff, and overall quality of life resulting from this project
- Baseline data to help identify the overall impact of this project
- Baseline data to assess whether the number of residents with a mental illness admitted into an RCFE increased or decreased prior to and after completion of this project
- Surveys completed by RCFE administrators assessing staff's confidence levels and ability to provide appropriate care for older adults living with a mental illness
    - Surveys will be completed prior to project starting, during project, and after project completion
- Staff surveys to examine the efficacy of the education and training provided, which will assess improvement in both knowledge and attentiveness around mental health

This project will analyze outcomes from 3 angles:

1. Willingness of the RCFE Administrator to admit older adults in their facility with a mental illness
2. The knowledge of RCFE staff to provide appropriate care for older adult residents
3. Overall wellness of the older adult residents living in these participating RCFEs

San Luis Obispo Behavioral Health contracts with California Polytechnic State University Master of Public Policy for the collection and analysis of data, methodologies, and final evaluation of this project.

If the evaluation reveals this project to be successful, the County will work with RCFEs to establish internal practices to better provide proper training to meet the needs of this population. Other funding may also be explored for project sustainability.

The Budget (see pgs 13-16 of project:)

4 Year Budget	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
Personnel	$ 126,348.00	$ 172,422.00	$ 172,422.00	$ 126,348.00	$ 597,540.00
Direct Costs	$ 16,500.00	$ 16,500.00	$ 16,500.00	$ 16,500.00	$ 66,000.00
Indirect Costs	$ 50,015.00	$ 48,215.00	$ 48,215.00	$ 50,015.00	$ 196,460.00
Total	**$ 192,863.00**	**$ 237,137.00**	**$ 237,137.00**	**$ 192,863.00**	**$ 860,000.00**

Funding Source	FY 23/24	FY 24/25	FY 25/26	FY 26/27	TOTAL
Innovation Funds	$ 192,863.00	$ 237,137.00	$ 237,137.00	$ 192,863.00	$ 860,000.00
Total	**$ 192,863.00**	**$ 237,137.00**	**$ 237,137.00**	**$ 192,863.00**	**$ 860,000.00**

San Luis County is requesting authorization to spend up to $860,000 in innovation funding over a four-year period.

- Personnel costs in the amount of $597,540 (69.5% of total project cost) will be used to staff the Program Coordinator, Behavioral Health Clinician and the Peer Advocate Positions.
- Direct costs total $66,000 (7.7% of total project) and will cover the following:
  - A total of $6,000 (0.7% of total project cost) has been allocated toward the cost of office supplies, postage, laptops, cell phones, training materials, and rental space for the EMBRACE team
  - Evaluation costs of this project is $60,000 (7.0% of total project) and will be completed by California Polytechnic State University, Master of Public Policy Department
- Indirect costs total $196,460 (22.3% of total project cost) and will cover the cost of presentation and marketing materials to build awareness around this project, as well as provide informational brochures to clients, family members, and other RCFE facilities.

[i] Residential Care Facilities for the Elderly: Definition
California.pdf (ahcancal.org)

[ii] Link to Department of Social Services RCFE Licensing Requirements:
Residential Care/Assisted Living Compendium: California (hhs.gov)

[iii] Steinberg Institute Report in collaboration with CBHDA:
Loss-of-Board-and-Care-Facilities-is-at-Crisis-Level-2.28.20.pdf (namisantaclara.org)

STAFF ANALYSIS –SANTA CRUZ

Innovation (INN) Project Name:	**Crisis Now Multi-County Innovation**
Total INN Funding Requested:	**$4,544,656**
Duration of INN Project:	**3 Years**
MHSOAC consideration of INN Project:	**September 28, 2023**

Review History:

Approved by the County Board of Supervisors:	Pending Commission Approval
Mental Health Board Hearing:	August 17, 2023
Public Comment Period:	July 14, 2023-August 17, 2023
County submitted INN Project:	September 11, 2023
Date Project Shared with Stakeholders:	July 14, 2023 and September 11, 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, increase the quality of mental health services, including measured outcomes, 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, including, but not limited to, prevention and early intervention, 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:

The Crisis Now Multi-County Innovation project presents Santa Cruz County and subsequent participant counties with an innovative opportunity to complement and strengthen their crisis response systems in a manner aligned to the Crisis Now Model, while allowing for flexibility in the context of competing priorities and challenges. This project aims to construct a model that is tailored to the unique needs of California, offering both fidelity to the Crisis Now Model and flexibility.

The Crisis Now model, in alignment with the Substance Abuse and Mental Health Services Administration (SAMHSA) National Guidelines for Behavioral Health Crisis Care, identifies four key guidelines that every crisis system of care should include:

1. High-tech Crisis Call Centers that coordinate all aspects of an immediate crisis response in real time.
2. 24/7/365 Mobile Crisis Outreach Teams that work in the community with those at risk and reduce the need for uniformed officers to provide mental health triage in the streets.
3. Facility-based, 23-hour crisis receiving centers that divert away from hospital emergency departments and arrest, booking, and detention, while providing crisis-specific interventions in safe and secure environments; and
4. Commitment to evidence-based safe care practices, such as Trauma-Informed Care, Zero Suicide principles, and a multidisciplinary approach to crisis resolution.

Participating counties will receive technical assistance throughout the project from RI International (RI), a national and international consultant and operator for the Crisis Now Model with over 30 years of experience as a provider in the behavioral health space.

The success of the project will be examined through an evaluation that will assess the project's impact toward the following goals:

- Improve and increase access to ongoing behavioral health crisis response services
- Divert individuals experiencing a behavioral health crisis from jail/carceral settings
- Reduce emergency department behavioral health admissions
- Increase the number of clients who voluntarily use crisis response services
- Improve long-term outcomes for service recipients

What is the Problem:

Many system level barriers continue to exist in the crisis system such as siloed mental health, substance use and medical services that lack the capacity to meet the actual need for services. Workforce shortages, fiscal sustainability concerns, unique challenges experienced in rural areas, and overall competing priorities create an ineffective system. These barriers contribute to individuals in need of care often being held in hallways in emergency departments (ED), or being unnecessarily incarcerated, leading to further deterioration of functioning.

In addition to system level barriers, other challenges have been identified by county personnel, community partners, and individuals accessing behavioral health (BH) crisis services reflecting: an overall lack of crisis care services and/or a lack of capacity, especially in youth crisis care; lack of coordination and/or siloed care within the systems; restrictive admission criteria; limited mobile crisis capacity; presence of uniformed and armed security during crisis; workforce shortages; and assistance needed with data and outcomes.

Locally, Santa Cruz County provided data showing that the regional call center they utilize to triage crisis calls reported a 93% increase in incoming calls from 2021 to 2022. The increase in crisis calls, feedback received during community program planning and the identified barriers in their crisis response system, led Santa Cruz to join the multi-county project as the pilot county.

RI evaluated the County's crisis system using the Crisis Now Scoring Tool (see page 8 of the main plan) and identified strengths and needs in each of the core areas:

- Someone to Call (Call Center Hub)
- Someone to Respond (Mobile Crisis Teams)
- Safe Place to Go (Crisis Receiving Care Facilities)
- Commitment to evidence-based safe care practices

Santa Cruz County currently utilizes best practices in suicide care, has some mobile crisis capacity, utilizes a regional 988 call center, and provides limited access to a receiving center but lacks peer support throughout their crisis response system. Overall, the Crisis Now Scoring Tool evaluated the Santa Cruz crisis system at a level 2 (basic) out of 5 levels (see pages 6, 8, 12 and 13 of the appendix for scoring details).

As detailed above, Santa Cruz has elements of a crisis system that meet portions of national best practices and the Crisis Now Model but is seeking support from RI to break down silos, integrate peer support and build a system that meets all 4 key areas and transforms their crisis continuum of care to better serve their community.

A well-designed system has a no wrong door approach and provides crisis services to anyone, anywhere, anytime. While California counties have implemented various components of a crisis system, none have implemented all aspects of the four components needed to score a level 5 using the Crisis Now Scoring Tool.

How this Innovation project addresses this problem:

This Crisis Now Multi-County Innovation Project is an innovative opportunity for a diverse group of participating counties to work together to implement and optimize their respective BH Crisis Response System for individuals experiencing a BH crisis using the nationally recognized and innovative Crisis Now Model.

As a component of the project, RI will facilitate an abbreviated Crisis Now Academy Training for each participating county to provide the following:

- In-depth understanding of the model and its principals
- Assessment and system design to inform and optimize the county's current crisis services
- Implementation plan for new services and/or principles
- Ongoing technical assistance with subject matter experts in the model through the life of this innovation project

RI will utilize assessment results and subsequent analyses of each participating county's crisis response system in comparison to national best practices. This process will be followed by developing a set of recommendations on how each county can optimize its crisis response system in alignment with best practices.

RI will support participating counties to utilize data and cost savings tools to shift to a "no wrong door approach." Additionally, a training, recruitment and retention plan will be developed for the peer workforce and partnerships for funding and advocacy will continue to be explored. RI and participating counties will engage community partners who will inform the planning, implementation, and evaluation of this project.

RI has supported and will continue to support Santa Cruz County to identify key areas of focus to support the transformation of their crisis system, including:

1. Elevating current mobile crisis to a 24/7 model
2. Elevating the current call center operation to dispatch directly to Mobile Crisis Teams
3. Dedicated crisis receiving center and crisis support for youth
4. Integrating Peer Support Specialists
    a. RI will support Santa Cruz County to conduct outreach with existing peer services including the 2nd Story Peer Respite house, the Mental Health Client Action Network peer-run drop-in center and NAMI Santa Cruz to address gaps in peer services and strategies to build up peer support in the crisis response system.

The overall assessment of Santa Cruz County's crisis response system against national best practice may score at a level 2, but Santa Cruz County is progressing rapidly and is in a strong position to optimize the crisis care continuum by fully implementing the Crisis Now Model. When this system is fully operational, Santa Cruz County will be able to lead other counties through their own crisis system transformation.

The Community Program Planning Process (see appendix pages 16-32)

Local Level

As part of their Three-Year MHSA planning process, Santa Cruz Behavioral Health Services convened a series of community meetings, surveys, and focus groups to inform program planning efforts and budget allocation. During this process, the community identified the need to strengthen its BH crisis response system as a priority for residents. In addition, state level mandates regarding mobile crisis created another opportunity for the County to look at the whole crisis system of care. Joining the Crisis Now Multi-County project was identified as a timely solution.

Beginning in February 2023, RI supported Santa Cruz to facilitate additional engagements with key community partners to determine the specific needs of diverse communities in the County. Engagements included surveys, open meetings, listening sessions and focus groups where feedback informed the development of this proposal. Participants supported the need to

improve crisis care and identified BH crisis response services and suicide prevention as a priority.

The County posted this plan for 30-day public comment on July 14, 2023, concluding with the local Mental Health Board hearing on August 17, 2023. Prior to posting, County staff facilitated a presentation to the County Board of Supervisors and received their support to move forward with local approvals.

Letters of support were received from the following groups (please see pages 33 through 41 of the plan appendix):

- The Diversity Center
- Superintendent of Santa Cruz City schools
- County Sheriff
- Pajaro Valley Prevention and Student Assistance
- Pajaro Valley Unified School District
- County Office of Education
- Watsonville Community Hospital
- Santa Cruz Police Department
- NAMI Santa Cruz

A final plan incorporating community input and technical advice from Commission staff was submitted for consideration on September 11, 2023.

Commission Level
Commission staff initially shared this project with community partners on July 14, 2023 and the final version was again shared on September 11, 2023.

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

Learning Objectives and Evaluation (see pgs. 16-20 of main proposal):

Utilizing the Crisis Now Resource Need Calculator, RI estimates that up to 6,582 individuals living in Santa Cruz County will need crisis services on an annual basis.

This project will assess the overall impact at both the systems-level and at the client-level. An outside evaluator will be hired to work with Santa Cruz County to identify key quantitative data to be collected and measured, as well as determine the most effective ways to capture the relevant data through current information systems (i.e., electronic health records, and automated reporting performance management systems). Qualitative data will be gathered by studying stakeholder and agency relationships, reviewing shared protocols, and examining formal partnerships with other systems like hospitals, schools, and law enforcement.

Evaluation questions that this project aims to answer include, but are not limited to, the following:

1. Will the implementation of the innovative Crisis Now Model:
    a. Improve patient access to BH crisis response services and overall outcomes, while decreasing BH ED admissions?
    b. Divert individuals experiencing a BH crisis from jail?
    c. Increase the number of clients who will enter crisis response services voluntarily, reducing the need of for involuntary 5150s?
    d. Improve service recipient outcomes?
2. Will the development, training, and recruitment of Peer Support Specialists improve overall workforce recruitment and decrease the number of vacant positions in BH crisis care services?
3. Will the optimization of the crisis response system lead to compelling cost savings?

RI and Santa Cruz County will utilize the four (4) Crisis Now Scoring Tools (Call Center Hub, Mobile Crisis Service, Crisis Receiving Center, and Crisis Now System) throughout the project. Scorecards will be utilized to assess and measure each County's progress and fidelity towards best practice in alignment with the Crisis Now Model.

The Budget (see appendix pages 19-23)

5 Year Budget	FY 23/24	FY 24/25	FY 25/26	**TOTAL**
Personnel	$ 254,193	$ 496,518	$ 510,646	$ 1,261,357
Operating Costs	$ 24,000	$ 21,000	$ 21,000	$ 66,000
Consultant Costs	$ 937,961	$1,466,863	$1,436,655	$ 3,841,479
Total*	$ 1,216,154	$1,984,381	$1,968,301	$ 5,168,836

*Number is higher due to rounding

Funding Source	FY 23/24	FY 24/25	FY 25/26	**TOTAL**
Innovation Funds	**$ 1,093,703**	**$1,737,154**	**$1,713,799**	**$ 4,544,656**
Federal Financial Participation	$ 122,451	$ 247,226	$ 254,501	$ 624,178
Total	$ 1,216,154	$1,984,380	$1,968,300	$ 5,168,834

Santa Cruz County is requesting authorization to spend up to $4,554,656 in innovation funding over a three-year period. The County anticipates leveraging up to $624,178 in Federal Financial Participation for a project total of $5,168,834.

- Personnel costs in the amount of $1,261,356 (24% of total project cost) include salaries and benefits for County staff to provide services and oversee community-based organization (CBO) staff contracted to operate crisis services. Positions will include:
    - Senior Mental Health Client Specialist II, including extra help and overtime
    - Mental Health Client Specialist II, including overtime
    - On call Senior Mental Health Client Specialist II
    - On call Mental Health Client Specialist II

- Operating costs in the amount of $66,000 will cover technology equipment such as laptops and cell phones, and costs for ongoing community program planning.
- Consultant costs total $3,841,479 (74% of total project costs) and represent most of the budget. The costs include the following:
    - A total of $2,941,140 (56% of total project costs) to fund 12 FTE CBO staff who will provide support for dispatch and mobile crisis services
    - A total of $450,339 to fund RI for consulting services
    - A total of $150,000 for training
    - A total of $300,000 (5% of total project costs) for evaluation services

Sustainability

RI will support Santa Cruz County to plan for a phased crisis response system optimization which will require monitoring service demand, utilization and performance, and metrics, while trying to secure sustainable funding. A comprehensive financial plan will be developed as part of this proposal that will delineate the costs associated with the Mobile Crisis Teams, Crisis Stabilization Units, and Psychiatric Health Facilities as those components are phased in while also protecting the revenue to offset these costs. The financial plan/model will align with CalAIM's payment reform initiatives.

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

AGENDA ITEM 6

Action

September 28, 2023 Commission Meeting
Substance Use Disorder Panel

Summary: The Commission will hear a panel presentation on substance use disorder (SUD) services, which will provide an overview of successful practices that may be considered for expansion through the Commission's Mental Health Wellness Act (MHWA) grant program. The panel will also highlight barriers to treatment and known gaps in the continuum of SUD services and approaches which may address the gaps.

Background: The Commission's budget includes $20 million per year to support the MHWA. Between 2014 and 2021, the Commission allocated funds to county behavioral health departments through a competitive grant process to build out crisis intervention response programs. The MHWA, as initially drafted, limited the use of these funds to hiring personnel to support county crisis intervention programs.

In October of 2021, through public hearings and site visits, the Commission began to identify challenges in the use of these funds and priorities for the investment of the next round of funding. In response to the Commission's request, staff sought statutory changes to the MHWA that would allow the funds to be used to support crisis prevention and early intervention strategies, in addition to crisis response services. Staff also sought support to use the funds to award grants to partners in addition to county behavioral health departments, to support strategies other than supplemental staffing, to allow matching fund requirements and to allow competitive or non-competitive procurements when doing so is in the public interest. During the 2022-23 budget process, the Legislature and Governor authorized those changes to the MHWA.

The Commission has identified five priorities for MHWA funding: 1) Strategies to reduce unnecessary Emergency Department utilization and hospitalizations, 2) Programs to meet the behavioral health needs of older adults, 3) Substance Use Disorder programs, 4) Opportunities to support services for children ages zero to five and their parents/caregivers, and 5) Peer respite programs.

Priority (1) was addressed in September 2022 when the Commission approved a $20 million allocation from Budget Year 2020/2021 to expand the number of Emergency Medical Psychiatric Treatment and Healing (EmPATH) units which provide services on the contiguous grounds of existing hospitals to individuals experiencing a mental health emergency. The funding also supports training and technical assistance to grantees, and funds to conduct program evaluation.

Priority (2) was addressed in November of 2022 when the Commission, through a collaboration with the California Department of Aging, approved an additional $20 million allocation from the 2020/21 Budget Year to expand the number of Program to Encourage Active and Rewarding Lives (PEARLS) programs and Age Wise programs throughout the state. These programs provide support to older adults who are experiencing mild, moderate, and severe symptoms of depression and other mental health conditions.

The Commission is now focusing on opportunities to improve access to SUD services, support the mental health and wellness needs of children ages zero to five and their parents/caregivers, and to explore avenues to expand and sustain peer respite programs.

The goal of the panel presentation and discussion is to engage the Commission and the public in a high-level conversation about SUD services, identify gaps in the continuum of care, highlight opportunities for funding that could fill the gaps and bring lasting change, and to identify opportunities to expand programs or services that could prevent substance use and improve SUD care. In response to the Commission's direction, staff will create a Request for Applications and enter into three-year contracts with the highest scoring applicants.

Presenters: 1) Tyler Sadwith, Deputy Director, Behavioral Health at California Department of Health Care Services; 2) Dr. Gary Tsai, Los Angeles County DPH Director of Substance Abuse Prevention and Control; 3) Dr. Rebecca Trotzky-Sirr, Los Angeles General Hospital; USC Clinical Assistant Professor of Psychiatry and the Behavioral Sciences; 4) Dr. Aimee Moulin, UC Davis Emergency Addiction Medicine and Substance Use Navigator; 5) Tommie Trevino, UC Davis Substance Use Navigator

Enclosures (3): (1) Presenter Bios; (2) Briefing Memo; (3) Invitation Letters

Handouts (1): The presentation will be supported by PowerPoint slides.

Proposed Motion: That the Commission approves the expenditure of $20 million in Mental Health Wellness Act funds to expand existing SUD programs or launch new SUD programs that address gaps in the SUD continuum of care; that the Commission directs staff to design and release a Request for Application (RFA) that addresses substance use prevention and treatment and award grants to the highest scoring applicants, and Commissioner Danovitch work with staff on this effort.

Substance Use Disorder

Panelists Biographies

Tyler Sadwith was appointed Deputy Director, Behavioral Health at the California Department of Health Care Services (DHCS) by Governor Newsom in June 2022. Tyler is responsible for leading DHCS' ambitious agenda to ensure high-quality and accessible specialty mental health and substance use disorder services in Medi-Cal and other public programs. He leads the development and implementation of policy and initiatives designed to strengthen behavioral health care access, quality, service delivery, and achieve equitable health care outcomes for 14 million Medi-Cal members and Californians served through other programs. He provides direct management to four divisions: Community Services, Licensing and Certification, Medi-Cal Behavioral Health Oversight and Monitoring, and Medi-Cal Behavioral Health Policy. Prior to his appointment, Tyler served as Assistant Deputy Director of Behavioral Health at DHCS, assisting to oversee the planning, implementation, coordination, evaluation, and management of the Department's behavioral health services. Tyler has also served as a Senior Consultant at Technical Assistance Collaborative, Inc., where he provided strategic advice and technical support to state health leaders on behavioral health policy and delivery system reforms. Additionally, he served as Technical Director at the Centers for Medicare & Medicaid Services (CMS), where he spearheaded efforts in supporting states to introduce comprehensive benefit, program, and delivery system reforms through Medicaid Section 1115 substance use disorder (SUD) demonstration waivers. He also implemented the agency's opioid strategy and oversaw the SUD portfolio of CMS' Medicaid Innovation Accelerator Program, a cross-agency strategic support and technical assistance platform designed to support service delivery and payment innovation in Medicaid. Tyler earned a Bachelor of Arts degree in History from Reed College.

Gary Tsai, M.D. is a physician executive who is the Director of the Substance Abuse Prevention and Control, a division of the Los Angeles County Department of Public Health. In this role, he is responsible for leading nearly 500 staff with a budget of approximately $460M, overseeing a full spectrum of substance use prevention, harm reduction, and treatment services for the 10 million residents of Los Angeles County. Dr. Tsai also serves on the Board of Directors of NAMI California and is a physician board certified in both general psychiatry and addiction medicine, after completing his medical training at the University of California, Davis School of Medicine. Having experienced the stigma and criminalization that often accompanies serious mental illness as the son of a mother with schizophrenia, Dr. Tsai is a passionate advocate for improving our behavioral health systems. In his pursuit of meaningful change, he founded Forgotten Films, a film production company focusing on social issue projects, specializing in behavioral health. Its first film, ***Voices*** (www.VoicesDocumentary.com), premiered on public television in May 2015 for Mental

Health Awareness Month and was awarded a SAMHSA Voice Award. He is also the award-winning author of ***Against All Odds: A Practical Guide to Successfully Navigate Psychosis and Behavioral Health Systems*** (www.AgainstAllOddsToday.com), which was published in July 2022.

Rebecca Trotzky, M.D. is a dedicated physician leader in Family Medicine with a subspecialty in Addiction Medicine. She also holds an M.D. from the University of Minnesota, and an M.S. in Civil Engineering, and a B.A. in Urban Studies and Urban Planning from Stanford University. Currently she is Director of Addiction and Community Medicine, Medical Director of Jail Ward services at Los Angeles General Medical Center and Los Angeles County Department of Health Services. In her previous roles Dr. Trotsky was Medical Director of the Urgent Care Center at Los Angeles General Medical Center, founding member of the California Bridge Program, and medical staff at the Program for Victims of Torture. She was a Robert Woods Johnson Foundation Clinical Scholar and Fulbright Scholar in Venezuela on Public Health. She currently volunteers at Homeboy Industries focusing on tattoo removal and violence prevention. Dr. Trotzky's career reflects a commitment to improving healthcare, advocating for marginalized communities, and contributing to medical education. Her leadership and expertise makes her a valuable asset to the healthcare field.

Aimee Moulin, M.D. is a Professor at UC Davis with a dual appointment in the Department of Emergency Medicine and Psychiatry. Dr. Moulin completed a fellowship in Quality Safety and Comparative Effectiveness through the Agency for Healthcare Research and Quality with a focus on acute care for patients with mental illness and substance use. She is boarded in both Emergency Medicine and Addiction Medicine. Dr. Moulin is Chief of the Division of Addiction Medicine in the Department of Emergency Medicine where she established a model Emergency Department Bridge program. Dr. Moulin is a founder of California Bridge, an effort to expand low threshold access to treatment for people with Substance Use Disorder.

Tommie Trevino is a motivational speaker and a certified Drug and Alcohol Counselor who specializes in drug use with co-occurring mental health disorders. He has over 20 years in recovery and brings valued dedicated services to those who suffer with addiction and support to their families. Tommie is a Substance Use Navigator working in the UC Davis Medical Center. With his dedication, hard work, and determination, he also supports the California Bridge program and is a mentor for other Substance Use Navigators statewide. Through his inspiring life journey, he is a great motivational speaker who has the passion to share knowledge and empower people to achieve greater success in recovery.

Mental Health Services
Oversight & Accountability Commission

Substance Use Disorder Panel Presentation

September 28, 2023
Public Hearing Brief

Purpose

The Commission's budget includes $20 million per year to support the Mental Health Wellness Act, which can be used for crisis prevention and early intervention in addition to crisis response services.

In October 2021, the Commission identified five priorities for these funds:
1) strategies to reduce unnecessary Emergency Department utilization and hospitalizations,
2) programs to meet the behavioral health needs of older adults
3) substance use disorder programs
4) opportunities to support services for children ages zero to five, and
5) peer respite programs.

In September 2022, the Commission approved $20 million to expand the number of Emergency Medical Psychiatric Treatment and Healing (EmPATH) units which provide services on the contiguous grounds of existing hospitals to individuals experiencing a mental health emergency. The funding also supports training and technical assistance to grantees, and funds to conduct program evaluation.

In November of 2022, the Commission authorized an additional $20 million to expand two programs identified by the California Department of Aging as promising approaches to serve older adults.

The Commission has not yet invested Mental Health Wellness Act funding in peer respite, early childhood, or SUD services.

The Commission directed staff to assemble a panel of experts on access to SUD services who will identify barriers to access, gaps in service delivery and make recommendations on how the Commission might direct MHWA funds to address those needs.

Background

The Mental Health Wellness Act fund can be used to support crisis prevention, early intervention, and crisis response services. The Commission has used these and other funds to:

- Expand approaches that respond to urgent needs. Examples include recent investments in EmPATH, PEARLS, and Age Wise.

- Develop new approaches that align with MHSA goals. The Commission has launched allcove6 youth drop-in centers, and the Psychiatric Advance Directives project.
- Incentivize partnership. The Commission has provided Mental Health Student Services Act grants to encourage partnerships at the local level.
- Strengthen strategic decision making as was done through the Crisis Now Innovation and the Data Driven Recovery Project.

The opportunities to close gaps and address barriers in SUD treatment exist at all stages of the SUD continuum of care and are not limited to one type of service. For instance, effective upstream prevention efforts could address the risks before the challenge begins, integrated SUD and mental health care can improve access to services, the provision of SUD services at the right time, to the right people, in the right place could improve treatment outcomes, and a focus on inequities within marginalized communities could address long standing obstacles to care.

Panel

Invited panelists will provide insight on the landscape of SUD services in California and will discuss new opportunities to address SUD in various settings. The panel will highlight the important role that integrated health, mental health, and SUD can play to increase access to effective treatment. The panel will also discuss the opportunities for capacity building approaches to ensure that providers are trained in and utilizing the American Society of Addiction Medicine standards of practice. The panel presentations will focus on best practices in treatment and prevention and early intervention efforts.

Panelists

1) Tyler Sadwith was appointed by Governor Newsom as the Deputy Director of Behavioral Health at the California Department of Health Care Services. Tyler is responsible for leading DHCS efforts to ensure high-quality and accessible specialty mental health and substance use disorder services in Medi-Cal and other public programs.

2) Dr. Gary Tsai is the Director of the Substance Abuse Prevention and Control, a division of the Los Angeles County Department of Public Health. In this role, he oversees a full spectrum of substance use prevention, harm reduction, and treatment services for the 10 million residents of Los Angeles County.

3) Dr. Rebecca Trotzky-Sirr is a physician in Family Medicine with a subspecialty in Addiction Medicine. Currently she is Director of Addiction and Community Medicine, the Medical Director of Jail Ward services at Los Angeles General Medical Center and Los Angeles County Department of Health Services

4) Dr. Aimee Moulin is a Professor at UC Davis with a dual appointment in the Department of Emergency Medicine and Psychiatry. She is board certified in both Emergency Medicine and Addiction Medicine and is the founder of California Bridge, an effort to expand low threshold access to treatment for people with substance use disorders.

5) Tommie Trevino is a certified Drug and Alcohol Counselor who specializes in drug use with co-occurring mental health. He has 20 years in recovery and is dedicated to the service of parents with loved ones that struggle with addiction. He is a Substance Use Navigator at UC Davis and serves as a mentor to other Substance Use Navigators across California.

Considerations

The Commission may wish to explore the following considerations:

- The MHSA emphasizes PEI. As we face a drug addiction crisis, how do we assess the tradeoffs between treatment and more upstream prevention approaches?
- What are the most significant problems we should be addressing and what solutions should we consider as we look to invest these funds?
- What should we be doing to address disparities in access to SUD treatment?
- What is the role of peers in this work and are we using peers to their fullest potential?
- How can we build capacity through skills training to ensure that SUD workforce is equipped with the tools they need to deliver quality services?
- The Commission has $20 million per year to invest in crisis prevention, early intervention, and crisis response services. Is this an adequate amount of funding to pilot programs or expand existing SUD programs?
- Should we consider using additional MHWA funds to address the needs of special populations such as prenatal or treatment for youth?
- How are we monitoring outcomes for SUD treatment?

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

September 21, 2023

Tyler Sadwith
Deputy Director, Behavioral Health
California Department of Health Care Services

Letter sent via email

Dear Mr. Sadwith,

Thank you for agreeing to present at the public hearing on Substance Use Disorders (SUD) during the Commission's September 28, 2023, meeting. Experts and community partners have been invited to discuss their current service delivery model, the barriers and gaps in care, and systemic challenges that hinder California's ability to serve those eligible for services.

The meeting begins at 9:00 a.m. PST, and the SUD presentations are scheduled to begin at approximately 10:00 a.m. and conclude at 12:00 p.m. PST following brief announcements and general public comment.

We request that your presentation be between 7 and 10 minutes and 80% focused on the challenges you see and the reforms that could improve care. Please consider the following topics as part of your presentation:

- An overview of the funding mechanism for SUD services.
- Information on CalAIM and how its implementation will transform Medi-Cal SUD.
- ASAM criteria and opportunities to invest in technical assistance and capacity building.

If you have not done so already, please send a brief biography and any relevant background materials related to your presentation by September 22, 2023, to Tom Orrock, Deputy Director, at tom.orrock@mhsoac.ca.gov. Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff.

Respectfully,

Tom Orrock, MA, LMFT
Deputy Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

September 21, 2023

Aimee Moulin, MD, MAS, FACEP
Professor
Division Chief Addiction Medicine
Department of Emergency Medicine
UC Davis Health

CA Bridge
Principle Investigator & Co-Founder

Letter sent via email

Dear Dr. Moulin,

Thank you for agreeing to present at the public hearing on Substance Use Disorders (SUD) during the Commission's September 28, 2023, meeting. Experts and community partners have been invited to discuss their current service delivery model, the barriers and gaps in care, and systemic challenges that hinder California's ability to serve those eligible for services.

The meeting begins at 9:00 a.m. PST, and the SUD presentations are scheduled to begin at approximately 10:00 a.m. and conclude at 12:00 p.m. PST following brief announcements and general public comment.

We request that your presentation be between 5 and 7 minutes and focused 80% on the challenges you see and the reforms that could improve care. Please consider the following topics as part of your presentation:

- The current system of siloed specialty addiction treatment
    - Misalignment with needs of population
    - Less than 10 percent of people with SUD accessed treatment in the past year
- The myth of treatment resistance in the California Bridge program
- Barriers to specialty addition treatment and the lack of treatment options for patients with co-occurring mental illness
- Effectiveness in engaging people in low threshold treatment models that emphasize the evidence-based medication treatment

If you have not done so already, please send a brief biography and any relevant background materials related to your presentation by September 22, 2023, to Tom Orrock, Deputy Director, at tom.orrock@mhsoac.ca.gov. Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff.

Respectfully,

Tom Orrock, MA, LMFT
Deputy Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

September 21, 2023

Rebecca Trotzky, MD
Director of Addiction and Community Medicine
Department of Emergency Medicine
Los Angeles General Medical Center

CA Bridge
Founding Member

Letter sent via email

Dear Dr. Trotzky,

Thank you for agreeing to present at the public hearing on Substance Use Disorders (SUD) during the Commission's September 28, 2023, meeting. Experts and community partners have been invited to discuss their current service delivery model, the barriers and gaps in care, and systemic challenges that hinder California's ability to serve those eligible for services.

The meeting begins at 9:00 a.m. PST, and the SUD presentations are scheduled to begin at approximately 10:00 a.m. and conclude at 12:00 p.m. PST following brief announcements and general public comment.

We request that your presentation be between 7 and 10 minutes and 80 % focused on the challenges you see and the reforms that could improve care. Please consider the following topics as part of your presentation:

- Co-occurring SUD is common among people with Serious Mental Illness (SMI)
- Risk of Death from overdose
    - Criminal Justice
    - Homelessness
- Medically Supervised Withdrawal
- Core Components of Treatment: Medications, Counseling, and Support
- Special Populations

- Harm Reduction
- MOTHER study – MOUD in pregnancy and babies

If you have not done so already, please send a brief biography and any relevant background materials related to your presentation by September 22, 2023, to Tom Orrock, Deputy Director, at tom.orrock@mhsoac.ca.gov. Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff.

Respectfully,

Tom Orrock, MA, LMFT
Deputy Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

September 21, 2023

Gary Tsai, MD
Bureau Director
Substance Abuse Prevention and Control
County of Los Angeles, Dept of Public Health

Letter sent via email

Dear Dr. Tsai,

Thank you for agreeing to present at the public hearing on Substance Use Disorders (SUD) during the Commission's September 28, 2023, meeting. Experts and community partners have been invited to discuss their current service delivery model, the barriers and gaps in care, and systemic challenges that hinder California's ability to serve those eligible for services.

The meeting begins at 9:00 PST a.m., and the SUD presentations are scheduled to begin at approximately 10:00 a.m. and conclude at 12:00 p.m. PST following brief announcements and general public comment.

We request that your presentation be between 7 and 10 minutes and 80% focused on the challenges you see and the reforms that could improve care. Please consider the following topics as part of your presentation:

- Opportunities to address service barriers and gaps in treatment with limited resources.
- Ensure delivery of services per ASAM standards.
    - Workforce training to achieve a level of certification
- Fragmented resources
    - Linkages to ensure quality improvement

If you have not done so already, please send a brief biography and any relevant background materials related to your presentation by September 22, 2023, to Tom Orrock, Deputy Director, at tom.orrock@mhsoac.ca.gov. Please note that written responses and biographies

will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff.

Respectfully,

Tom Orrock, MA, LMFT
Deputy Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

September 21, 2023

Tommie Trevino
Substance Use Navigator
Department of Emergency Medicine
UC Davis Health

Letter sent via email

Dear Mr. Trevino,

Thank you for agreeing to present at the public hearing on Substance Use Disorders (SUD) during the Commission's September 28, 2023, meeting. Experts and community partners have been invited to discuss their current service delivery model, the barriers and gaps in care, and systemic challenges that hinder California's ability to serve those eligible for services.

The meeting begins at 9:00 a.m. PST, and the SUD presentations are scheduled to begin at approximately 10:00 a.m. and conclude at 12:00 p.m. PST following brief announcements and general public comment.

We request that your presentation be between 5 and 7 minutes and 80% focused on the challenges you see and the reforms that could improve care. Please consider the following topics as part of your presentation:

- How lived experience informs your work as a substance use navigator and empowers people to achieve greater success recovery.
- Barriers to SUD treatment engagement.

If you have not done so already, please send a brief biography and any relevant background materials related to your presentation by September 22, 2023, to Tom Orrock, Deputy Director, at tom.orrock@mhsoac.ca.gov. Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff.

Respectfully,

Tom Orrock, MA, LMFT
Deputy Director

AGENDA ITEM 8

Action

September 28, 2023 Commission Meeting

Amador County Innovation Project

Summary: The Commission will consider the approval of Amador County's request to fund the following innovation project:

1. **Workforce Recruitment & Retention Strategies - $1,995,129 in MHSA Innovation funds over five years.**

Amador County – consistent with the entire State – is facing extreme workforce challenges that impede their ability to deliver services and support. At the request of Amador's community partners and stakeholders, the County has been asked to prioritize the recruitment and retention of behavioral health professionals.

The County states they would create an Innovations Team that would be responsible for holding and facilitating key focus groups and development of surveys that would allow the community to shape this project by bringing the most supported ideas forward to recruit and retain behavioral health professionals. Additionally, the creation of the Innovations Team would oversee the planning and implementation of this project.

In brainstorming ideas to address this challenge, Amador County has identified a few potential solutions that will ultimately be vetted and discussed in collaboration with the community and the Innovations Team. Some of the ideas under this proposed innovation project may include:

- Benefits and stipends for employees who respond to individuals in a mental health crisis
- Access to continuing education and higher education opportunities for existing employees
- Programs that may help employees with housing and relocation assistance
- Activities that would promote staff morale and career development

The County currently utilizes their annual allocation of MHSA Workforce Education and Training (WET) funds; however, additional efforts are needed to meet their workforce needs beyond the stream of WET funding.

The County's MHSA community planning process for its FY 2020-2023 provided feedback indicating there was a workforce shortage as well as a lack of providers and inability to retain providers. The County began to ask the community about how to address these workforce issues within the behavioral health system and over the past three years, the recruitment and

retention of behavioral health staff was identified as a priority, prompting this project to begin development. This Innovation proposal is intended to respond to the workforce shortage as identified by the community.

Community members provided input via surveys (both online and paper) and focus groups that target specific communities and groups, including but not limited to: Veterans, older adults, Amador Unified School District and the Office of education, local law enforcement agencies, Native Americans, LGBTQ+, Consumers, Family Members and County staff (see pg 19 for complete list of participants).

The County held their public comment period between June 19, 2023 and July 19, 2023, followed by their Mental Health Board Hearing on July 19, 2023. Amador received approval from their County Board of Supervisors on August 22, 2023.

Commission Level

This project was initially shared with Community Partners on June 22, 2023, and the final version was again shared on August 10, 2023.

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

Enclosures (3): (1) Commission Community Engagement Process; (2) Biography for Stephanie Hess, Amador County Presenter; (3) Staff Analysis: Workforce Recruitment & Retention Strategies

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

Additional Materials (1): A link to the County's Innovation Plan is available on the Commission website at the following:

https://mhsoac.ca.gov/wp-content/uploads/Amador_INN-Project_Workforce-Retention-Strategies_Final_08022023.pdf

Proposed Motion: That the Commission approves Amador County's Workforce Recruitment & Retention Strategies Innovation Project for up to $1,995,129 over five (5) years.

Mental Health Services
Oversight & Accountability Commission

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**
  i. Innovation project is initially shared while County is in their public comment period
  ii. County will submit a link to their plan to Commission staff
  iii. 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)**
  iv. Comments received while County is in public comment period will go directly to the County
  v. Any substantive comments must be addressed by the County during public comment period
- **Procedure – Final Sharing of INN Projects**
  i. 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)**
  ii. 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**
  i. Comments received during the final sharing of the INN project will be incorporated into the Community Planning Process section of the Staff Analysis.
  ii. Staff will contact community partners to determine if comments received wish to remain anonymous
  iii. Received comments during the final sharing of INN project will be included in Commissioner packets
  iv. Any comments received after final sharing cut-off date will be included as handouts

WELLNESS | RECOVERY | RESILIENCY

Stephanie Hess, Mental Health Services Act (MHSA) Programs Coordinator, Amador County Behavioral Health (ACBH) has been with ACBH for ten years. For the past seven years, she has acted as the MHSA Programs Coordinator and is responsible for the administration, planning and development of all MHSA-related activities and programs in Amador County.

Prior to her position as MHSA Coordinator, she was a Senior Finance Assistant for ACBH and served as the Secretary-Treasurer for the non-profit organization, California Behavioral Health Administrator's Association. She has also served on various non-profit boards supporting local organizational efforts and community services.

STAFF ANALYSIS – AMADOR COUNTY

Innovation (INN) Project Name:	**Workforce Recruitment & Retention Strategies**
Total INN Funding Requested:	**$1,995,129**
Duration of INN Project:	**5 Years**
MHSOAC consideration of INN Project:	**September 28, 2023**

Review History:

Approved by the County Board of Supervisors:	August 22, 2023
Mental Health Board Hearing:	July 19, 2023
Public Comment Period:	June 19, 2023-July 19, 2023
County submitted INN Project:	August 2, 2023
Date Project Shared with Stakeholders:	June 22, 2023 and August 10, 2023

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 applying a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system.*

Project Introduction:

Amador County – consistent with the entire State – is facing extreme workforce challenges that impede their ability to deliver services and support. At the request of Amador's community partners and stakeholders, the County has been asked to prioritize the recruitment and retention of behavioral health professionals.

The County states they would create an Innovations Team that would be responsible for holding and facilitating key focus groups and development of surveys that would allow the community to shape this project by bringing the most supported ideas forward to recruit and

retain behavioral health professionals. Additionally, the creation of the Innovations Team would oversee the planning and implementation of this project.

In brainstorming ideas to address this challenge, Amador County has identified a few potential solutions that will ultimately be vetted and discussed in collaboration with the community and the Innovations Team. Some of the ideas under this proposed innovation project may include:

- Benefits and stipends for employees who respond to individuals in a mental health crisis
- Access to continuing education and higher education opportunities for existing employees
- Programs that may help employees with housing and relocation assistance
- Activities that would promote staff morale and career development

The County currently utilizes their annual allocation of MHSA Workforce Education and Training (WET) funds; however, additional efforts are needed to meet their workforce needs beyond the stream of WET funding.

What is the Problem:

Amador's community has prioritized addressing the stark reality that the public behavioral healthcare system is facing a severe work shortage, and if ignored, individuals who seek and need behavioral health services will continue to be unserved/underserved.

The following data has been provided by the County that presents the need to focus on workforce challenges (see pgs 3-7 of project for details on the County's need):

- When fully staffed, there are approximately 25 behavioral health staff as well as one part time employee and 2 crisis workers that provide extra coverage as needed
    - All behavioral health staff respond to crisis services and are on call 24/7
    - Behavioral health clinicians and psychiatric staff also provide mental health services at the Amador County Jail, including evaluation services, weekly consults, and medical telehealth or in-person visits
    - Recruitment for the 2 crisis workers who provide extra coverage is ongoing
- Over the past 3 years, the County has faced the following challenges:
    - Clinician vacancies remain unfilled for an average of 2 months and once filled, these positions are held for less than two years
    - Only half of clinicians remain in their positions for longer than 2 years
    - Crisis counselors that provide extra help are difficult to recruit for
    - Clinician and Crisis Counselor positions experience 60% employee turnover
    - The County has recently filled one of its 2 full time Personal Services Coordinator (PSC) positions; however, it took over 6 months to recruit and hire for that one position
        - Average employment of PSC position is also less than 2 years
    - The County has 2 peer PSC positions that took an average of 3 months to fill

- A total of 24 behavioral health staff have been hired since 2019 (clinicians, crisis counselors, extra help crisis counselors, crisis coordinators, PSC's and peer PSC'S)

Exit interviews of staff who resigned were performed by the County and resulted in some of the proposed components in this project. In developing this project, the County also conducted extensive research on workforce challenges experienced by other counties and businesses and utilized that data to frame the components of this project (see pgs 11-16).

Given the unique considerations facing Amador as a small rural area, the County struggles with limited staffing and resources. The County is trying to address this challenge through this innovation project and hopes to test and pilot the use of financial incentives to assess the efficacy of those solutions to strengthen staff recruitment, employment, and retainment. Following evaluation of this proposed project, its learnings can be shared more broadly and with other counties, both large and small, who face similar challenges in their workforce.

How this Innovation project addresses this problem (see pgs 5-9 of project):

Amador County would like to test and implement various approaches, which include utilizing financial incentives, improving staff morale, offering career development and access to higher education, and providing housing assistance to recruit and retain staff within the public behavioral health workforce.

Crisis Pay and Shift Differential (see pgs 7-8)
The County is proposing to offer an increase in crisis standby pay, currently $4 per hour to $6 per hour in recognition and appreciation for the crisis hours worked.

Additionally, the County would like to offer a shift differential for crisis hours worked outside of the normal work day, inclusive of holidays and weekends.

The County proposed to offer annual stipends for crisis workers in exchange for a service commitment with the dollar amounts increasing for each year of service commitment during the life of this project.

Higher Education (see pg 8)
The County currently has an existing College Connect scholarship and would like to expand funding to allow additional staff to pursue a bachelor's degree in behavioral health.

The County would also like to create an internal scholarship program, contingent upon a service commitment, for staff to pursue higher education and would cover costs associated with books, supplies, transportations costs, etc.

Housing and Relocation Assistance (see pg 8)

One of the challenges expressed by the County is a shortage of housing within the County. This component seeks to attract behavioral health workers by offering incentives towards housing and relocation.

One of the solutions being proposed is to create a program that will assist behavioral health employees with a downpayment in return for a service commitment. The County states behavioral health staff salaries are not adequate enough to afford housing given the current market. Another potential housing program would allow financial assistance for staff that are relocating into the County in return for a service commitment.

The County is setting aside a total of $37,500 for all of the proposed housing components of this project:

- $2,500 would be provided for home loan downpayment assistance for employees per year of service commitment
- Employees who choose to relocate to Amador County would receive one-time funding of $2,500 to assist with moving costs

The Commission may wish to consider if the use of innovation funding is an appropriate mechanism for home loan downpayment assistance.

Staff Morale (see pg 8)

The County would like to offer monthly or quarterly activities and programs to build team morale and promote self-care and overall wellness.

Programs to Recruit and Retain (see pgs 8-9)

Amador County would like to offer the following programs and repayment options for employees that will allow continuance of their career development, advancement, and continuing education:

- The creation of an internal loan repayment program ($2,500 annually) in exchange for a service commitment
- A program that would assist in paying for license and registration fees of certified employees
- Financial assistance to allow unlicensed professionals to acquire their licensure including costs associated with testing requirements
- Financial assistance for the costs of continuing education (license, registration, and certification fees)

Career Development (see pg 9)

Amador would like to invest in identifying career advancements opportunities for behavioral health staff to allow upward mobility and will create a training plan that will align with an employee's development goals.

Childcare Support (see pg 9)

Part of this project will include the County's research into the feasibility and possible implementation of a program that would offer childcare programs for their behavioral health staff. The County states this component needs to be vetted out and will be dependent upon community input and provider availability to assist in determining next steps.

Note: During technical consultation with Amador County, Commission staff relayed concern over a previous innovation project brought forward in June 2023 (San Diego County) that proposed to offer financial incentives for home ownership. Although the project was ultimately approved, the programmatic component pertaining to funding of home ownership was not approved.

The County informed Commission staff that they consulted with San Diego regarding the home ownership program, and Amador believes that their proposed housing assistance component differs from what San Diego previously brought forward.

The Community Program Planning Process (see pgs 19-23 of project):

Local Level

The County's MHSA community planning process for its FY 2020-2023 provided feedback indicating there was a workforce shortage as well as a lack of providers and inability to retain providers. The County began to ask the community about how to address these workforce issues within the behavioral health system and over the past three years, the recruitment and retention of behavioral health staff was identified as a priority, prompting this project to begin development. This Innovation proposal is intended to respond to the workforce shortage as identified by the community.

Community members provided input via surveys (both online and paper) and focus groups that target specific communities and groups, including but not limited to: Veterans, older adults, Amador Unified School District and the Office of education, local law enforcement agencies, Native Americans, LGBTQ+, Consumers, Family Members and County staff (see pg 19 for complete list of participants).

The County held their public comment period between June 19, 2023 and July 19, 2023, followed by their Mental Health Board Hearing on July 19, 2023. Amador received approval from their County Board of Supervisors on August 22, 2023.

Commission Level

This project was initially shared with Community Partners on June 22, 2023, and the final version was again shared on August 10, 2023.

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

Learning Objectives and Evaluation (see pgs 17-18 of project):

The County hopes to serve employees working with Amador County's Behavioral Health system (N=35) with the overarching goal of increasing access to and improving service delivery of mental health services for all individuals living within the County.

The County has established the following three learning goals to guide this project:

- Will Amador County Behavioral Health be able to increase the length of time that clinical and personal service coordinator positions are retained?
- Will Amador County Behavioral Health be able to meet unique workforce needs through the implementation of this project?
- Will Amador County Behavioral Health be able to improve and/or maintain staff morale as a result of the increased support through staff appreciation and self-care activities?

Measurement of these established learning goals will be both qualitative and quantitative and the evaluation of gathered data and outcomes will be completed internally. Amador has set forth the following desired outcomes that may assist in gathering data:

- Increase the length of clinical staff and personal service coordinators to minimum of three years
    - Current baseline data reflects these positions are retained for less than two years
- Improved levels of communication between staff and leadership to allow employees to feel supported in their professional development
- Decline in vacancy and work attrition rates in comparison with historical trend
- Improvement in workforce engagement and overall job satisfaction

Amador County states the final evaluation of this project will help to determine the programmatic components that will be continued and hopes to utilize MHSA funding (CSS and WET funding) long-term sustainability (pg 24).

The Budget (see pgs 28-30 of project:)

5 Year Budget	FY 23/24	FY 24/25	FY 25/26	FY 26/27	FY 27/28	TOTAL
Personnel	$ 142,497.00	$ 190,505.00	$ 238,762.00	$ 287,280.00	$ 336,072.00	$ 1,195,116.00
Direct Costs	$ 90,750.00	$ 90,750.00	$ 90,750.00	$ 90,750.00	$ 90,750.00	$ 453,750.00
Indirect Costs	$ 48,982.00	$ 59,064.00	$ 69,198.00	$ 79,386.00	$ 89,633.00	$ 346,263.00
						$ -
Total	$ 282,229.00	$ 340,319.00	$ 398,710.00	$ 457,416.00	$ 516,455.00	$ 1,995,129.00

Funding Source	FY 23/24	FY 24/25	FY 25/26	FY 26/27	FY 27/28	TOTAL
Innovation Funds	$ 282,229.00	$ 340,319.00	$ 398,710.00	$ 457,416.00	$ 516,455.00	$ 1,995,129.00
Total	**$ 282,229.00**	**$ 340,319.00**	**$ 398,710.00**	**$ 457,416.00**	**$ 516,455.00**	**$ 1,995,129.00**

Amador County is requesting authorization to spend up to $1,995,129 in innovation funding over a five-year period.

- Personnel costs in the amount of $1,195,116 (59.9% of total project cost) will be used to increase standby pay for crisis coverage ($305,012 over 5 years); provide a shift differential for clinicians responding to crisis coverage after-hours ($244,579 over 5 years); as well as provision of a $1,500 annual stipend retention for crisis response staff ($645,525 over 5 years)
- Direct costs total $453,750 and include the following:
    - A total of $37,500 (1.9% of total project cost) has been allocated toward the home loan downpayment assistance program; staff would be offered $2,500 per year of service commitment or staff relocating into Amador County would be provided a one-time payment of $2,500
    - A total of $82,500 (4.1% of total project) will be provided for the creation of the County's internal scholarship program
    - A total of $25,000 (1.3% of total project) will be utilized to supplement an already existing College Connect Scholarship within the County
    - A total cost of $187,500 (9.4% of total project) is allocated towards staff loan repayment
    - A total of $101,250 (5.1% of total project) will be funded towards County behavioral health staff to maintain licensing fees, testing and continuing education (all employees would receive $100 per year for registration and licensing costs; $500 to cover testing every 2 years; and $1,000 maximum on an annual basis for continuing education units)
    - Approximately $20,000 (0.1% of total project) would cover costs associated with programs to inspire team morale and activities that promote self-care and overall wellbeing
- Indirect costs total $346,263 and cover the County's administrative costs as well as the evaluation of this project ($100,000 or 5% of the total project)

AGENDA ITEM 9

Action

September 28, 2023 Commission Meeting
Request for Proposal Outline for Advocacy Contracts

Summary: The Commission will consider approval of the Request for Proposal (RFP) Outline for advocacy, training, education, outreach and engagement on behalf of six populations: Clients and Consumers, Diverse Racial and Ethnic communities, Families of Consumers, LGBTQ+ Communities, Parents and Caregivers, and Veteran Communities.

Background: The Commission, as directed by the State Legislature, oversees funding awarded to community-based organizations to support the mental health needs of underserved populations through advocacy, training and education, and outreach and engagement activities. The Commission provides these funds through a competitive application process and awards contracts to the highest scoring applicants. These contracts are focused on supporting the mental health needs of nine populations which have been identified as being historically underserved in California. These nine populations are:

- Clients and Consumers
- Diverse Racial and Ethnic Communities
- Families of Clients and Consumers
- Immigrant and Refugee Populations
- K-12 Students
- LGBTQ+ Communities
- Parents and Caregivers
- Veteran Communities
- Transition Age Youth (TAY)

These contracts, originally awarded on a sole source basis, were transferred to the Commission after the dissolution of the Department of Mental Health in 2011. Through 2015, the Commission administered four sole source contracts for activities supporting consumers, family members, parents and caregivers, and TAY. The Budget Acts of 2015/16 and 2018/19 increased funds in the Commission's budget to include the five additional populations.

From 2016-2019, contracted advocacy organizations focused primarily on state level advocacy activities which included legislative visits, gatherings at the Capitol, public comment at Commission meetings, and interaction with other state agencies about mental health needs.

In 2020, the contract requirements were updated to increase local level engagement across more counties. Awarded organizations were asked to subcontract with 15 local level entities across all five mental health regions to bolster community outreach, training for providers and clinicians, and engagement of community members at the local level.

Current Funding Available: Advocacy contracts for Clients and Consumers, Diverse Racial and Ethnic Communities, Families of Clients and Consumers, LGBTQ+ Communities, Parents and Caregivers, and Veteran Communities will expire on September 30, 2023, and six new contracts are proposed to be issued in the amount of $2,010,000 each for three-year grant terms. The total funding allocation is $12,060,000.

Community Engagement: Commission staff conducted an extensive community engagement process to gather feedback and inform the six new RFPs. This process included meetings with current organizations, listening sessions, and surveys.

Presenter: Tom Orrock, Deputy Director, Operations; Lester Robancho, Health Program Specialist

Enclosures (3): (1) Advocacy RFP Outlines; (2) Community Engagement Summaries; (3) Overview of Advocacy Contracts 2020-2023

Handouts (1): PowerPoint Presentation

Motion: That the Commission approves the proposed outline of the Request for Proposal for advocacy, training and education, and outreach and engagement and that the Commission authorizes staff to initiate a competitive bid process and enter into contracts with the highest scoring applicants for a total of $12,060,000.

Mental Health Services
Oversight & Accountability Commission

Proposed Request for Proposal Outline for Advocacy Contracts
September 28, 2023

The Commission is proposing to release six (6) Request for Proposals (RFP) for statewide organizations to conduct state and local level advocacy, training and education, and outreach and engagement activities on behalf of six underserved populations. One statewide organization will be awarded an advocacy contract for each population. The six populations are:

- Clients and Consumers
- Diverse Racial and Ethnic Communities
- Families of Clients and Consumers
- LGBTQ+ Communities
- Parents and Caregivers
- Veteran Communities

The full contract term will be three years (36 months). The total amount available for each statewide advocacy organization is $670,000 per year for a three-year total of $2,010,000. Total funds available for the six contracts is $12,060,000.

State and Local Advocacy

Interested organizations will be asked to create a workplan for statewide and local-level activities that meet the critical mental and behavioral health needs of the target population. The workplan will include the methods used to evaluate the impact of state and local advocacy efforts. Interested organizations will publish an Annual Report that is designed to highlight community voices and inform state policy makers and will be created in a medium or format that is most relevant and accessible for the target population.

Local Level Partnerships

The RFP will ask organizations to partner with a minimum of five local level entities (LLEs) across the five mental health regions to assist in conducting local advocacy, training, and outreach activities. Statewide organizations will determine the appropriate funding amount (minimum of $5,000) to each LLE.

Addressing Current Needs

The RFP will ask interested organizations to address the current mental and behavioral health needs of the target population. Findings from the community engagement conducted by Commission staff in August 2023 will be included in each RFP as an attachment.

Outline for the RFP Responsibilities

For each of the six RFPs, one contract will be awarded to the highest scoring statewide organization to conduct advocacy, training, and outreach activities on behalf of the population.

Additional Funding for State Level Support

Each contract year, a total of $10,000 of the $670,000 (approx. 1.5%) will be allocated towards supporting additional state level projects or initiatives which are not part of the proposed workplan. Use of the additional funding may be initiated by the Commission or proposed by the organization. If some or all of the $10,000 remains at the end of the contract year, the statewide organization may allocate those funds towards other proposed activities.

Contractor Responsibilities

The contracted statewide organization will propose a workplan that meets the following goals:

Statewide

- Elevate the mental and behavioral health needs of the population to state level decisionmakers and uplift community voice and local stories to the State Legislature.
- Advocate for statewide policy initiatives and legislation that will have the most impact and bring positive outcomes for the target population.
- Increase statewide advocacy on the population's rural communities.
- Publish an Annual Report each year that highlights the voice of community members using relevant media formats with the intent to inform state policymakers of the critical mental health needs.

Local Level

- Represent the needs of the population at the regional and local levels by utilizing strategies that target local decision-making entities including county behavioral health departments, community program planning processes, behavioral health advisory boards, and local mental health boards.
- Enter into partnership with a minimum of five LLEs in all five mental health regions to bolster regional and local advocacy efforts and to strengthen the capacities of the LLE partners.
- Provide training and education that aim to strengthen the behavioral health workforce and build the knowledge and skills of clinicians, providers, and peer workers who serve the population.
- Hold outreach and engagement activities and events to create opportunities for community members to connect and engage with each other, to raise awareness of mental health services, and to develop the capacity for self-advocacy.

The statewide organization will provide a workplan of activities that meet the above goals, and a budget on how the funds will be spent as part of the workplan.

Minimum Qualifications

All eligible bidders must meet the following minimum qualifications:

1. Be an established statewide organization which has been in operation for 2 years and has experience with programs and services related to the unique mental health needs of the RFP population;
2. Be a non-profit organization, registered to do business in California;
3. At least 50% of the paid staff, board members, or advisory board members identify as members of the RFP population.

Desired Qualifications

1. Have experience and capacity to subcontract with, provide technical assistance to, and support local community-based organizations;
2. Have experience and familiarity with evaluating mental health programs and state policy outcomes;

RFP Timeline

RFPs will be released, due, and awarded in groups of two.

- RFPs released to the public:
    - October 10, 2023
    - October 17, 2023
    - October 24, 2023
- Deadline to submit proposals:
    - December 1, 2023
    - December 15, 2023

    - December 22, 2023
- Commission issues Notice of Intent to Award:
    - December 2023 – January 2024

Mental Health Services
Oversight & Accountability Commission

Advocacy Partner Collaboration Meeting
June 2023

Commission staff held a collaboration meeting with the current contract advocacy partners to gather feedback on the advocacy funding and contracts. Below is a summary of that feedback.

Effective Advocacy

- Different regions, counties, and communities exist in different ecosystems.
- Teaching people how to advocate and helping them acquire the skills to translate their experiences into policy is invaluable in changing the system
- Stories have an impact no matter the scale—a story about one individual can have meaningful impact to a decisionmaker. Just make sure the story is made known
- Art bridges policy makers to the artmaker because it is meaningful
- The role of the MHSOAC is to standardize the outcomes and data gathered and achieved by the advocates. Utilize the research capacity the Commission possesses. Standardize performance outcome data. Help tell the story

State and Local Focus

- Keep both state and local focus. If done right, state and local advocacy efforts will lean on each other to maximize impact
- Local focus on advocacy
    - It is powerful to connect and bring ideas from community members to local decision makers
    - It should be noted: there is no one-size-fits-all approach to local advocacy. Different communities have different needs, resources, time, etc. Rural communities will have different capacities for advocating than communities in Los Angeles
    - Regional advocacy can be achieved in different ways, not just through county reach requirements
- State focus on advocacy
    - Bringing community voice to the state level further elevates ideas and issues to legislators who can pass impactful laws
    - Statewide advocacy events have been well received by the LLEs. They enjoy the opportunity to connect with state legislators and statewide decision makers

Procurement and RFPs

- Pay attention to projected timelines on the RFP, especially between contract award and contract execution. Workplans should be allowed to be flexible. Consider time needed for awarded organizations for staffing, partnering with local partners, etc.
    - Timelines should consider the time it takes for organizations to react to award announcement and inform and prepare their local partners.
- Eligibility: boards and staff should represent the population served. 50 percent representation is good benchmark, but it should vary by population. It is more challenging to meet the 50 percent requirement for TAY-serving organizations, for example.

- Awarded organizations should have solid experience influencing state level decisions. Consider increasing the two-year minimum requirement.

Contract Structure

- Current structure (15 local events, 3 yearly state events) doesn't work for all populations and/or organizations
- LLE model can be effective but capacities of different local organizations have to be considered. Many LLEs, especially smaller organizations, will have a steeper learning curve, and may fall behind the more experienced ones
- Unanticipated disadvantage with current structure: majority of time and resources were dedicated to subcontracting and administrative work. Was not proportional to the pay.
    - Time and funding for local advocacy events instead went towards contact management, which is not the intent of the funding.
- One-size-fits-all approach does not work for LLE model. LLEs want to make systemic changes, not check off a box.
    - The 15-county LLE model is too rigid and doesn't work with all populations.
    - If a similar LLE model is used, consider having all LLEs start together rather than having staggered start times (Year 1, Year 2, etc.). Currently, Year 3 LLEs will only have a year of ramp up before funding ends, with work not being able to continue.

Deliverables

- Deliverables to the MHSOAC should not take precedence over meeting the needs of communities. Deliverables should be designed with changing the mental health system in mind
- Data should be a large part of required deliverables—gathering, analyzing, and explaining data should be included in deliverables to MHSOAC
    - Accurate data helps with tailoring local interventions and state level policy recommendations
- Streamlining: deliverables should be clearly defined and specific to the population
- Quarterly reports: written reports may not fully capture the experiences and progress of advocacy work on the ground. Having conversations, however, does a better job of communicating experiences. Conversations are more efficient when it comes to reporting o advocacy. Consider minimizing reporting and increasing conversations

Funding

- There should be flexibility in the funding
    - A set amount of money will have different impact in different counties--$30,000 in a small county will go a long way while being a drop in the bucket in a large county
- If local subcontracting will be kept, provide more flexibility on how it is paid
    - Accountability is important. Contractor should have discretion on how funding is paid to an LLE
    - All money paid up front with no accountability in the current contracts has caused several issues with ensuring work is done and keeping partnerships
    - Having partners is important, but mandatory LLEs is not the best model for most organizations. Operationally, nothing ever goes as planned, and things snowball very quickly
- Funding should be set aside for translators and interpreters
    - Translators and interpreters are expensive, and often takes up most of the money for an advocacy event or administrative funds

- MHSOAC should consider providing contractors and resources to help support advocacy organizations. Resources that can be offered include
    - Evaluation
    - Technical assistance
    - Translation or interpretation
- Organizations were stretched thin with the funding structure of the current contracts

Disseminating Information/Connecting to Commissioners

- Historically there have been opportunities to present advocacy work to the commission but there has never been any feedback
- It is worth making time to present in front of the Commissioners to share highlights. Some ideas were offered:
    - Regular updates on the agenda
    - Interactive workshops
    - Annual convening
- Dissemination can also take the form of more sustained platforms
    - Webpage updated regularly
    - Dedicated email listserv or channel
    - Discussion groups
    - Annual report
    - Videos (30 seconds-2 minutes) with community leaders speaking on needs and sharing stories. Can easily shared on websites, sent to legislators, etc.
- Getting feedback from Commissioners can also be done number of ways
    - Periodic surveys
    - A Commissioner can be “appointed” as the dedicated liaison for a population. For example, the LGBTQ contractor will have direct line of communication with Commissioner X for sharing ideas for Commissioner X to consider to bring up to Commission
- It is worth thinking outside the box. Art is the deepest form of self-advocacy. Artwork is the manifestation of feelings and thoughts and experiences.

Mental Health Services
Oversight & Accountability Commission

Advocacy Community Engagement and Listening Sessions
August 2023

The Commission conducted a series of virtual listening sessions between August 1 – August 17, 2023 to gather input from community members on the most pressing mental health needs of six underserved populations. The listening sessions will inform the Commission's upcoming request for proposals (RFP) to be released in the Fall of 2023.

The community input from each listening session are provided in this document.

Clients and Consumers

Listening Session Meeting Summary

Date August 1, 2023
Location Virtual Only

1. What are the most critical mental health needs of clients and consumers in California today?

- Change the way that mental health is addressed to more of a disability or social justice perspective
- Look at mental health from an intersectional point of view. Normalize a full continuum of feelings and emotions.
- Awareness of services being offered in the community – who qualifies for those services and how to get into them. True outreach and engagement that is focused on building trust over time rather than one-time asks to engage in services.
- Transportation to services – some individuals cannot afford public transportation.
- Mental health support post-incarceration.
- Culturally-based wellness centers for Black and Indigenous people of color (BIPOC) communities.
- Shorter wait times for public services.
- Access to on-site services, such as at homeless service centers or shelters.
- Access to voluntary residential treatment that is trauma-informed that addresses the intersection of substance use and behavioral health challenges.
- More trauma-informed safe spaces.
- More client-run respite centers where individuals can go for more than 23 hours.
- More voluntary crisis services in more appropriate settings, where individuals can go outside of hospitals.
- Increased prevention and early intervention funding. Prevention is the foundation for all other public health conditions. There are no negatives to prevention – it is based on science, compassionate, and fiscally responsible. The Administration's efforts are focused downstream on services for individuals who are already severely ill. This problem needs to be attacked sooner than that.
- Educate the public about what being severely mentally ill is, offer tools to combat it and to be first responders, offer places to go to voluntarily access services when they are ill, and do not punish them with programs such as CARE Court and forced treatment once they are severely ill.
- Include education and training on severe mental illness in schools for teachers, administrators, and students in all grade levels through college.

- Educate parents in what to look for so children do not suffer in silence.
- Normalize the mental health conversation to battle stigma. Increasing awareness and empathy in the average individual will be beneficial in many ways.
- Move beyond the National Alliance on Mental Illness (NAMI) model to a culturally-responsive model that is more reflective of communities and values.

2. What are the barriers or challenges to accessing mental health services and supports?

- The biggest barrier is that services and supports, such as peer respites and Emergency Psychiatric Assessment Treatment Healing (EmPATH) facilities, do not exist on the level they are needed. These need to be in every community.
- Transportation is an ongoing issue.
- Hours outside of 9:00 a.m. to 5:00 p.m. for community-based supports and childcare.
- Provide information on mental health programs and services in emergency rooms to extend reach to people affected by crisis.
- Advocate with the federal government to increase the housing vouchers so more individuals can have stable, permanent housing.

3. What are the barriers or challenges to staying engaged with services and supports?

- Environments are not welcoming. Many clinical providers do not treat individuals with respect and office staff look at individuals suspiciously as if they are dangerous.
- There are a lack of availability of services—waiting lists are a common experience over recent years. This is partly due to a lack of new providers to the workforce.
- Increase education and awareness programs for mental health for all ages, including youth. This will reduce stigma and increase funding for programs.
- Treatment teams frequently rotate in some providers, particularly in FSPs. Trust needs to be rebuilt with each new treatment team.
- High turnover and constant shuffling of providers makes it difficult for consumers to stay engaged with services. Filing a grievance or request for change in provider tend to be rejected.
- Individuals experiencing homelessness often move around and change counties so they are unable to maintain services.
- Language. Accessible translations should be culturally-appropriate, and not just word-for-word but with an understanding of the meaning and the culture behind the language.

- No “real” seat at the table. There is a systemic barrier having to do with representation that includes consumers to check the box. The public has been asking for some of these policy recommendations for decades – programs that are best practices, community-defined, person-centered, and culturally-appropriate. There is a power dynamic in the decision-making such that, when trying to decide on a proposal, the Commission tends to invite county officials or business owners to present who have already made a significant financial investment. The ideas presented typically “reinvent the wheel” or are about changing programs to other similar programs but none that are necessarily person-driven. It is stigmatizing.

4. **On a scale of 1 to 10, how satisfied are you with the responsiveness of local leaders to provide better access to appropriate behavioral health services for you and your community?**
    - **What would have to happen for your score to increase by one?**

- Ventura County Behavioral Health Department is making a significant change due to CalAIM and in response to public feedback about the trauma around the inconsistencies in the intake process. In two weeks, individuals can walk into a clinic, meet with a member of the treatment team – a clinician, a peer, or a community services worker – and talk about what is going on for half an hour, such as follow-up and updates on medications. This can be billed without a diagnosis.
- Sonoma County: 3. Through 2017, the county had a robust community engagement process working towards transformation. Current community engagement needs to widen. There is one-person representation from different communities on a hand-picked community committee. Peers seem muzzled. Peer-run agencies are under the auspices of a larger social service agency and are being told not to advocate for themselves and that the directors of the programs will speak for them. This needs to change.
    - Open dialogue with the new behavioral health director would be helpful.
    - Remove the factors that cause community-based organizations to fear losing their livelihoods if they speak up.
- Riverside County: 0. The speaker’s family in a rural community in Blythe started an organization called Peace from Chaos (PFC) that has been advocating for minimum services. PFC brings individuals to the county to build connections but the county does not want to fill gaps or assist with services. Individuals can never see providers because appointments are continually rescheduled. Local leaders are aware of this issue – PFC has held listening sessions to share about the needs in the community, yet the county continues to read the same script in response for almost two years.
- San Mateo County: 0 to 6, depending on the broad issues in mental health. The hole is getting bigger and deeper when underfunded. Advocacy work needs to be funded adequately, not only in terms of training advocates to speak out on

certain issues but also educating on the different issues of mental health and, most importantly, educating the next generation of advocates. A wellness literacy program is needed to provide this education.

  - Leaders who understand the value of advocacy.

5. **What types of training and education activities would promote the needs of clients and consumers?**

- Peer advocacy trainings, such as the Cal Voices ACCESS Ambassador Program.
- Trainings for providers that normalize what mental health consumers experience to increase compassion and decrease stigma.
- Train providers on how to practice shared decision-making with a client.
- Train service recipients and family members on their rights and what receiving services should look like in order to keep providers accountable. Recognize that there is that power differential. Some communities may defer to a provider because culturally that is what they have been taught to do.
- Trainings for public behavioral health staff in shared decision-making, equality of discussions, and how to conduct discussions for voluntary services.
- It benefits behavioral health boards to invite community members from different parts of their community to share their cultural and mental health experiences. Sometimes boards are reluctant to open their meetings to anything outside their own agendas.
- Foundational trainings on how to do advocacy work, such as the Let's Empower, Advocate, and Do (LEAD) program and the Cal Voices ACCESS Ambassador program.

6. **What are the most effective outreach and engagement activities for clients and consumers?**

- Hold free events and provide food and water.
- Small, in-person gatherings are the best outreach.
- Block clubs in communities and neighborhoods that meet regularly to share resources and challenges in trusting environments.
- Door-to-door invitations to community meetings.
- Accessible outreach for individuals with disabilities, where it is not overly complicated to participate remotely.
- Be a good host – ensure that spaces are welcoming, safe, and accessible from the beginning. Use plain language, be culturally responsive to communities, and be mindful that clients and consumers are being engaged as part of the process, not just because of a diagnosis

  - Encourage engagement by offering incentives, stipends, or reimbursements to individuals and communities. Include food and water as part of engagement activities because many individuals travel long distances to participate.
  - Provide places for individuals to sit, activities for children, and restroom facilities.
  - Honor individuals for their lived experience and their lived expertise that they are bringing by participating in engagement activities.
  - Instead of having rules for meetings, have community agreements where everyone feels safe and welcome.
- Talk about mental illness and share stories to decrease stigma. Peace From Chaos provides monthly micro-events and two big events that support the community with resources for LGBTQ, mental health awareness, suicide prevention, and substance use. Share your story to enable other to share theirs.
- Ensure that policy makers and leaders spend time with community but without looking at their watches. Just showing up is not good enough. It is important to listen to the conversation all the way through. As an example, the representative of CalHHS asked why the community thinks that they are not being listened to, but then they left prior to public comment.
- Fund effective mental health services advocacy efforts to educate the public to hold elected officials accountable.
  - The Governor's proposal to put 30 percent of the MHSA into homelessness will not address the root cause issue. The CARE Court program and upcoming modernization of the LPS Act broadens the ability for authorities to bring individuals into forced treatment. Bringing clients into treatment without adequate services traumatizes them. The result will be that people will be retraumatized so they will no longer seek services.

7. How should statewide advocacy organizations and local advocacy organizations collaborate toward positive impact on the mental health needs of clients and consumers?

- A hybrid approach would be beneficial but it was suggested that smaller grants go to local organizations and not regions because some counties are distinct within their region. Consider that, if there are counties where there are strong advocacy organizations but there are other dynamics at play that preclude direct funding with a statewide organization, it might be beneficial to put out the local organization grants with some sense of how they should be allocated across the state. For the people who are leaders of the countywide advocacy group, part of the grant would be to meet monthly like a learning collaborative to talk on a statewide level. This is where some of the training, education, and brainstorming can happen so it is really from the ground up. Relationships are key.

- Strengthen advisory boards to the way they were initially conceived to see if the required membership on each board is taking place.

- Utilize an affiliate program. Los Angeles County is uniquely different from any other county in the state but, because Sacramento is a decision-making city, it puts communities at a disadvantage, especially rural communities because they must travel so far and yet they are uniquely impacted because of their lack of representation. The decision-making process is more powerful when everyone is present in person with the decision-makers. Regions need to have a way to report on the work the region is doing and have a supportive presence at the state level.

- There needs to be a structure with the funding and how it is distributed because there are many rural communities that do not get anything. They are allocated to get funding but no one is held accountable. Funding is allocated to the city of Blythe in Riverside County but, because it is so far from urban centers, the funding is given to larger towns. The funding is there, but no one is held accountable to distribute it.

- The Cal Voices ACCESS Ambassador Program is a model that has been working well. It is broken up between five regions. The only caveat about this program is that it is not well-funded. Having regional meetings and a state-level meeting will glean group dynamics of ideas on how to tackle this issue.

- Five regional local partners would provide more funding into those areas for advocacy work. Combining that with advocacy training and regional meetings with the state-level meeting is a great idea. What is missing is not enough funding going into the smaller contractors to do the work. Also, if that were merged into one and made larger, it could be more efficient, but also combining having the advocacy training and leading groups meeting on a state-level would make a dynamic program that would have a greater impact.

Diverse Racial and Ethnic Communities

Listening Session Meeting Summary

Date August 3, 2023
Location Virtual Only

1. What are the most critical mental health needs of diverse communities in California today?

- Cultural competence in mental health care. Trust is important for diverse communities.
- Remove stigma surrounding mental health services and address larger systemic barriers that include lack of interpretation, intersectional issues, crisis intervention, and prevention.
- Access to services requires outreach to the clients on what is available, either from social workers, peers, and the providers themselves.
- Increase the number of providers who understand the cultures and speak the languages of their clients.
- Available services outside of normal working hours.
- Increase access to Black mental health therapists.
- Culturally and linguistically appropriate services are needed and lacking, particularly for the Southeast Asian community.
- Access to basic needs such as housing, food security, transportation, and a viable income.
- Mental health workshops and evaluations.
- Healing-centered practices. Honor roots and traditions.
- Options for low-cost and free child care.
- Basic access to mental health to maintain wellness as a part of health.
- Embed early intervention into the education curriculum, specifically with representation of the Black community. Ensuring that there are Black faces is just as important as ensuring accessible language.
- Take historical and generational trauma into consideration, particularly with mental health and providing resources to the community. Redress is needed. The Assembly Bill (AB) 3121 Task Force outlines mental health recommendations for the Black community.
- More advocacy voices are required at the state level representing all the diverse and ethnic communities. Each community has different needs.

2. **What are the barriers or challenges to accessing mental health services and supports?**
    - The lack of providers who look like their clients and overall the lack of trust.
    - The lack of funding for services including language and interpretation
    - Navigating the system to get insurance or for appointments.
    - Generational support for older adults, youth, and children.
    - Many individuals who receive peer support counseling or attend a group feel that that is enough.
    - Not highlighting the trauma unique to communities creates a barrier to access.
3. **What are the barriers or challenges to staying engaged with services and supports?**
    - Lack of understanding about historical oppression that has occurred without a reckoning.
    - Fear of repercussions if individuals share honestly.
    - Misdiagnosis and over-diagnosis for individuals who do not feel safe or have access to food.
    - Lack of options - individuals may find healing in community but not from therapists.
    - Lack of trust.
    - Frequent provider turnover.
    - Follow-through with follow-ups.
    - Long waiting periods for appointments and services.
    - Lack of access to basic needs.
    - Lack of transportation.
    - Technology, especially for older adults.
    - Come to the people. Serve the people. Ask what they need and help work towards that.
4. **On a scale of 1 to 10, how satisfied are you with the responsiveness of local leaders to provide better access to appropriate behavioral health services for you and your community?**
        - **What would have to happen for your score to increase by one?**
    - Riverside County: 7. The county brought in nine liaisons to represent different communities.
        - More transparency.

- County score: 5. The county has access mental health funds to train mental health advocates in the community.
    - Establish and fund mental wellness centers in Black communities.
- County score: 5. Funding for mental health is not just going to a therapist and talking about historical traumas but must include full-time wellness activities.
    - Wellness centers that work for each community. The county needs to look more big-picture at how to help specifically Black communities beyond therapy to the wellness side.
- Orange County: 8. County officials are receptive to making mental health advocacy more open and accessible.
    - Formalize community participation.

5. How would you like to see statewide and local advocacy organizations collaborate toward positive impact on the mental health needs of diverse communities?

- Recognize the multifaceted identities, experiences, and needs that make up that diverse community. It is not one size fits all.
- Individualized and affirming resources and care.
- Tailor solutions to address specific needs.
- More leadership and advocacy training for community members in their language.
- Annual listening sessions with local partner communities. Gatherings where people can heal together.
- Provide opportunities for communities to meet locally with their elected officials to share needs.
- Engage the community directly. Meet people where they are in the community. Respect and honor community members.
- Community wellness spaces in the Black community. These will address stigma. Often, the Black narrative gets lost in the politics and discussions. Add Black representation to some of the provider lists.
- Organizations that are Black-led and focus on mental health needs in the community statewide.
- The use of data as a means of accessing funding for advocacy needs to consider those groups that have been harmed the most in this country by government, mandated policies, and anti-Black discrimination.
- Technical assistance and workshops for local and statewide partners to come together to find solutions.

- State agencies and local leaders cannot fund programs that are already doing this work. Do not reinvent the wheel.
- The Commission should have projects and goals that specifically reduce mental health disparities, not just have it as a "general priority" within other projects.

Families of Consumers

Listening Session Meeting Summary

Date August 7, 2023
Location Virtual Only

1. **What are the most critical mental health needs of families of consumers in California today?**
    - A tiered approach – entry-level parenting up through a high level of medical and psychological care.
    - More treatment beds, hospital beds, and subacute beds.
    - Acute and subacute beds for children. Access to care for children who are beginning to exhibit psychotic symptoms.
    - Subacute treatment in Sacramento County for adults and augmented board-and-care for individuals who need extra help.
    - Expansion of the criteria of "gravely disabled" so they can qualify for treatment.
    - Difficulty finding a therapist, therapists who do not respond, therapist changeover, and therapists who go on vacation without backup.
    - Inadequacy in the degree of care in state hospitals. Extended care while in therapeutic secure settings such as psychiatric hospitals would be beneficial.
    - More step-down programs to help individuals transition from locked facilities to outpatient, which has minimal supervision.
    - It is a travesty that it takes the judicial system to get consumers into the right level of care. It is important to be given every opportunity to get well but not in a cell.
    - Step-down programs are important before releasing patients out into the streets.
    - Appropriate training for people who are hired to talk to patients prior to release. They ask what the patient would like to do when the patient's level of thinking is not back to full normal speed. There is no guided decision-making and no recognition of the intellectual incapacity at that moment.
    - Do a cognitive assessment while looking for the step-down bed so that the appropriate level of supervision can be delivered. The individuals with appropriate training can link patients to those beds.
2. **What are the barriers or challenges to accessing mental health services and supports?**
    - Parents reach out for help but are told that their child must commit a crime in order to receive help.

- Private insurance does not cover intensive services, which is the Coordinated Care Treatment Model that EPI-CAL is piloting across California.
- Senate Bill (SB) 855 mandates that private insurance companies cover intensive treatment. The Department of Managed Health Care (DMHC) just held a public comment period on regulations that should be published soon.
- The law and the interpretation of the LPS Act. Definition of “gravely disabled” and “danger to self or others” need to be expanded.
- Available providers, especially with Medicare, is a problem. Many clinics substitute physician assistants or psychiatric nurses for psychiatrists. Consumers who need a higher level of care need psychiatrists, not someone to prescribe medications.
- Lack of resources to help consumers who are a danger to self or others, including mental health providers, ambulances, and a lack of coordination between law enforcement and outpatient programs.
- County behavioral health staffing to run programs.
- Peer mentorship programs.
- Workforce. Engage permanent part-time workers. There are often delays in linking people to services due to staffing problems.
- Provide more access to telehealth school supports and generally more access in the schools.
- Need for provider-level improvements including flexibility, billing, etc.
- Transportation to services and housing.
- Full wrap housing – not independent living homes or board-and-cares, but something that has tiny houses with a core of social services and engagement being provided. More beds and easier access to things like Crestwood and Alpine. This is necessary for the most ill individuals who do not recognize how ill they are.
- Law enforcement should not make the decision on whether someone goes to the hospital or to jail. Locked facilities do not solve all problems.
- The theme of drug use versus severe mental illness. Treatment for both at the same time is best.

3. What are the barriers or challenges to staying engaged with services and supports?

- Families are often pushed away from or denied support or information on an adult child’s treatment.
- Families are not told what their rights are or how to advocate for their children. Many providers view families as a problem, in the way, and a hassle to deal with.

Advocate for families to be engaged in helping their children, even if it is not fully engaged.

- Families have many needs. Each family is unique in their needs and often have many demands. Bring services to where at least the children are during the day.
- Work with families when those families are clearly providing healthy support/healing homes.
- Cultural components, the comfort of families, and trust building also need to be considered. Building trust with therapists takes time, especially when including mental health issues.
- Include peers in programs to connect with individuals and families to provide a source of hope, support, and navigation. Include both consumer peers and family member peers in all treatment teams and approaches.
- Hospitals release people to the streets who are not stabilized, or have not even been treated.

4. **On a scale of 1 to 10, how satisfied are you with the responsiveness of local leaders to provide better access to appropriate behavioral health services for you and your community?**
    - **What would have to happen for your score to increase by one?**
    - San Diego County. The system is reticent to hear criticism.
        - Have a system that takes anonymous tips to help inform the community and bring action from advisory boards.
    - San Diego County: 3. The county is planning for better services and funding various programs.
    - San Diego County: 2: The hospital often releases consumers to the streets, sometimes in the middle of the night. The staff at the ACT program, which is supposed to be the highest level of care outside of a locked facility, are many times not accessible in crisis.
    - Sacramento County: 4. Funding sources are often convoluted so leaders protect their own projects.
        - Collaboration from County Departments could lead to better outcomes. They could include the services of families and voices of consumers to better the outcomes.
5. **What types of training, education, and advocacy activities at the local and state levels are most effective for families of consumers?**
    - The most effective advocacy that families can do is to contact the local behavioral health services problem resolution line, reach out to the local NAMI affiliate, and participate at the adult and children's systems of care committee meetings of county mental health boards to let their voices be heard.

- Comprehensive training on the MHSA for counties and advisory boards.
- County liaisons who outreach to families are effective in bringing families in.
- Public service announcements through the school districts. This targets the whole community for children in schools.
- Define and provide training on the roles and responsibilities of advisory boards for advisory board members across the state so the right people can be recruited for the job and so they can make more informed contributions to their governing bodies.
- Advocacy training program to educate clients and family members on the rights and challenges of the MHSA, like what Cal Voices did with the ACCESS Ambassador Program. NAMI offers family-to-family education classes at no cost.
- Put together a library of videos and vignettes from counties on questions polled on practices in each county and what the county is doing on certain issues.
- Include more youth and school representation on county boards so youth can be heard locally and better partnership can be built.
- Offer education and training through the schools. These parents may also have adult children who need services.
- Supportive services need access to a shared medical record and a single shared "Authorized Representative" form.
- Counties refuse to count the family "beds" or recognize that families provide all the services of an FSP, only on an individualized level. Our needs are left undocumented; this affects the loved one's needs being augmented by services.
- Families are leaned on far too much and expected to handle situations and loved ones who are severely ill.
- Leaders could do a better job attracting providers (primarily psychiatrists and clinicians).

6. How would you like to see statewide and local advocacy organizations collaborate toward positive impact on the mental health needs of families of consumers?

- Increased dialogue between family member community and client community using non-violent communication methods. Special interest groups drive a wedge between these two communities and pass legislation that is not in the interest of either group.
- There needs to be an effort to bridge the differences between the peer advocacy organizations and those perceived to be family-oriented.
- Hold quarterly update meetings that are open to the public to hear from families about what is working well in programs and about what could be working better.

- It improves families' mental health when they feel that they are interfacing with FSPs or other services being offered, that there is sensitivity to the work the family is doing, and to separate what is being asked of families from the family connection. This helps keep the family trust and the sense of larger family intact. This is empowering.
- There is a huge population of families who have their loved one at home. In many cases, counties do not know about this person or the amount of support an elderly family member is giving to "keep it together."
- More openness and opportunities for connection and feedback between the state level advocacy organizations and the individuals at the local level. There often does not seem to be a connection between that and families on the ground. It is often impossible to find the name and number of an individual to contact within these organizations, such as NAMI California. Some advocacy organizations are more open and accessible to individuals who are not in the direct line of power within their organization while others are less so.
- Access funded by CDCR through CCJBH.

LGBTQ+ Populations

Listening Session Meeting Summary

Date August 9, 2023
Location Virtual Only

1. **What are the most critical mental health needs of LGBTQ populations in California today?**
    - Lack of culturally-competent providers and recruitment struggles, especially in diversity of language and culture. This is especially true for trans individuals.
    - Lack of culturally-relevant services that understand the intersectionality in individuals' identities. LGBTQ-affirming services are usually only available during working hours.
    - Hostile providers, conversion therapy, expensive and inaccessible services.
    - Suicidal ideation, particularly amongst young, transgender, and genderfluid individuals.
    - Youth do not have meaningful access to healthcare because they lack funds and transportation and may not be able to safely ask their parents for help.
    - Housing and general expenses, especially for transition-age youth.
    - Mental healthcare for unhoused individuals.
    - Older adults facing issues such as isolation or coming out or transitioning at an older age. Fear for safety in public events and resource centers for attendees and employees. Seniors especially in rural areas find it difficult to be out.
    - Intersectionality is very important, especially for Black and Brown individuals. Consider more than race, class, and age.
    - Lack of mental healthcare and social support groups for LGBTQ leaders. Much of California is rural and anti-LGBTQ and, as anti-LGBTQ hostility grows across the country, leaders are experiencing mental health distress and secondhand trauma as they provide services and training to their communities.
    - Things that bring joy and safe spaces in an increasingly dangerous national climate, particularly in rural areas. Accessing services in rural areas is much more challenging than in urban areas. Support groups, knitting hours, movie nights – these things promote wellbeing.
    - Employment, financial, transportation, isolation and loneliness, and discriminatory hiring issues. It is important to find happiness and be able to leave unsafe situations.
2. **What are the barriers or challenges to accessing mental health services and supports?**

- Lack of services and long wait times. The need is greater than the capacity, especially for youth.
- Transportation. This compounds with safety issues, wait times, and long distances.
- Lack of availability of and accessibility to providers who are LGBTQ-affirming or LGBTQ themselves.
- In rural areas, individuals must drive long distances to reach safe providers. There is nothing safe locally. This is expensive and inaccessible and leads to many individuals being forced to give up the care they need and deserve, which exacerbates their other health and mental health issues.

3. **What are the barriers or challenges to staying engaged with services and supports?**
    - Finding appropriate services based on need – crisis services, residential, housing, eating disorder services, individual or family counseling, etc.
    - Negative experiences with providers, including around other intersectional identities. Lack of knowledge and understanding are negative.
    - Unrealistic costs. With MediCal, each appointment may be with a different provider, which creates anxiety and is an inefficient use of appointment time. Affirming providers may not take insurance.
    - Consistency – lack of providers and infrequent service availability.
    - Support group facilitator burnout.
4. **On a scale of 1 to 10, how satisfied are you with the responsiveness of local leaders to provide better access to appropriate behavioral health services for you and your community?**
        - **What would have to happen for your score to increase by one?**
    - Stanislaus County: 4. As a rural area, the culture is not accepting, so local leaders do not do much to enforce or implement the laws or policies the state passes. For example, students' rights may be violated when teachers refuse to respect their pronouns and preferred names, while the teachers' behavior continues without correction.
        - Figure out how the laws that are being passed to support LGBTQ people who have access to mental health services are being followed through.
    - Calaveras, Tuolumne, and Mariposa Counties: 1 or 2. Rural schools prevent students from discussing anything related to LGBTQ identities or experiences. Elected officials actively oppose LGBTQ communities and rights. LGBTQ individuals are actively denied basic care and existence as citizens and human beings.

- Alameda County. In the Bay Area, queerness is visible but overlooked as a marginalized identity. It is hard to advocate when the community is dismissed as not needing focused care.
- Amador County: Schools do not abide by rights of LGBTQ students and will not until they are sued and fined.
- Sacramento County: 6.
    - Listen to the community and acknowledge there is still work to do. Avoid complacency and invest in community services.
- Los Angeles County: 5. The county is so large that local leaders subcontract most LGBTQ mental health services, which increases wait times.
    - Mandatory LGBTQ competency training for Department of Mental Health staff and therapists would help.
- Stanislaus County: 5 or 6. CBOs and partners are allies, but local leaders – school districts, city councils, boards of supervisors – must change.
- Amador County: 1. The Board of Supervisors claims the county "does not welcome nor serve" the LGBTQ community.

5. What types of training, outreach, and advocacy activities at the local and state levels are most effective for LGBTQ populations?

- Basic LGBTQ "101" is not common knowledge unless actively seeking to learn about or belonging to the community. It is important for mental health providers, shelter workers, law enforcement personnel, etc. who will certainly be working with the LGBTQ community at some point. Many stereotypes exist due to ignorance, not maliciousness, but the resulting microaggressions and demands for information can burn out LGBTQ individuals and make constructive dialogue difficult. Funding is crucial. Some counties resist.
- Training for providers has no follow-up to develop deeper understanding. Mandatory refreshers are important as information evolves.
- Required LGBTQ-affirming training for all medical and mental health providers. This includes providers who are affirming towards all LGBTQ identities, not only affirming to some to the exclusion of others.
- Workforce development for providers who are LGBTQ.
- Training on confidentiality, grief support, language-based support, especially for Spanish speakers, education on what affirming is—affirming means more than tolerant, SOGI data collection training, and working with individuals who are neurodivergent.
- Resources directing individuals to affirming, competent providers.
- Trainings for specific types of providers, such as addiction counselors.

- Much of the training work is reestablishing relationships with organizations whose employees have burned out and left the area to offer refreshers before any incidents occur. This is inefficient. Additionally, LGBTQ training is not required for many organizations, and some outright refuse.
- Organizations like #Out4MentalHealth provide training and peers to alleviate the burden on LGBTQ leaders as they work in places where they are not understood or accepted.
- Partnerships with community centers and community-based organizations that provide other services to which LGBTQ clients can be referred.
- County-level advocacy, because many decisions about services, priorities, funding, and so on are made at the local level.
- If Los Angeles County would subcontract with LGBTQ grassroots organizations, they could provide up-to-date training. Instead, the county pays UCLA to create trainings, and the people who create them are sometimes not LGBTQ.
- State-level advocacy to enforce existing laws and hold counties, providers, and health plans accountable in unsupportive counties.

6. **How would you like to see statewide and local advocacy organizations collaborate toward positive impact on the mental health needs of LGBTQ communities?**
    - Shared objectives to move forward on. Organizations are more effective when communicating and coordinating than when working toward a common goal separately. Staffing and funding go further when shared. A better network across California would be beneficial.
    - Sharing resources to support leaders.
    - Network-building across counties to connect rural individuals with community members.
    - #Out4MentalHealth helps coordinate collaboration between organizations in the fight for mental health equity.

Parents and Caregivers

Listening Session Meeting Summary

Date August 15, 2023
Location Virtual Only

1. What are the most critical mental health needs of parents and caregivers in California today?

- Advocacy organization mostly focus on the mental health needs of children rather than the mental health needs of parents and caregivers.
- Parents and caregivers, as well as siblings and other family members, need their mental health needs met.
- Parents and caregivers advocate for their children and experience secondary trauma from what their children have endured. There are no resources or supports to help. Once their children reach adulthood, it becomes even more difficult. What systems are in place to support parents and caregivers are ineffective.
- Parents and caregivers may have their own mental health needs and lived experience, and may come from generations who did not receive support. They are judged, disrespected, criticized, and reported as they try to raise their children.
- Parents and caregivers and their children are blamed and shamed for their experiences and reactions to those experiences, even if they are victims of crimes.
- Additionally, the educational system is often not aligned with children's needs. They face reprimands, suspensions, and expulsions when they need assessments instead.
- Racism and classism in school and mental health arenas. Parents and caregivers are blamed for causing or exacerbating their children's mental health needs.
- Increased need for parent and consumer advocates.
- Need for respite, free childcare, self-care education, funding for more support programs
- Effective support comes only from other parents and caregivers, Parents Anonymous, and the help line. Other groups who claim to understand do not really understand. It is difficult to find support without judgment or shame.
- Compassion and acceptance. Ask what parents and caregivers need and treat them as humans. Unconditional positive regard.

- Empowerment, connection to people with similar experiences, community, and access to trauma-informed wellness activities.

2. **What are the barriers or challenges to accessing mental health services and supports?**
    - Constantly having to advocate and know more about the system than providers do. Parents and caregivers do not know how to find and access services.
    - Siloes and disconnections. Providers do not communicate with each other.
    - Lack of spaces for parents and caregivers to connect.
    - Having to discover and meet certain criteria in order to get an assessment or diagnosis for children.
    - High turnover of therapists, which causes stress to parents and caregivers and children. Children cannot make progress when they must continually start over and relive their trauma with yet another therapist.
    - Long wait-times, too much paperwork. Scheduling appointments is a barrier, especially coupled with delays.
    - Many departments and organizations feel that what they have is the best or only thing for an individual. Parents and caregivers need to have a variety of resources available so they can choose any and all that will help them. Needs change, and sometimes multiple resources at once are necessary.
3. **What are the barriers or challenges to staying engaged with services and supports?**
    - When finally receiving support, being questioned about trauma responses and feeling unheard. One experience may cause people to become dismissive about other experiences and needs and even blame the individual for having them.
    - Sharing too much or asking for too much help can cause parents and caregivers to be reported and lose their children.
    - Burnout. Advocating for so long to get services, then struggling with turnover and unstable or subpar services.
4. **On a scale of 1 to 10, how satisfied are you with the responsiveness of local leaders to provide better access to appropriate behavioral health services for you and your community?**
        - **What would have to happen for your score to increase by one?**
    - Sacramento County: 3. Even local leaders with some lived experience have not talked with the public to hear about a variety of experiences. There is a disconnect between policy and what is actually happening on the ground. Decisions are made based on theory. Communication with consumers and families is necessary.

- Los Angeles County: Less than 3. Money is being thrown around with little to no results.
- Local leaders seem to want to listen to communities only because they are forced to, and what they hear is never implemented. It feels that they have already made their plans and are not influenced by community feedback.
- There is not enough staff to handle mental health needs anywhere.

5. What types of training and education activities would promote the needs of parents and caregivers?

- Having parents and caregivers at the table everywhere. It is often difficult for them to participate in meetings, especially in person.
- Meeting with district representatives. More opportunities to train and educate parents on how to advocate at the local and state levels. Advocacy is crucial.
- Many parents and caregivers must learn by experience without education.
- Network-building, support groups, shared leadership, training on general parenting.
- Statewide Advocacy Day is very effective. Personal contact with legislators makes a difference.
- The Community Advisory Committee for Special Education focuses on all types of disabilities, including mental health, and offers training on the systems and on how to advocate.
- Helping parents and caregivers to get certificates and degrees, such as through stipends for programs that focus on lived experience.

Veterans

Listening Session Meeting Summary

Date August 17, 2023
Location Virtual Only

1. **What are the most critical mental health needs of veteran populations in California today?**
    - Someone to hear and understand veterans.
    - To express themselves as a whole person and not just for their military service.
    - Suicide prevention and early intervention. Isolation versus community.
    - Substance abuse treatment. Support for veterans who choose to use methods of therapy that may be mistakenly grouped under substance abuse.
    - PTSD, mood disorder, behavioral management treatment.
    - Cognitive behavioral therapy that supports veterans as they transition out of the service.
    - A safe place to share what they are going through and take them out of their pain. Safe spaces with trusted community to share issues in order to get help.
    - Focus on female and marginalized veterans.
    - Understanding of cooccurring needs and the differing needs of cohorts such as older veterans.
    - Bridging gaps between active duty and post-service veterans to assist with transition.
    - A nationwide collaboration between therapy programs.
    - Advocacy for more art therapy, along with outreach and engagement for such programs on long term art programs. Accessibility to creative arts and socialization.
    - Transportation to free classes and other services.
    - Basic needs: housing, food, etc, lack of empowerment, financial issues.
    - Lack and need for holistic healing, community, camaraderie, and belonging.
    - State, legislative, and community collaboration to make change. Veterans are not fully represented in MHSOAC advocacy funding. Veteran services and advocacy are still underfunded statewide.
2. **What are the barriers or challenges to accessing appropriate mental health services and supports?**
    - Lack of consistent funding. Misconceptions that all veterans are eligible.

- The shortage of healthcare workers in the VA and in the broader medical community. Constant turnover at the VA, especially for residents in psychiatry.
- The shift to telehealth causes challenges for older veterans.
- Stigma and distress of healthcare services. Stigma around institutionalization and therapy.
- Learned military behaviors, such as not asking for help. Compartmentalization of conflicting identities – the tough military façade concealing vulnerability.
- Lack of recognition, respect, and rewards for veterans and their families. Lack of support for, or prohibition of, bringing children to appointments and activities.
- Cooccurring issues, such as serious mental illness that only manifests at the age an individual has joined the military.
- Veterans should be able to get a broad spectrum of care in their communities due to being citizens of California, and yet they are expected to get everything they need at the VA.
- It is a challenge for family members and spouses to access the health records of their veteran loved ones.
- Nationwide attitudes of hate and bigotry towards intersecting identities that cause veterans to feel that their service is invalidated.
- Lack of peer support and training.
- Brief services that draw out veterans' issues before ending, leaving them to deal with healing alone. Open-door programs that let veterans work through their healing at their own pace are crucial.
- Lack of ease of access, including long wait times, lack of transportation.
- Lack of advocacy.

3. What are the barriers or challenges to staying engaged with services and supports?

- Homelessness and addiction are two most common negative outcomes among veterans.
- Veterans who experience chronic homelessness do not receive enough support within the permanent supportive housing structure to be able to get effective services and care.
- Lack of culturally-aware training for mental health clinicians serving veterans. Many clinicians do not know how to engage with veteran-specific trauma or how to identify a veteran's family status which further impacts both the veteran and loved ones.
- Staffing in community-based settings. General lack of funding for veteran mental and behavioral health care.

- PTSD, isolation, depression, substance abuse, and suicidality.
- Lack of attention on the intersectionality of veterans, including women, LGBTQ+, minorities, housing, formerly incarcerated.
- LGBTQ veterans who are commonly discriminated against due to their sexuality during and after service.
- It is important for veterans to have a seat at the table for conversations with local leaders to happen.

4. **On a scale of 1 to 10, how satisfied are you with the responsiveness of local leaders to provide better access to appropriate behavioral health services for you and your community?**
    - **What would have to happen for your score to increase by one?**
- San Luis Obispo County: 4. Often put on a waitlist at the county mental health services even for urgent needs
- Sonoma County: 4. There is a depth of variety in service organizations and resources, and local leadership are generally receptive to veteran requests. However, there could be more initiative from the local leaders as well.
- The VA clinic in Ventura County has a high turn over rate for ppsychiatrists and counselors. A provider had shared that they are underpaid and overworked.
- Veterans are needed on behavioral health advisory boards to inform decision makers of first hand experiences.
- Local leaders typically do not consist of veterans and are unaware of veteran-related barriers and challenges. Engagement with Supervisors and council members are key to bringing broad issues of lack of funding for veterans at the county level.
- County mental health services need to receive training on veteran cultural competency, risk factors, veteran-specific trauma informed care, as well as the awareness of bureaucratic barriers to care.
- VA services tend to be separated by long drives and typically involve driving between counties to reach services.
- County supervisors are divided by political lines which leaves veterans to suffer as a result.

5. **How should statewide and local advocacy organizations collaborate toward positive impact on the mental health needs of veteran populations?**
- Connect veterans with other veterans. Veterans know themselves the best.
- The building of a grassroots network to support advocacy is essential.

- Better coordination and engagement, particularly at the state level, is necessary with the upcoming Senate Bill 326 and Assembly Bill 531. The funding structure for mental health will change dramatically.
- Present veterans with more opportunities to do things for other people, build community, and find purpose.
- State policies to overhaul the VA and increase the capacity of the VA to serve veterans are severely needed.
- Increase workforce capacity with geriatric training, substance use disorders, trauma informed care, harm reduction, cognitive decline (substance use and aging), long-term homelessness, TBI, PTSD, moral injury, long-term care.
- Increase outreach and education activities that focus on Medicare and Medi-Cal, SSI and SSDI, VA Aide and Attendance programs, caregiver support, and VA pensions.
- Outreach towards non-veteran specific venues and providers such as educators, clergy, and community clinics. Reduce the framing of veteran outreach as overly patriotic, which could carry negative experiences for the veteran.
- Building a library of accessible resources. This can include social media, libraries, VSO meetings, and the VA.
- Programs like the Combat to Community course provided by Swords to Plowshares are good models to adopt by the VA and other service providers and agencies.

Mental Health Services
Oversight & Accountability Commission

Advocacy Contracts 2020-2023
Summary of Accomplishments

In 2020, the Commission contracted with six statewide organizations to conduct state and local level advocacy on behalf of the mental health needs of underserved populations. These organizations were the following:

Organization	Population
California Association of Mental Health Peer Run Organizations (CAMHPRO)	Clients and Consumers
California Pan Ethnic Health Network (CPEHN)	Diverse Racial and Ethnic Communities
NAMI California	Families of Clients and Consumers
California LGBTQ Health and Human Services Network (CA LGBTQ HHS Network)	LGBTQ+ Communities
United Parents	Parents and Caregivers
The Veterans Art Project (VETART)	Veteran Communities

Each statewide organization subcontracted with up to 15 local level entities across California to assist in holding local mental health advocacy events and provide representation for community members at the state policy level.

Between 2020-2023, 71 local community organizations engaged in advocacy across 41 counties. Statewide organizations and their local partners organized focus groups and listening sessions, facilitated local advocacy events, interacted with county decision-makers, and advocated for mental health policies and initiatives at the State Capitol. All local community organizations received funding over the three years.

Clients and Consumers

- Listening sessions consisting of consumers and peers were held each year in partnership with a total of 15 local consumer-run advocacy organizations where consumer needs were heard and gaps and policy solutions were identified
- Listening sessions culminated into three annual LEAD Summit statewide conferences which championed consumer and peer voice and hosted state level leaders and state legislators

Diverse Racial and Ethnic Communities

- CPEHN, in partnership with its local and state partners, facilitated 15 listening session events that opened spaces to learn and hear from BIPOC voices
- Listening sessions and partnerships led up to three annual statewide events titled *A Right To Heal* which acted as both statewide learning events and collective celebrations of California's BIPOC communities

Families of Clients and Consumers

- NAMI CA and affiliate partners facilitated numerous community level advocacy events where family members received support and were provided the opportunity to voice their experiences to others
- NAMI CA held three Advocacy Days and multiple statewide town halls which addressed issues relevant to the mental health needs of family members

LGBTQ+ Communities

- The CA LGBTQ HHS network and cohort of local organizations supported LGBTQ+ mental health advocacy through monthly convenings focusing reaching 15 different counties
- The learnings and advocacy at the local level fuled the annual California LGBTQ Health and Human Services Convenings which brought together LGBTQ+ leaders across the state to network and build skills related to program development, policy engagement, and advocacy strategies

Parents and Caregivers

- In partnership with local organizations and established coalition, United Parents hosted multiple workshops and outreach events aimed at providing the tools needed for caregivers and parents to advocate for themselves across 15 counties
- United Parents held three Advocacy Day at the Capitol events where they brought parents and caregivers across the state to Sacramento to advocate for impactful mental health policies to legislative members and their staff

Veteran Communities

- VETART held its successful Pop-Up Community Creative Arts Café in 14 counties where veterans and family members learned to treat isolation with art-based and creative modalities
- Two statewide Pop-Up Community Creative Arts Café (Third scheduled for October 2023) brought veteran community members to the Capitol West Steps where their art was used as advocacy tools to communicate with state policy makers

Local Level Entity Partners

CAMHPRO	*NAMI California*	*VETART*	*CA LGBTQ HHS Network*	*CPEHN*	*United Parents*
Consumers Self Help Center	NAMI Butte	AMOCA	Amador Arts Council TCA	Altamed	California Alliance of Caregivers
Fresno Center	NAMI Fresno	Arts Council of Mendocino County	Fresno EOC	Bakersfield American Indian Health Project	Capital Adoptive Families
Happier Life Project	NAMI Orange	Cal Berkeley	Imperial Valley LGBT Resource Center	Be Smooth	Growing @ Home
Living in Wellness	NAMI Santa Cruz	Cal Veterans Center	LA Gender Justice	California Black Women's Health Project	Mayfair Seventh Day Adventist Churh
Manzanita Services	NAMI Stanislaus	Deprise Art Gallery	La Jolla Band of Luiseno Indians	FIRM	Parents and Caregivers 4 Wellness
Mental Health Client Action Network	NAMI Tehama	El Dorado Arts and Culture	Metamorphosis	Hmong Cultural Center of Butte County	Siera Native Alliance
MHA San Francisco	NAMI West Los Angeles	Life on Earth Art	Oakland LGBTQ+ Community Center	Mixteco Indigena Community Organizing Project	The Whole Child
Painted Brain		MONCA	Queer Humboldt	ONTRACK	
Peer Recovery Services		Oceanside Museum of Art	Radiant Health Centers	Restorative Justice for Oakland Youth	
PEERS		Riverside Arts Council	Rainbow Community Center	The Cambodian Family	
Project Return		Shasta County Arts Council	Rainbow Pride Youth Alliance	True North	
Riverside University Health System		Up 2 Peace	San Joaquin Price Center	Vision y Compromiso	
Safe Space		USS Iowa	Shasta NorCal OUTreach	Vista Community Clinics	
SHARE!		Yuba-Sutter Arts and Culture	Still Bisexual		
Transitions			The Source		

MISCELLANEOUS ENCLOSURES

September 28, 2023 Commission Meeting

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

Mental Health Services
Oversight & Accountability Commission

Summary of Updates

Contracts

New Contracts: WestEd, Third Sector

Total Contracts: 5

Funds Spent Since the June Commission Meeting

Contract Number	Amount
17MHSOAC073	$ 0.00
17MHSOAC074	$ 0.00
21MHSOAC023	$ 0.00
22MHSOAC025	$ 100,000.00
22MHSOAC050	$ 0.00
TOTAL	**$ 0.00**

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: $2,089,594.40

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)	Complete	1/15/21- 3/15/23	No

Deliverable	Status	Due Date	Change
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	Complete	1/15/21-3/15/23	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
Draft**s** Formative/Process Evaluation Final Report (a and b)	Complete In Progress	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

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: $2,089,594.40

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)	Complete	1/15/21- 6/15/23	No
Formative/Process Evaluation Plan Implementation and Preliminary Findings (11 quarterly reports)	Complete	1/15/21- 6/15/23	No

Deliverable	Status	Due Date	Change
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
Draft**s** Formative/Process Evaluation Final Report (a and b)	Complete In Progress	3/30/23 7/15/23	No
Final Report and Recommendations	Not Started	11/30/23	No

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
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

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Not Started	06/30/2024	No

WestEd: MHSSA Evaluation Planning (22MHSOAC025)

MHSOAC Staff: Kai LeMasson
Active Dates: 06/26/23 - 12/31/24
Total Contract Amount: $1,500,000.00
Total Spent: $100,000.00

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

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

Mental Health Services
Oversight & Accountability Commission

Third Sector: FSP Evaluation (22MHSOAC050)

MHSOAC Staff: Melissa Martin Mollard
Active Dates: 06/28/23 – 6/30/24
Total Contract Amount: $450,000.00
Total Spent: $0.00

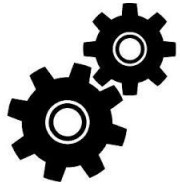
This project will evaluate the effectiveness of FSPs through community engagement, outreach and survey activities culminating in a final report to the Commission with specific recommendations for strengthening the implementation and outcomes of FSP programs throughout the State.

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

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD

SEPTEMBER 2023



UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	3	3	**6**
Participating Counties (unduplicated)	3	3	**6**
Dollars Requested	$7,399,785	$113,368,609	**$120,768,394**

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

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
2023-2024	1	1	$11,938,639	1

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	Los Angeles	Kedren Children and Family Restorative Care Village	$109,109,252	5 Years	6/2/2023	Pending
Under Review	Tri-City	Community Planning Process	$675,000	3 Years	7/5/2023	Pending
Under Review	Yolo	Crisis Now	$3,584,357	3 Years	6/1/2022	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	Amador	Workforce Retention Strategies	$1,995,129	5 Years	6/19/2023	8/2/2023
Under Final Review	San Luis Obispo	Embracing Mental & Behavioral Health for Residential Adult Care & Education (EMBRACE)	$860,000	4 Years	7/14/2023	9/12/2023
Under Final Review	Santa Cruz	Crisis Now Multi-County Innovation Plan	$4,544,656	3 Years	7/14/2023	9/11/2023

APPROVED PROJECTS (FY 23-24)

County	Project Name	Funding Amount	Approval Date
Santa Clara	TGE Center	$11,938,639	7/27/2023

DHCS Status Chart of County RERs Received
September 28, 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 August 30, 2023. This Status Report covers FY 2020 -2021 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.

DCHS MHSA Annual Revenue and Expenditure Report Status Update

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	5/19/2023	5/19/2023		8/16/2023
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
September 28, 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	5/25/2023
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
September 28, 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	7/18/2023	7/24/2023	8/24/2023
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**	**59**	**56**	**41**	**56**

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Rolling Commission Meeting Calendar (Tentative)

At its January 2023 meeting the Commission identified four priorities: Data/Metrics, Full-Service Partnerships, the Impact of Firearm Violence, and Strategic Planning. The draft calendar below reflects efforts to align the Commission meeting schedule with those priorities. **All topics and locations subject to change**.

Dates	Locations	Priority*
September 28	Los Angeles	**9/27** – SUD Site Visit to Street Medicine Program **9/28 -** Substance Use Disorder Discussion
October 25-26	San Francisco	**10/25**-UCSF Neuropsychiatry Site Visit **10/26**-Impact of Firearm Violence Panel
November 16	Virtual	Strategic Plan- DRAFT Election of Chair and Vice Chair FSP Panel Presentation
December	(no meeting)	
January 25, 2024	Santa Barbara	2024-2027 Strategic Plan Adoption Impact of Firearm Violence Report-DRAFT
February 21-22	Napa	**2/21** – Site Visit to Napa State Hospital **2/22** - Priority agenda items for February 2024 through June 2024 will be determined after adoption of the 2024-2027 Strategic Plan
March 28	TBD	TBD: Pending New Strategic Priorities
April 25	TBD	TBD: Pending New Strategic Priorities
May 23	TBD	TBD: Pending New Strategic Priorities
June	TBD	TBD: Pending New Strategic Priorities

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