WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Meeting Materials Packet

Commission Meeting

October 24, 2024

9:00 AM – 3:00 PM

Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING NOTICE AND AGENDA

October 24, 2024

NOTICE IS HEREBY GIVEN that the Commission will conduct a meeting on October 24, 2024, at 9:00 a.m.

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

DATE	October 24, 2024
TIME	9:00 a.m.
LOCATION	1812 9th Street, Sacramento, CA 95811 and Virtual

ZOOM ACCESS
Zoom meeting link and dial-in number will be provided upon registration.
Free registration link: https://mhsoac-ca-gov.zoom.us/meeting/register/tZMrce2rqj8vG9LDzbQEQnIBGxGNBBiuSmSz

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

Our Commitment to Excellence

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

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

Meeting Agenda

It is anticipated that all items listed as "Action" on this agenda will be acted upon, although the Commission may decline or postpone action at its discretion. Items may be considered in any order at the discretion of the Chair. Public comment is taken on each agenda item. Unlisted items will not be considered.

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

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

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

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

9:15 a.m. **3. General Public Comment**
Information

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

9:35 a.m. **4. August 22, 2024, September 11, 2024 and September 26, 2024 Meeting Minutes**
Action

The Commission will consider approval of the minutes from the August 22, 2024, September 11, 2024, and September 26, 2024 Commission meetings.

- Public Comment
- Vote

9:40 a.m. **5. Transformational Change in Behavioral Health: Early Intervention & Full Service Partnerships**
Action

The Commission will hear a presentation from the Department of Health Care Services on the vision for Early Intervention services and Full Service Partnerships. Proposition 1 directs counties to identify early intervention approaches to address the negative outcomes of mental illness and sets aside 35% of BHSA funding for Full Service Partnerships. This presentation and discussion will provide an opportunity for discussion on these two key areas of behavioral health reform; *presented by Marlies Perez, Division Chief, DHCS*

- Public Comment
- Vote

11:00 a.m. **6. Closed Session – Personnel Matter**

Closed Session – Government Code 11126 (a) (1) related to a personnel matter.

1:30 p.m. **7. Report Out from Closed Session**

Chair Madrigal-Weiss will share any reportable actions that took place during closed session.

1:40 p.m. **8. 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.

1. Level Up – Community Driven Practices for Health Equity: Shasta
2. Psychiatric Advanced Directives (PADs) Phase 2: Alameda & Tri-Cities
3. Information Technology Contract Update
4. Reallocation of unencumbered MHWA funds - EmPATH

- Public Comment
- Vote

1:50 p.m. **9. Chair and Vice-Chair Elections**

Action

Nominations for Chair and Vice-Chair for 2025 will be entertained. The Commission will elect the next the Commission Chair and Vice-Chair; *led by Sandra Gallardo, Chief Counsel*

- Public Comment
- Vote

2:20 p.m. **10. Mental Health Student Services Act Report**

Action

The Commission will consider approval of the draft biennial progress report to the legislature on the Mental Health Student Services Act and a contract up to $4 million for phase 2 of the MHSSA evaluation; *presented by Melissa Martin- Mollard, PhD., Chief of Research and Evaluation*

- Public Comment
- Vote

3:00 p.m. **11. Adjournment**

Our Commitment to Transparency

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

Our Commitment to Those with Disabilities

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

Notes for Participation

For Public Comments: Prior to making your comments, please state your name for the record and identify any group or organization you represent.

Register to attend for free here:
https://mhsoac-ca-gov.zoom.us/meeting/register/tZMrce2rqj8vG9LDzbQEQnIBGxGNBBiuSmSz

Email Us: You can also submit public comment to the Commission by emailing us at publiccomment@mhsoac.ca.gov. Emailed public comments submitted at least 72 hours prior to the Commission meeting will be shared with Commissioners at the upcoming meeting. Public comment submitted less than 72 hours prior to the Commission meeting will be shared with Commissioners at a future meeting. Please note that public comments submitted to this email address will not receive a written response from the Commission. **Emailing public comments is not intended to replace the public comment period held during each Commission Meeting and in no way precludes a person from also providing public comments during the meetings.**

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

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

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

→ If joining in person. Complete a public comment request card and submit to Commission staff. When it is time for public comment, staff will call your name and you will be invited to the podium to speak. Members of the public should be prepared to complete their comments within 3 minutes or less, unless a different time allotment is needed and announced by the Chair.

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

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

In accordance with California Government Code § 11125.7(c)(1), members of the public who utilize a translator or other translating technology will be given at least twice the allotted time to speak during a Public Comment period.

AGENDA ITEM 4

Action

August 22, 2024 Commission Meeting

August 22, 2024 Meeting Minutes
September 11, 2024 Meeting Minutes
September 26, 2024 Meeting Minutes

Summary:
The Mental Health Services Oversight and Accountability Commission will review the minutes from the July 25, 2024 Commission meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Enclosures (6): (1) August 22, 2024 Minutes; (2) August 22, 2024 Motions Summary (3) September 11, 2024 Minutes; (4) September 11, 2024 Motions Summary, (5) September 26, 2024 Minutes; (6) September 26, 2024 Motions Summary

Handouts: None

Proposed Motion: The Commission approves the August 22nd, September 11th, and September 26th meeting minutes.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date August 22, 2024

Time 9:00 a.m.

Location San Diego County Office of Education
6401 Linda Vista Road
San Diego, California 92111

Members Participating:

Mara Madrigal-Weiss, M.Ed., Chair
Mayra Alvarez, M.A., Vice Chair
Mark Bontrager, J.D., M.S.W.
Sheriff Bill Brown, M.P.A.*
Steve Carnevale
Rayshell Chambers, M.P.A.
David Gordon, Ed.M.*
Gladys Mitchell. M.S.W.
Jay Robinson, Psy.D., M.B.A.
Alfred Rowlett, M.B.A., M.S.W.

*Participated remotely

Members Absent:

Keyondria Bunch, Ph.D.
Shuo Chen, J.D.
Assembly Member Carrillo, M.A.
Senator Dave Cortese, J.D.

MHSOAC Meeting Staff Present:

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

1: Call to Order and Roll Call

Chair Mara Madrigal-Weiss called the Meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:02 a.m. and welcomed everyone. The meeting was on Zoom, via teleconference, and held at the San Diego County Office of Education (SDCOE), located at 6401 Linda Vista Road, San Diego, California 92111.

Chair Madrigal-Weiss stated the Commission's Strategic Plan for 2024-27 was approved at the January, 25, 2024, Commission meeting. She reviewed a slide about how today's agenda supports the Commission's Strategic Plan Goals and Objectives, and noted that the meeting agenda items are connected to those goals to help explain the work of the Commission and to provide transparency for the projects underway.

Roll call was postponed until Vice Chair Alvarez's arrival as there was not a quorum in the room.

Chair Madrigal-Weiss invited Gloria Ciriza, Ed.D., Superintendent of Schools, SDCOE, to say a few words.

Dr. Ciriza welcomed the Commission to the SDCOE and highlighted key projects including mental health literacy, stigma reduction, suicide prevention, and coordinated referral pathways for students in need of services. She stated the COVID-19 pandemic has changed the everyday life for all, but specifically for children. Addressing the mental health and wellness of students is one of the most important issues currently being faced. She applauded the Commission for its important work to support youth and for its dedication, passion, and commitment to students, families, and educators.

Dr. Ciriza stated the U.S. Surgeon General has described what children are currently facing as a "mental health pandemic for youth." She stated, to address the youth mental health pandemic in a relevant and compassionate way, all systems and disciplines must work together. San Diego County school and health systems work in unison to address the needs of youth to ensure that they are safe and cared for and have the tools they need to succeed.

2: Announcements and Updates

Chair Madrigal-Weiss gave the announcements as follows:

Commissioner Update

Commissioner Itai Danovitch completed his term on the Commission and will no longer be serving as a Commissioner. The Governor's Office is vetting potential candidates to fill his position. The Commission will honor Dr. Danovitch's years on the Commission with a resolution at the September Commission meeting in Los Angeles.

Site Visit

The Chair, Vice Chair, and a few Commission staff made a site visit yesterday to For the Village, which provides free doula services to all families in the San Diego area with an emphasis on marginalized groups – people of color, LBGTQ, and low-income

families. Chair Madrigal-Weiss asked Vice-Chair Alvarez to share a little more about the site visit.

- Vice Chair Alvarez thanked Commission staff for coordinating the site visit to the Urban Restoration Counseling Center, a Black, Indigenous, and people of color (BIPOC)-led mental health counseling center in the community. One of their programs is “Therapy for All,” which opens the doors to everyone regardless of their ability to pay and figures out a way to help community members so that they can help not only themselves but their families. The Center speaks to the importance of community partnerships between community mental health centers and other partners with clients with mental health questions and challenges who need somewhere to go through a trusted source.
- Vice Chair Alvarez stated the site visit included visiting For the Village, a community-based doula network that helps individuals have healthy babies. The warm handoff to this mental health center is only possible because of the relationship that is supported by county and private funds. It was an incredible example of lifting up community leadership and where there is wisdom and leadership in community members.

Commissioner Comments & Questions

Commissioner Chambers stated she met in Oakland with the California Health Care Foundation (CHCF) and the top doulas in the state, promotoras, and community health workers to talk about Medi-Cal managed care plans and about the need for “practitioners of lived experience” to come together to advocate for greater equity, getting benefits out to Medi-Cal recipients, equity in pay across the board, and the importance of linking postpartum and mental health. She stated the importance of ensuring that commercial health plans and county managed care plans understand the need for the continuum of care for birthing individuals with mental health issues so they can come back and thrive in communities.

Commissioner Chambers stated she has learned about how the system is now adding fitness into the medical model and how doulas have had to advocate just to get into these rooms. She stated concern that doulas still have issues with access to hospitals to try to serve individuals.

Chair Madrigal-Weiss stated it is up to Commissioners to continue to ask for site visits and updates to encourage conversations with the Department of Health Care Services (DHCS) and the California Department of Public Health (CDPH). She suggested setting up more site visits to keep the conversation going to elevate current issues.

<u>Legislative Update</u>

A legislative update was included in the meeting packet with information on bills supported by the Commission that are on their way to the Governor’s desk. For more information on the status of all bills, please contact Legislative Deputy Director Kendra Zoller.

Upcoming Events

- The Commission will host two final community engagement events in September as part of the Impacts of Firearm Violence Project. One event will be held in Lassen County and the other in Los Angeles County.
- The Commission is sponsoring Words 2 Deeds 2024 on September 5th and 6th in partnership with the Council on Criminal Justice and Behavioral Health (CCJBH). The hybrid convening will bring together thought leaders from a variety of sectors to establish metrics to measure success in preventing individuals with behavioral health issues from becoming involved with the criminal justice system. These metrics will be useful to policymakers, service providers, and members of the public in the work of reducing criminal justice involvement and promoting the goal of prevention and early intervention.
- All Commissioners are invited to these events and can reach out to staff for more information on registration.

Event Invitations

The Commission has been invited to attend and participate in important events highlighting its work in the behavioral health field:

- Executive Director Ewing was invited to attend the Diana Awards on behalf of the Commission. The Diana Award was established in memory of Diana, Princess of Wales. The Diana Award is the most prestigious honor a young person aged 9 to 25 years can receive for their social action or humanitarian work.
- Executive Director Ewing and Commissioner Carnevale will represent the Commission at the Berkeley Innovation Forum, where they will discuss how emerging health care technologies and business models may transform the future, specifically around open innovation in global health care.
- Executive Director Ewing and Commissioner Carnevale will moderate a fireside chat hosted by the UC and CSU Collaborative for Neuroscience, Diversity, and Learning in September at UCLA. The purpose of the fireside chat is to connect emerging research to evidence-based policy and practice.

Client and Family Leadership Committee Update

Chair Madrigal-Weiss asked Commissioner Chambers, Chair of the Client and Family Leadership Committee (CFLC), to update the Commission on the activities of the CFLC.

Commissioner Chambers provided a brief update of the July 17, 2024, CFLC meeting:

- The CFLC discussed the role and responsibility of the CFLC in regards to the MHSOAC Strategic Plan Implementation. The Committee identified three Committee goals that align with the Strategic Plan's Goal 2: Catalyze Best Practice Networks, Objective 1, support organizational capacity building; Goal 2: Catalyze Best Practice Networks, Objective 3, develop adequate and reliable funding sources; and Goal 3: Inspire Innovation and Learning, Objective 1, curate an analytical-based narrative on the potential for innovation to improve behavioral health outcomes.

- General comments detailed how peer-run housing throughout the state could be a welcoming innovation and how to practically measure success as the Committee goes about each of these goals and objectives. The Committee hopes to stay adaptable to changes that may occur due to Proposition 1 and embrace transformational change by being proactive in its efforts that include mental and behavioral health programs and initiatives.
- The next CFLC meeting will take place on Wednesday, September 25, 2024.

Commissioner Chambers thanked Committee Members and members of the public for the robust solution-driven discussion. Their input and feedback were instrumental and important to making things happen. She stated she looks forward to seeing the difference the Committees can make in informing the Commission on their priorities that align with the strategic goals.

Cultural and Linguistic Competency Committee Update

Chair Madrigal-Weiss asked Vice Chair Alvarez, Chair of the Cultural and Linguistic Competence Committee (CLCC), to update the Commission on the activities of the CLCC.

Vice Chair Alvarez provided a brief update of the August 19, 2024, CLCC meeting:

- The CLCC had a robust discussion about how the Committee and its structure can support implementation of the Commission's Strategic Plan and in particular how the Committee can ensure that the expertise and perspectives of Committee Members from marginalized communities or organizations that are serving marginalized communities can better guide the work of the Commission. The discussion revolved around concrete actions that can be included as part of the Committee work, such as reviewing Requests for Proposals (RFPs), community engagement, and work that advocacy partners are doing and how the CLCC can be a good partner in that work.
- The CLCC discussed Committee makeup and the importance of filling in the gaps of Committee Members. Next year will be an exciting year for the Commission with many questions being faced. The Commission will need to rely on the expertise and guidance of its Committees to be stronger in its response to the implementation of Proposition 1 and the implementation of the Commission's strategic plan and the goals set forward. New Members are being planned to be brought in in 2025. Over the next few months, the Commission will rely on existing Committee Members for their guidance and expertise.
- The next CLCC meeting will take place on Wednesday, October 16, 2024.

Vice Chair Alvarez acknowledged the great comments provided by Committee Members and members of the public. There continues to be appreciation for the Commission's commitment to community engagement and to listening to community. This is an asset this Commission brings not only to its work but to the collective work of the Administration and its commitment to mental health. She suggested continuing to consider how to best leverage the Committees during the implementation of Proposition 1.

Social Media

The Commission has increased its presence on multiple social media platforms to share events, resources, information on policy work, and more through social media.

Chair Madrigal-Weiss encouraged everyone to follow the Commission's work through these platforms.

Chief Counsel Gallardo confirmed the presence of a quorum in the room. Roll call was taken. Attending in Person: Chair Madrigal-Weiss, Vice Chair Alvarez, and Commissioners Bontrager, Carnevale, Chambers, Mitchell, Robinson, and Rowlett. Attending Remotely: Commissioners Brown and Gordon.

Amariani Martinez, Commission staff, reviewed the general public comment protocols.

3: General Public Comment

Dr. Lynn Rivas, Executive Director, California Association of Mental Health Peer-Run Organizations (CAMHPRO), appealed to Commissioners as individuals who have an impact beyond this Commission on behavioral health care policy in the state of California. The speaker stated, as a person with lived experience with mental health challenges, they need and count on peer support. The effectiveness of peer services has been proven by countless studies. Peer-run services are best at maintaining fidelity to the Recovery Model, which is known to be efficient and will result in the greatest mental health services value.

Dr. Rivas stated small peer-run organizations are particularly in peril from the upcoming Proposition 1 cuts, yet they are the best equipped to deliver locally-informed, culturally-competent services that result in more equity for underserved communities. The speaker stated CAMHPRO suggests that 10 percent of all non-medical Behavioral Health Services Act (BHSA) dollars be devoted to peer-run services, which will allow services to expand and will make it possible to fund living wages for peers.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), thanked Dr. Rivas for their comments and Vice Chair Alvarez for doing an excellent job facilitating the CLCC meeting, and commended Commissioner Rowlett for participating in the meeting. The speaker noted that this shows genuine interest and commitment to reducing disparities for underserved communities. Representatives from BIPOC and LGBTQ communities take note of this.

Stacie Hiramoto stated appreciation to Deputy Director Tom Orrock and Riann Kopchak, Commission staff, for reaching out to REMHDCO after the meeting to discuss some of the concerns raised during the meeting regarding the Committee and the RFP process.

Stacie Hiramoto urged the Commission to form a Committee on the Innovation Partnerships Fund.

Sandy Rives, Program Supervisor, Transitions-Mental Health Association (TMHA), stated peer support is an evidence-based practice for individuals living with mental health conditions. The speaker stated peer support is invaluable because it lowers the overall cost of mental health services by reducing rehospitalization rates and days spent

in in-patient services. It also improves the quality of life and engagement with services of those living with mental health issues, and increases whole-health management and self-management.

Sandy Rives stated peer support workers are uniquely positioned to facilitate recovery through empathetic engagement with service users and their support networks. By sharing their lived experiences, peers meet service users where they are, model coping strategies, and provide hope and an example of recovery to those dealing with mental health conditions.

Sandy Rives stated California has finally recognized the value of peers by creating a state certification. The speaker asked the Commission to facilitate and advocate for a living wage for California peers and to dedicate 10 percent of non-Medi-Cal dollars to peer-run organizations in the state of California.

Damon Domici, Peer Support Specialist and Advocacy Coordinator, CAMHPRO, advocated for a living wage for Peer Support Specialists in California.

4: July 25, 2024, Meeting Minutes

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

There were no questions from Commissioners and no public comment.

Action: Chair Madrigal-Weiss asked for a motion to approve the minutes. Commissioner Bontrager made a motion, seconded by Commissioner Robinson, that:

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

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

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

The following Commissioner abstained: Commissioner Mitchell.

5: Consent Calendar – Innovation

Chair Madrigal-Weiss stated the Consent Calendar includes the approval of two innovation programs from Orange County. The first request is to allow Orange County to join Phase 2 of the Psychiatric Advance Directive (PADs) Multi-County Collaborative. The second is a request of an extension for Orange County for their previously approved Community Program Planning Project. Both projects were shared with the Commission's community partners and LISTSERV on July 18th and again on July 26th.

Chair Madrigal-Weiss stated two comments were received in response to Orange County's request to join the PADs Multi County Collaborative. Commission staff forwarded both comments to the county and PADs Contractor. A written response was provided for one of the comments received and a phone conversation was had with the

individual who left the second comment. The first comment received and the written response were included in the meeting materials.

Chair Madrigal-Weiss stated, at the May Commission meeting, Commissioner Rowlett suggested that any innovation proposals brought forward to be considered on consent contain information on how the proposal aligns with BHSA priorities, sustainability under the new BHSA funding areas, and consideration of the impact of the BHSA to existing programs. Both of Orange County's proposals outline BHSA alignment and sustainability.

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

1. Orange County: Psychiatric Advanced Directives (PADs) Phase Two.
2. Orange County: Community Planning Process Extension

Commissioner Chambers recused herself from the discussion and decision-making with regard to this agenda item pursuant to California law.

There were no questions from Commissioners and no public comment.

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

The Commission approves the Consent Calendar that includes:

- *Funding for Orange County to join Phase 2 of the Psychiatric Advance Directive (PADs) Multi-County Collaborative Innovation Project for up to $4,980,470; and*
- *Funding for Orange County's Extension of the Community Program Planning Innovation Project for an additional amount of up to $1,000,000, for a total project amount of $1,950,000.*

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

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

Commissioner Brown noted that the date has changed for the September 12, 2024, IBF follow-up meeting that will be held in Lassen County. The new date is September 16, 2024.

Commissioner Chambers rejoined the meeting.

6: Full-Service Partnership Funding Allocation

Chair Madrigal-Weiss stated the Commission will hear a presentation on Full-Service Partnership (FSP) funding needs and the potential to use Mental Health Wellness Act funding to strengthen California's FSP programs. At the February Commission meeting,

the Commission approved setting aside $20 million in Mental Health Wellness Act funds to fortify the operations and impacts of FSPs. The passing of Proposition 1 has placed new emphasis on the role of FSPs and strategies to measure and monitor their impact. Staff will present a proposal designed to strengthen California's FSP programs and better align incentives with outcomes to support the implementation of Proposition 1 reforms. She asked staff to present this agenda item.

Melissa Martin-Mollard, Ph.D., Chief, Research and Evaluation, provided an overview, with a slide presentation, of the learning efforts, findings, Proposition 1, and alignment with Commission goals for FSPs. She stated FSPs reflect the goal of developing a partnership between the person being served and the service provider, and offering a full array of services, through a "whatever it takes" approach to meeting needs.

Dr. Martin-Mollard stated the DHCS is currently in the process of establishing a Center of Excellence for evidence-based practices and service delivery models, including those that focus on FSPs. While these efforts promise to provide much-needed support to counties in the implementation of effective service delivery models, there remains a lack of technical assistance and capacity-building supports in these and other areas.

Dr. Martin-Mollard stated four areas of potential investment to strengthen FSPs are sustainable funding, workforce development, accountability, and infrastructure. Today's proposal focuses on the sustainable funding and infrastructure levers, while the workforce and accountability areas require further collaboration with other state agency partners to assure that efforts are aligned. She proposed putting out a competitive bid for technical assistance and capacity building with a focus on value-based contracting and performance management and improved service delivery.

Dr. Martin-Mollard stated the primary goals for this four-year effort are to catalyze the restructuring of the current funding system focusing on client outcomes as opposed to only billable services, which would incentivize county participation by subsidizing the transition to an outcomes-based model, and to increase internal capacity of counties and FSP service providers through the creation and implementation of a work group or several work groups aimed at supporting counties in the implementation of evidence-based practices, Community-Defined Evidence Practices (CDEPs), and other innovative solutions to support improved service delivery in FSPs.

Commissioner Comments & Questions

Vice Chair Alvarez stated Proposition 1 implementation will have a huge emphasis on FSPs. She asked how the work overlaps and dovetails with investments.

Dr. Martin-Mollard stated the investments in FSPs in terms of MHSA dollars will remain stable. There is additional funding for housing, and the DHCS establishing a Center of Excellence to support evidence-based practices will help with technical assistance efforts. The idea is to see Proposition 1 as an opportunity to dovetail efforts and align some of the work the Commission has already been doing to support FSPs to support the agenda to reduce homelessness, incarceration, and hospitalization.

Dr. Martin-Mollard stated this is a targeted effort to support what the state is doing through all its initiatives, including Proposition 1 and the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)

1115 Waiver Demonstration. She noted that counties and providers want to help achieve good outcomes but need additional support.

Commissioner Chambers stated she attended the FSP site visit and has developed FSP programs. She stated she is excited about evidence-based practices and the additional housing supports that Proposition 1 will bring. She stated many clinicians say FSP programs are one of the most effective programs in general; however, they are the most burdensome on staff. She asked how to alleviate that.

Dr. Martin-Mollard stated one of the questions clients and partners were asked at the site visit was how the state should be thinking about measuring success. One of the first things they talked about was staff turnover and how critical it is to establish trust. Working with someone who is their champion, advocate, cheerleader, and support, but having that staff then leave is devastating.

Commissioner Chambers noted that consumers of FSPs have told her that FSPs work with housing and peer supports. She advocated for ensuring that, whatever the DHCS creates with evidence-based practices, counties will be able to hire and retain staff to implement the FSPs and that there will be value-based incentives for the staff.

Dr. Martin-Mollard agreed that any workforce effort needs to recognize how critical the relationship piece is and incentivize individuals who are excited about doing this work to get them into the field and to keep them. Part of the decision to support workforce is that the work can already begin without contracting with outside consultants and start working with the Department of Health Care Access and Information (HCAI) to help shape their specific strategies to support workforce in FSPs.

Dr. Martin-Mollard stated staff also heard from both sides about the challenges of hiring staff and staff turnaround. They clearly need to be incentivized and supported. All partners are excited about peer opportunities.

Commissioner Bontrager stated counties are good at value-based purchasing but paying for outcomes is difficult. Counties need to be on board from the outset so there will be potential for adoption.

Dr. Martin-Mollard stated county pilot programs are currently underway. Feedback received indicates that the initial work has already been impactful. She agreed that asking those counties to share lessons learned, successes, and challenges will be important for bringing on other counties.

Executive Director Ewing stated the original FSP model that predates the MHSA was an outcome-based contract model with employment as one of the outcomes. One of the models in the UK that Commissioners Brown and Carnevale and Chair Madrigal-Weiss participated in was incentive financing built into the contract for staged outcomes such as initial housing, housing stability, employment, etc., with incentive payments built into the contract. The point of the proposed $10 million investment is to build the capacity in counties.

Executive Director Ewing recognized that, over the past 25 years, the behavioral health system has moved away from that strategy because of the emphasis on drawing down federal funding. The challenge will be parsing the tensions between an outcome-based financing strategy and a federal draw-down strategy. He noted that one of the things

that needs to be explored is a stronger understanding of not just the return on investment for an individual or an FSP program but how that impacts the broader state budget, including opportunities to reduce the number of individuals who are landing in state hospitals, which cost over $300,000 annually per person.

Executive Director Ewing stated it is about positioning FSPs in the context of the broader behavioral health system and recognizing the potential billions of dollars in cost avoidance to shift that tension between an outcome-based finance strategy and a fiscal incentive that is targeting the drawdown of federal funds because there are currently conflicting incentives or priorities around FSPs.

Executive Director Ewing stated the proposed $10 million will not dramatically rework this space in an area where billions are being spent. The goal is to get started and to use the knowledge coming out of the counties and providers with peers and families thinking about how this should become – with early psychosis intervention as the crown jewel of California's behavioral health system for individuals who need it – a "Whatever it Takes" Model with the goals of stable housing with employment, avoiding justice involvement, and avoiding both county and state hospitalization. The dollars are enormous.

Commissioner Bontrager agreed that the dollars are enormous. He stated this is not just about cost avoidance. Part of it is to incentivize and create capacity amongst providers, instead of always having providers deal in the realm of scarcity and yet expect positive results. This speaks to the workforce issue too, when providers are dealing in a scarce scenario. They are not going to be able to retain and attract the best. He stated he looks forward to any opportunity to incentivize providers to be well and do well.

Commissioner Carnevale stated he agrees with everything that has been said, particularly Commissioner Bontrager's comments about the realm of scarcity. He stated, when he first become a Commissioner, he did not know what an FSP was. When he learned what it was, he began explaining it to other individuals who were not in the system. He stated, when it is explained, it makes sense – offering a piece of service, such as housing, is not effective. "Whatever it takes" for someone to be successful must be provided. He stated he has become passionate about FSPs and about prevention and early intervention programs and the innovation work.

Commissioner Carnevale stated he also has become passionate about outcome-based contracting because that is the only way that the Commission should be doing contracting. He spoke in favor of the staff proposal but noted that the system constantly operates in the realm of scarcity with all initiatives, including FSPs.

Commissioner Carnevale stated one of the four levers mentioned in the presentation was sustainable financing. He recommended exploring the idea of creating a Center for Sustainable Financing in Mental Health to help address some of the scarcity. He stated he would like to look at a broad-sweeping view of this because outcome-based contracting is only one of the pillars. Another pillar talked about in a previous meeting was around making more investment capital available through all public and private entities. There is the issue of catalyzing public and private partnerships to harness all the dollars that are being spent to go into public services.

Commissioner Carnevale stated the last and possibly biggest piece is pricing and reimbursement itself. He stated the big-picture item he has learned over this past month is that, while mental health comprises approximately 16 percent of the health care system in terms of disease management, it is only 2 percent of the budget. This is the differential. Most commercial providers are reimbursing on average less than 20 percent of what is required to deliver these services. This is the core of the problem. The Commission must start going after that core and doing whatever it takes to do the "whatever it takes" approach. He noted that it is time to take this issue head on because sustainable financing underscores literally every piece of work the Commission does.

Commissioner Robinson referred to the presentation slide that listed what the responses to the RFP will be judged on and asked how the requirement for "strength of relationship with stakeholders" will be measured.

Dr. Martin-Mollard stated staff is still working with the procurement officer to refine the requirements. A successful proposal would acknowledge the importance of established relationships within the community and an understanding of the relationship with FSPs within the larger continuum of care.

Commissioner Robinson asked if it would be measured.

Dr. Martin-Mollard stated the goal of having a scoring component is to be objective.

Executive Director Ewing clarified that the scoring rubric is made public as part of the process so that all applicants know the criteria they will be assessed against.

Commissioner Rowlett stated he wanted to disclose that the organization that he is the chief executive officer of has the unique privilege of operating FSPs in five Central California counties. He stated he had the opportunity to engage staff around this project. He stated his perspective around the four levers is the same – they are the primary measures but data sharing needs to be a separate outcome. He noted that it is important for FSP providers to understand how other providers are doing; however, this is not currently done well.

Commissioner Rowlett stated he was skeptical about moving to value-based payment since California is still focused on maximizing the federal Medicaid dollar. The current fee-for-service system is based on scarcity. If that is not the provided service, he questioned how to cover the essential costs that are believed necessary to reduce the issues that the person is experiencing that may not be covered under Medicaid, such as transportation. That is another dilemma that FSPs experience.

Commissioner Rowlett asked how to make behavioral health in the outpatient contracted part of the system a career versus a transitional stop, because many individuals come into behavioral health with a belief that it is a transition to an ultimate career and that their position and role will not be done for an extended period of their career. Individuals who receive services are negatively impacted when their case managers keep changing. Case managers do not approach the job as long-term but see it as a step along their career path. He asked how this impacts outcomes in FSPs.

Commissioner Rowlett asked the Commission to more carefully define FSPs, how they are evaluated, and what value-based care looks like in an FSP, especially since

35 percent of Proposition 1 is dedicated to FSPs. He stated the need to highlight sustainable, exemplary FSP practices.

Commissioner Chambers asked how to leverage the lessons learned that will be taken back to the DHCS. The language is ambiguous about drawing down federal funding. She asked if the federal drawdown system and value-based care work together.

Dr. Martin-Mollard stated it is complex but it is not either/or. Any sustainable financing strategy must acknowledge both the federal dollar drawdown as well as incentives that can be mapped on top of that to support transportation and other services that are not billable through Medi-Cal.

Vice Chair Alvarez stated there are parallel conversations in the physical health world, such as enhanced care management and population-based models. She stated she is encouraged by the fact that these models are client-centered. She stated the need to support entities such as the Urban Restoration Counseling Center in becoming an FSP that can connect birthing individuals to housing services, domestic violence services, etc.

Dr. Martin-Mollard stated she will report back on what it would take for an agency to become eligible to receive FSP dollars. She stated it comes down to how the eligibility criteria is articulated for who can be served. Another way to think of it is this “whatever it takes” model – the FSP service is the home for the partner or client but case workers are working through their incredible networks (housing, other community support, employment, and social activities networks). She stated linking partners to the services that are most going to change their trajectory and support their recovery is already happening.

Vice Chair Alvarez stated approximately half of a county’s FSPs are for young people. She asked how these dollars will track how the investment will continue, and if there is an opportunity for a Center of Excellence or technical assistance to ensure that those data points are tracked and prioritized.

Executive Director Ewing stated FSPs were developed as a strategy to support individuals who otherwise would have been historically served in a locked facility. That is why the original goals were around reducing hospitalization. The vast majority of individuals were placed in locked state mental hospitals with the reduction of criminal justice involvement as a secondary goal. Criminal justice involvement often came about because individuals were unhoused. Reducing the number of individuals who were unhoused was the third primary goal.

Executive Director Ewing stated there is more to that story but generally it was about providing a level of service that did not previously exist for individuals for whom there was no alternative but to put them in institutional care knowing that that was inappropriate.

Executive Director Ewing stated FSPs can do whatever it takes. The money was used to provide what would allow what was needed to be successful and to evaluate the outcomes as opposed to an aggressive compliance and audit function relative to drawing down federal funds. In other words, it is doing what Medi-Cal pays for versus doing what the client needs. The pressures that counties face to draw down federal

funding has shifted the pendulum away from a user experience-driven program design to a reimbursement-driven program design.

Executive Director Ewing stated this has created the tensions around what staff can be paid because of this resource-scarcity environment. It has moved back to the “bad old days” as evidenced by the increase of $1 billion per year that are invested in state hospitals to respond to individuals who are being deemed incompetent to stand trial who are back on the streets, in the justice system, and in the state hospitals at enormous costs.

Executive Director Ewing stated there is also a recognition that there is no step-down care or FSP-lite. That lends itself more to opportunities for individuals both to transition out of an FSP and to get support so that their needs do not escalate to the level that they would need an FSP, meaning they can manage their housing but they need support versus a high level of support. The Commission’s work on early psychosis interventions, school mental health, and allcove youth drop-in programs are upstream strategies intended to take pressure off the FSP systems, which are designed to take pressure off hospitals, jails, and streets in terms of being the only alternative to individuals with significant needs.

Executive Director Ewing stated it is recognized that, while the allcove model has been developed that targets transition age youth (TAY) as a drop-in, integrated primary health care, and primary behavioral health care, something comparable has not yet been done for individuals who are not TAY.

Executive Director Ewing stated staff is not suggesting that FSPs are the be-all, end-all; it is the idea of how to design a system that does not rely on FSPs because more outcome-based strategies can be built into the broader service delivery system. FSPs are not necessarily the goal. Individuals are often in an intensive level of care for a couple of years or longer, but the idea is, if that person has been supported through peer strategies to help transition them into independent living, the original goal is a job. With a job comes purpose, hope, health insurance, and enough money to pay for housing. That is not the goal today.

Commissioner Mitchell thanked Executive Director Ewing for helping Commissioners better understand the FSP history. She asked how individuals can stay at outcome-based services that are consistent and that are not chasing fee-for-service models.

Commissioner Mitchell referred to the strategic objective of improved public awareness and asked if this refers to improving county, end user, or other public awareness.

Dr. Martin-Mollard stated all of the above. Individuals and family members would know that this service exists and where they can receive help within a county system. Referral sources know where to refer to and what services they provide. She stated FSPs are not well-known to the public in general. Raising awareness in the broader continuum is needed.

Vice Chair Alvarez stated she also appreciated the review of FSP history because looking at it in black and white can help clarify that individuals are referred to an FSP to better meet their needs only if they are identified as costing the system more, and yet all individuals deserve to have their needs met. She stated the need to consider what it

looks like upstream and noted that it starts at school. Adverse childhood experiences (ACEs) cause billions of dollars in mental health and economic crises.

Commissioner Carnevale stated this is all about sustainable financing. This is not about spending more money that is not available; if the systems around prevention and early intervention are designed right, they repeatedly save funding. This is what the psychosis report showed. Less than 10 percent of psychosis patients are being served today. He noted that serving 90 percent of psychosis patients will save money. The systems need to be built to do this.

Commissioner Rowlett stated dependence on specialty mental health care was not the goal in early FSPs. The goal was not for individuals to be in FSPs for their whole lives. From a population health management perspective, he stated he appreciated helping individuals understand how to utilize their Medi-Cal benefits more effectively, including early intervention strategies. One of the goals was to help individuals learn how to use their benefits so that they did not have to come back to urgent care to get their health care or behavioral health care needs met.

Commissioner Rowlett stated the pendulum has swayed away from that. FSPs do not get paid to do that but are paid to do the four big levers mentioned in the presentation: sustainable funding, workforce development, accountability, and infrastructure. What is implied there is to keep individuals in FSPs to ensure that those things do not happen. It must be shifted back to reimbursing organizations to do the kinds of things that result in individuals ultimately realizing the true benefit of Medi-Cal and what they can do to address issues early on for children, youth, young adults, adults, and older adults.

Commissioner Chambers stated there are contracting challenges with managed care plans. Getting someone into services is complex and no one knows where to send individuals for help for psychosis. The investment question is broader. The new law says that MHSA dollars will mostly be concentrated in areas with the most severe need. That is already the approach. If the focus is on keeping individuals out of jail, she asked about the help a person with psychosis will get in this new system. She stated it is impossible to contact health plans for community supports to help women. She asked how to talk about real priorities, if the new priorities will keep individuals from getting out of higher levels of care, and where the access points are to refer someone to.

Commissioner Brown echoed Commissioners Carnevale and Rowlett's comments. He stated he sees the staff proposal as a step to leverage existing FSPs or prospective FSP resources as the Commission starts to provide the technical assistance and do these additional support measures, but as the Commission transitions from the successes that it has seen from FSPs and those that are anticipated will come as a result of this proposal and the implementation of Proposition 1, the Commission must realize that all of that needs to be juxtaposed alongside the need for good strategic planning to achieve scale and long-term sustainability that will be necessary for something of this change in magnitude that is underway with Proposition 1.

Commissioner Mitchell stated this issue is complex. Whatever the Commission does needs to include access for individuals to successfully navigate the system. This does not happen without a lot of work. The earlier an individual comes into the system, the greater opportunity they have for success. Coming in as a teen or an adult is too hard to

get the help they need because there is no consistent door for them to go through. It would be helpful to have one stop, one process, one procedure, or one phone call to help individuals get started on the path to wellness.

Chair Madrigal-Weiss asked about the recidivism rate for FSP.

Executive Director Ewing stated Commission staff identified a drop-off of approximately 20,000 clients from year 1 to year 2; however, there are tremendous problems in the data system. The DHCS is in the process of redesigning its data system. This is one of the elements that staff hopes to come back to Commissioners with. The Commission asked to set aside $20 million. Today's proposal is for $10 million on the finance side. More discussions are required on the DHCS data system work. Staff has been mapping FSP client data against criminal justice data to better understand the positive versus negative outcomes.

Executive Director Ewing stated one expression of recidivism is justice involvement, not just leaving an FSP and then returning. In conversations with the California Hospital Association, there is frustration that they do not know who is in an FSP when someone arrives in their emergency department. The Commission will coordinate with the DHCS, the HCAI, which has the workforce dollars, the California Health and Human Services Agency (CalHHS), which will be designing the accountability system including reporting around finance, and the Department of State Hospitals. There are greater challenges in terms of understanding, communication, coordination, and data analytics than can be addressed with the funding available today, but the goal is to get started with approval of the staff proposal.

Chair Madrigal-Weiss asked Commissioner Carnevale to work with staff to identify strategies and best practices around sustainable funding.

Vice Chair Alvarez asked if updated guidance or regulations on FSPs is expected.

Executive Director Ewing stated the DHCS has new authority to establish standards around early intervention. There is a series of opportunities for the state to take a more facilitating role in workforce, prevention, early intervention, FSP, and finance. That touches upon FSPs in a number of ways, including opportunities to support individuals so they do not need an FSP. Staff is talking with the Administration about how best to engage the DHCS about their vision and opportunities that will be rolling out over the next 24 months and beyond. The DHCS has asked if they could present on early intervention at the September Commission meeting.

Public Comment

Clare Cortright, Policy Director, Cal Voices, thanked Executive Director Ewing for providing the brief history on FSPs. It was helpful and outlined the tensions. Currently, the regulations for FSPs call out peer support as part of the full spectrum of community services and supports, but because of the funding structure under Senate Bill (SB) 803 for peer support and the new mandates in the BHSA, peer support could be facing real problems in remaining a service that is funded under the MHSA.

Clare Cortright stated FSPs were originally given the flexibility to do "whatever it takes." This is not a pre-planned menu of services. That is one of the places where including peer support and ensuring that it is mandated in the new FSP regulations maintains

flexibility in funding. Individuals in crisis need more support than a case manager can provide. Being able to be in a residential setting with flexibility of MHSA, BHSA, or noninsurance funding allows the workforce a wider scope of practice to help individuals during crisis when traditional models and Medi-Cal-funded services are not sufficient support.

Clare Cortright stated peer support is a way within an FSP model for greater consistency and accountability that also maintains some of that original virtue of doing "whatever it takes." Peer support with a full scope of practice is a way to do that.

Clare Cortright stated the state needs to disambiguate the criminal justice system from the civil side of the house because misdemeanor incompetent to stand trial cases are a choice that does not need to be made.

Steve Leoni, consumer and advocate, thanked staff for the background materials. The speaker commended Executive Director Ewing for his comments. The speaker stated the selection strategy to fund the FSP says that proposals will be judged on seven things. The speaker asked to add an understanding of recovery as it is seen by clients. "Building" rather than "fixing" is one way to put that. The recovery process is about building the person up and helping them to navigate their issues.

Steve Leoni stated one of the things the RFP will be judged on is "familiarity with California behavioral health systems." The speaker suggested ensuring that this familiarity includes things such as psychosocial rehabilitation, which was one of the core values of the original FSPs.

Steve McNally, family member and Member, Orange County Behavioral Health Advisory Board, speaking as an individual, stated they loved the presentation and interaction between Commissioners. The speaker stated the hope that the DHCS's PowerPoint slides to be presented at the September Commission meeting are delivered to staff early for Commissioner and public review prior to the meeting.

Steve McNally thanked Commissioner Carnevale for pointing out the budget, which is something California struggles with, particularly between the Medi-Cal reimbursement rates and private insurance, and how private insurance seems to be able to walk away from schools and any serious mental illness.

Steve McNally thanked Commissioner Rowlett for his comments. The speaker stated trust can be measured in linkages. The FSPs that can motivate better can link individuals more. The speaker suggested paying someone extra in the county to be the "super navigator" across all county programs with an additional fee. Solano County has a two-tiered workforce program so that members of the disability community can work.

Steve McNally suggested finding the lanes where county mental health versus Medi-Cal mild to moderate fit because Enhanced Care Management and FSPs seem similar. At some point, individuals may move between them.

Steve McNally suggested a two-tiered system with one line being urgency and another effectiveness, with the goal of being both urgent and effective. An unlicensed workforce is the target but, although this is certified, the DHCS is making it hard to get it billable and for providers to get on board. The speaker asked the Commission to look into this. It is taking 24 months to get certain individuals through the system to become providers.

Commissioner Discussion

Commissioner Rowlett stated he was intrigued by Steve McNally's suggestion about finding the lanes where county mental health versus Medi-Cal mild to moderate fit because Enhanced Care Management and FSPs seem similar. He asked how Enhanced Care Management could be incorporated into FSP-type services.

Action: Chair Madrigal-Weiss asked for a motion to approve the staff recommendation. Commissioner Rowlett made a motion, seconded by Vice Chair Alvarez, that:

- *The Commission approves the allocation of $10 million in Mental Health Wellness Act funds to support the capacity building and technical assistance efforts as specified in the FSP Funding Proposal.*

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

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

7: Mental Health Student Services Act Report

Chair Madrigal-Weiss stated the Commission will hear an overview of its work to support school mental health, including an update on a legislatively-mandated report on the implementation of the Mental Health Student Services Act (MHSSA), results of the recent MHSSA Request for Applications (RFA), a report-out on Commission-supported MHSSA Technical Assistance Teams, and the potential for new investments in supporting school mental health.

Chair Madrigal-Weiss stated the presentation will include local MHSSA grant partners and students who will share information on their elementary school program, Hope Squad. Hope Squad is an evidenced-based suicide prevention and mental well-being peer support program. She asked staff to present this agenda item.

Dr. Martin-Mollard provided an overview, with a slide presentation, of school mental health in California, the MHSSA, implementation successes, lessons learned, and next steps. She recommended that the state establish an Office of School Mental Health to support collaborative leadership, make additional investments to fill the gap between implementation and long-term sustainability, and develop an accountability structure including school mental health standards and metrics.

Heather Nemour, Coordinator, Student Wellness and School Culture, SDCOE, continued the slide presentation and discussed the goals and objectives, progress made, need for ongoing funding and statewide support, and next steps of San Diego County's MHSSA program Creating Opportunities for Preventing and Eliminating Suicide (COPES). She stated the county chose to use their funding to build the capacity of their 15 school districts and 16 charters for sustainability. The model is to build liaisons within each lead educational agency (LEA) that is a part of this grant to champion mental health, create communities of care within the schools, and have suicide prevention subject matter experts within each LEA.

Riann Kopchak, Chief of Community Engagement and Grants, continued the slide presentation and discussed the areas of funding for the recent RFA competitive bid process to award $25 million in funding for the next round of MHSSA grants. She announced the counties awarded for each funding category that will increase services to marginalized youth, provide support to identify sustainability pathways, provide guidance to implement universal screening, and promote programs relative to nuanced county needs. The counties awarded were as follows:

- Category 1: Marginalized and Vulnerable Youth: Alameda, Amador, Mariposa, Nevada, Orange, Riverside, Santa Cruz, Sonoma, Stanislaus, Tehama, and Trinity.
- Category 2: Universal Screening: El Dorado, Lassen, Placer, San Diego, Santa Clara, Santa Cruz, Siskiyou, Stanislaus, and Yolo.
- Category 3: Sustainability: Alameda, El Dorado, Fresno, Glenn, Lassen, Madera, Marin, Mendocino, Nevada, Placer, San Luis Obispo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Tehama, Trinity, Tuolumne, and Yolo.
- Category 4: Other Programs: Fresno, Los Angeles, Madera, Orange, Placer, Riverside, San Benito, San Luis Obispo, Santa Barbara, Siskiyou, and Trinity.

Rachel Wegner, Project Specialist, Student Wellness and School Culture, SDCOE, stated a portion of the funding for the COPES grant was spent on peer programing. She shared information on one of the MHSSA programs used in San Diego County, Hope Squad. She introduced five students who shared why they joined Hope Squad and the impact that Hope Squad has made on their campus and at home.

The students asked Commissioners to reflect on their own experiences with mental health and hope, to write down a short message related to hope, resilience, or support on a piece of paper, and to put their messages into the student's Hope Jar. Then, everyone selected a message to read aloud. Examples of messages from the Hope Jar were:

- "You are you. Don't ever change that."
- "There's always someone there for you. Keep going and know you're valued and loved."
- "Never give up when it gets hard."
- "We are connected. When you do well, I do well."

Commissioners chatted with the students and asked them questions about their experiences in being a part of the Hope Squad program. The Commission gave gifts to the students to thank them for being a special part of the meeting today.

Commissioner Comments & Questions

Commissioner Carnevale stated one thing that jumped out at him was that his 15 years of experience in education, having started the UCSF Dyslexia Center, has taught him two things. One is that literacy issues will not be solved until mental health issues are solved. This is why these two issues need to be coordinated, which led to his second

point, which is that the two systems are currently separated from each other more than they are together.

Commissioner Carnevale stated he loved the idea of an Office of School Mental Health, but stated, if another office is set up that is floating in its own silo, it will add to the problem. This would only make sense if it is a joint office that is embraced by CalHHS and the California Department of Education (CDE) or if it sits in the Governor's Office. He suggested including this in the recommendations.

Chair Madrigal-Weiss agreed.

Commissioner Gordon also agreed and stated an Office of School Mental Health is much too small because there are two huge systems – health and education. One is good at some things and the other is good at other things. He stated the need for a high-level connection between the two. California has over 9,800 schools. This is a huge asset with access to places where health systems do not normally have access. There are many other opportunities to use schools for things that they are good at in both delivering and screening for health issues.

Commissioner Gordon stated, in the interest of pushing prevention rather than treatment, there are many things that can be done to push prevention down earlier in the systems. For example, children are now starting school at four years old. It is important to access children in the zero-to-five space and do what the educational system is good at to build a culture of prevention and early intervention throughout the whole system. He offered to share his thoughts about the MHSSA Report with staff offline.

Chair Madrigal-Weiss agreed that she and Commissioner Gordon should work closely with staff. She agreed with Commissioner Carnevale that creating an Office of School Mental Health would be too small. It is not right that an Office should sit with only education or mental health. The CDE does well with the academic side of the house but it is not a mental health expert, nor does it want to be.

Chair Madrigal-Weiss stated everyone agrees with the need for metrics and measuring what is treasured. She stated the importance of measuring wellness, which is not done. She asked why wellness is not considered except for a few questions in the California Healthy Kids Survey (CHKS). She suggested looking at innovations that focus on student wellness, such as the work of Dr. Jeff Duncan-Andrade at San Francisco State University. Student suggestions in the MHSSA Report are around relationships, care environments, safe spaces, and peer services, not bringing in more counselors. It is critically important to honor student voice and to stop making assumptions as adults when building out these systems.

Commissioner Bontrager stated it is a wonderful $280 million investment but asked how to sustain these great efforts.

Ms. Kopchak stated that is the big question. The hope is that the most recent round of grants will include paying for employees whose job it is to find sustainability options.

Vice Chair Alvarez acknowledged that the larger narrative from across the country is making safe spaces and welcoming environments from book vans to anti-transgender efforts. This trickles down to young people. She stated schools shape who children are

eight hours a day. She commended the Commission and its many-year commitment to school mental health to lay the groundwork for California to hopefully lead the way to healthy school environments.

Commissioner Carnevale stated the issue of sustainability is often an issue because the place where money is spent is not where value is captured. This is a classic question and an argument for a multidisciplinary office or entity because, while literacy rates may be impacted, the cost associated with services for children with mental health issues is not generally seen in the education system but is seen in the community, health care, and in law enforcement systems. This is why something larger than just education or even CalHHS is required to deal with school-based mental health. That is how to get to sustainability – by recognizing this and connecting those dots.

Public Comment

There was no public comment.

8: Lunch

The Commission took a one-hour lunch break.

9: Proposition 1 Implementation Follow-Up

Chair Madrigal-Weiss stated the Commission will hear an update on items related to implementation of Proposition 1, with emphasis on reforms that impact the Commission and its operations. She stated the Commission will discuss implementation strategies and future planning for Proposition 1.

Chair Madrigal-Weiss stated, at the July Commission meeting, Commissioners discussed some of the changes to the Commission under Proposition 1, including the composition of the Commission. Several Commissioners agreed to work with staff to plan for priority, goal, and vision changes associated with the size and composition of the Commission, the role of Committees, branding of the Commission, and onboarding of the new Commissioners. She asked staff to provide an update on the progress of these areas.

Presentation

Kendra Zoller, Deputy Director of Legislation, provided an overview of the timeline of Proposition 1 implementation activities. She noted that the Commission will concentrate on four key areas over the next four months to ensure a smooth transition: meetings, Committees and Subcommittees, name change/branding, and onboarding. Staff has been collaborating with Commissioners to develop proposals for these four areas. She and Jigna Shah updated the Commission on the progress to date.

Jigna Shah, Chief, Innovation and Program Operations, discussed the plans for meetings and Committees and Subcommittees. She stated, beginning January 1, 2025, the Commission will grow to 27 appointees. Since the July Commission meeting, staff reached out to multiple state-level Boards and Commissions with a list of questions regarding their operations to better understand how the Commission structure may need to change to continue the work of the Commission while also supporting the mandates of the BHSA.

Ms. Shah stated staff met with the California Workforce Development Board, the California Commission on Aging, and the California Behavioral Health Planning Council (CBHPC) to discuss board size, meeting structure, and the role that the Committees and Subcommittees play. Staff learned that the frequency of board meetings varied from four to ten times per year. Several of the boards had multiple functioning Subcommittees whose role it was to bring recommendations to the full board on a variety of topics.

Ms. Shah stated staff also learned about the potential of hosting multiple satellite locations across the state for Commission meetings. Staff is working with Chief Counsel Gallardo to discuss the Commission's ability to do that within the requirements of the Bagley-Keene Open Meeting Act and within staffing capacity.

Ms. Shah stated, as part of the research, staff also looked at the content of Commission meetings from August of 2021 to July of 2024. Staff did an analysis of the data to help staff understand the ideal number of Commission meetings and the ideal format and role of Subcommittees for the Commission to operate effectively. Staff identified the amount of time the Commission spent on action items versus informational items. She stated 52 percent of the Commission's time was spent on action items, including voting on legislation, innovation, and approval of grants and policy reports. The remaining 48 percent of the Commission's time was spent on informational items, including announcements, public comment, and updates on projects and policy projects.

Ms. Shah stated, in 2023, the Commission spent approximately 30 hours on action items, which means that a minimum of six meetings would need to occur each year just to accommodate the action items and general public comment. She stated staff will continue to break down this data and will work with the Chair to bring forward recommendations.

Ms. Shah stated staff met with the CLCC this week and got their feedback on the Commission and Committee structures. Feedback received included ideas for specific Committees, including an Innovation Partnership Fund Committee and an idea for creating a Legislative Committee. She stated the CLCC also highlighted the importance of having the Committees and Subcommittees include representatives of underserved communities, including the BIPOC and LGBTQ communities. She noted that staff plans to meet with the CFLC at their upcoming meeting to gather feedback from Committee Members.

Ms. Shah asked Commissioners about their experiences around larger boards and their thoughts on how to ensure that meetings are effective and efficient.

Commissioner Comments & Questions

Commissioner Chambers agreed with delegating work to the Committees for recommendations to allow more time to conduct business at Commission meetings. She stated the CFLC is looking forward to providing feedback to staff at the next Committee meeting.

Chief Counsel Gallardo cautioned that, by law, Committees are recommending bodies. The full Commission has authority as approving body to get actions done. She stated the work done in Committees requires presentation at full Commission meetings for approval.

Commissioner Chambers stated appreciation that the work of analyzation and discussion can be done in Committees prior to advising the full Commission and presenting recommendations for approval. Committees provide another opportunity to gather public input on important issues.

Commissioner Carnevale asked if there were entities that had longer but fewer meetings, such as two-day meetings.

Ms. Shah stated some boards had meetings over two to three days where they often would go to an off-site location.

Commissioner Carnevale stated three days may be too much, but it already takes two days for Commission meetings when including travel time and site visits. He suggested having fewer but longer meetings.

Commissioner Rowlett suggested talking with the American Board of Regenerative Medicine (ABRM) about their structure. The ABRM is comprised of the UCs, their appointees, and other legislative appointees for a total of approximately 30 individuals. They have a robust funding structure for grants. All Board and Committee meetings are governed by the Bagley-Keene Open Meeting Act. The Committees bring recommendations to the Board for approval. He noted that their structure works for a large group.

Commissioner Rowlett stated there is an opportunity for the Commission to utilize Committees in a more robust way, provided all Commissioners understand the commitment made to those Committees. He stated he loves the good things he hears about public comment in Commission meetings and the Commission's commitment to transparency. It is important that a certain amount of time in every meeting is dedicated to public comment. He stated public comment is a unique, positive feature of Commission meetings.

Commissioner Rowlett recommended that, whatever structure is finally determined for Commission meetings, these things continue to be upheld. He spoke against reducing the opportunities for public comment by reducing the number of Commission meetings and stated he was glad that staff used data to analyze and determine that a minimum of six meetings would be necessary in order to accommodate public comment.

Presentation, continued

Deputy Director Zoller continued the presentation and discussed meeting planning, branding, and onboarding. She stated the meeting planning for the coming year will align with opportunities outlined in Proposition 1. Staff is coordinating with the Administration to schedule presentations on the key areas of population-based prevention, substance use disorder (SUD), housing, workforce, accountability, and transparency. These discussions will help staff explore how the Commission can best support these initiatives and will kick off with a panel discussion on early intervention next month.

Deputy Director Zoller stated, also related to meetings, the Commission needs to address how it delegates authority to the Chair and Executive Director. This will require a formal Commission resolution, as the last resolution was adopted in 2011. Once passed, this resolution will be integrated into the Rules of Procedure, which will also need formal adoption by the Commission. She noted that staff recommends making these decisions after the expansion to 27 Commissioners as their input will be crucial.

Deputy Director Zoller stated there was discussion at the last Commission meeting about adopting an informal abbreviated name for the Behavioral Health Services Oversight and Accountability Commission (BHSOAC). Staff is working with Commissioner Carnevale to enhance messages, elevate the mission, and develop a cohesive brand guide to ensure consistency, clarity, and strong brand identity.

Deputy Director Zoller stated staff believes the California Behavioral Health Commission is a fitting nickname and is gathering feedback from community and consulting with other commissions like the California Children and Families Commission (First 5 Commission) to learn from their experiences of using a nickname.

Deputy Director Zoller stated staff also explored ways to improve the onboarding process for new Commissioners. The goal is to align priorities, focus efforts, and ensure a thorough understanding of the Commission's functions and objectives. Staff, in collaboration with Commissioner Robinson, is developing an onboarding outline that includes team building activities, an exploration of individual motivations and approaches, comprehensive training on Commission programs, external partnerships, performance expectations based on the strategic plan, and budget and finance training that will cover budgetary processes, funding sources, and financial oversight responsibilities. This is to help Commissioners better understand the Commission's various funding categories, such as the MHSSA, the Mental Health Wellness Act, advocacy, allcove youth drop-in centers, early psychosis intervention, FSPs, innovation, research, and communication.

Deputy Director Zoller asked for thoughts or suggestions regarding branding and onboarding.

Commissioner Comments & Questions

Commissioner Gordon asked about the rationale for adding 11 new Commissioners and the expectations the new Commissioners might have about what the Commission might do differently.

Executive Director Ewing stated, in conversations with the Administration regarding the additional Commissioners, there were a couple of drivers behind that decision. One was to strengthen the representation on the Commission with the various seats, particularly around the integration of traditional mental health with the SUD space, reflective of the priorities of Proposition 1. The other was growing interest in serving on the Commission and creating opportunities for that.

Executive Director Ewing stated the onboarding conversation is a unique opportunity. He stated, over the past ten years, one or two new Commissioners would come every year or every other year. It was done one-on-one with staff and being partnered with another Commissioner to help them acclimate to their new position. He asked Commissioners what was helpful and what would have been helpful during their onboarding process.

Executive Director Ewing stated onboarding one Commissioner with a new perspective at a time and to slowly shift some of the agenda to reflect that new perspective within the patterns of work that the Commission was pursuing, recognizing staff capacity is relatively easy. This will be different when adding 11 new Commissioners all at once. He stated there may be turnover, even with the seats filled today, that would require new appointees by the Governor with little, if any, advance notice.

Executive Director Ewing asked how to ease the transition for future Commissioners, including the at least 11 new Commissioners who will be part of the Commission on January 1, 2025.

Commissioner Gordon cautioned against inadvertently creating two groups of Commissioners – the old and the new – rather than integrating and becoming a part of the overall group. He suggested pairing each new Commissioner with an experienced Commissioner to be their helper or buddy.

Commissioner Chambers agreed with Commissioner Gordon's peer strategy for the optimal onboarding experience. She stated travel costs to meetings may cause challenges for new or even current Commissioners.

Commissioner Carnevale stated he came on board during the COVID-19 pandemic when meetings were virtual so he did not get much of a sense of anything in the first year. This is a reminder that, like everything else, you get out of it what you put into it. He stated the ability to meet in person is important for attending meetings, going to site visits, etc. Being a Commissioner is not just about showing up and sharing an opinion about an issue.

Commissioner Carnevale stated the new Commissioners can learn much from this diverse group and can end up making decisions as a group. To do this, Commissioners must be part of that group to get in the flow of the discussion. That is what should be communicated to incoming individuals. This is not a casual thing; it is a big commitment, if they want to be effective.

Vice Chair Alvarez asked about a Commissioner job description because there are different opportunities for a Commissioner's role on this Commission. There are different activities that Commissioners can choose to participate in. They can just show up at meetings and vote, but they also have opportunities to weigh in on the Commission's special projects or lead specific initiatives. She stated outlining opportunities to new Commissioners can help them better understand possible levels of engagement.

Vice Chair Alvarez suggested outlining Commission projects and the progress that has been made to help new Commissioners understand how they can contribute to future opportunities.

Chair Madrigal-Weiss suggested including projects and reports in the onboarding packet to help new Commissioners learn about the work the Commission has done so they can see where to tie in their interests. She suggested including a checklist of individuals and entities to connect with.

Commissioner Mitchell stated the importance of helping new Commissioners understand how mental health ties into everything and that they will be representing mental health for their part of the system or for their focus area that they were appointed for.

Commissioner Rowlett emphasized Commissioner Gordon's question about the expectations of the new Commissioners. He stated Executive Director Ewing provided a succinct description in today's meeting of Assembly Bill (AB) 34, AB 2034, Proposition 63, and Proposition 1 as it pertained to FSP. He stated learning the history of the role the Commission has had as it pertains to Proposition 63 and Proposition 1 as a part of the new Commissioner orientation would be helpful. He suggested providing key points in the history of the Commission to help new Commissioners be more effective.

Commissioner Robinson agreed with everything that has been said and stated the importance of sharing successes of the Commission, when bringing on new individuals who are new to the process. It would expedite understanding of the work to learn about the Commission's past accomplishments.

Commissioner Robinson suggested that current Commissioners share why they do this work as part of the Commission, perhaps by including a short video of clips from each Commissioner. Hearing that will help others connect the dots and find their own "why." He stated this would be valuable for new staff as well as new Commissioners.

Commissioner Bontrager addressed the Commission's name change and branding. He asked about the proposed "California Behavioral Health Commission" and where that came from.

Commissioner Carnevale stated it is a subject for debate but part of it was trying to streamline the process so it would not require much new branding. Most individuals currently know the Commission as the "Mental Health Commission." It should be something easily remembered. Changing the name to the "Behavioral Health Commission" seemed easiest.

Deputy Director Zoller noted that no alternative names have been offered from the community.

Commissioner Gordon suggested bringing all new Commissioners together with existing Commissioners as soon as possible. He stated a day-long event with briefings and a meal or two, etc., where everyone can interact would be welcoming to the group.

Chief Counsel Gallardo stated a day-long or a two-day retreat at a nice location is a good way to onboard Commissioners with bonding and team-building exercises and learning sessions.

Public Comment

Stacie Hiramoto encouraged the Commission to form Committees and begin working on Proposition 1 implementation prior to January 1, 2025, and onboard Commissioners as they come because appointments are not always timely. The Innovation Partnership Fund is one of the most important and sought-after aspects of the Commission. The Fund begins in July of 2026. RFPs must go out at least six months prior to beginning services. Creating the Committee in January only leaves one year to develop an entirely new RFP for an entirely new responsibility or program for the Commission.

Jay Calcagno, Policy Analyst, California Council of Community Behavioral Health Agencies (CBHA), echoed Commissioner Rowlett's comments on uplifting the role of the Commission's Subcommittees and the role of public comment to bolster the work of the Commission, especially as new Commissioners are added. The speaker stated there is uncertainty among providers, including the ones represented by the CBHA, on exactly how Proposition 1 will impact their ability and capacity to provide services, especially for programs that are overseen by the MHSOAC.

Jay Calcagno stated the CBHA is committed to working with the Commission on the implementation of Proposition 1, especially as it concerns the changes that will impact the Commission itself. The speaker stated the CBHA shares the Commission's goal of ensuring that California's most vulnerable communities continue to have equitable, comprehensive access to the services they need in the communities where they live.

Steve Leoni stated, with all due respect to the work that went into the study on the amount of time the Commission spent on informational items versus action items, everything is changing. The speaker stated, during the time of the study, much time was devoted to action items on innovation but innovation has now changed. The Commission will now include many new Commissioners who will require informational items to learn more about the Commission and its work. The speaker stated, other than a baseline and as a part to move forward from, that study of past Commission meetings will not provide insight on the ideal division of topics or times to meet per year. Everything is changing.

Steve Leoni agreed with Commissioner Gordon that the Commission should make an effort to incorporate new Commissioners into the Commission or it will end up as the new versus the old Commissioners. The speaker pointed out that it is not only about new people but new subjects. What is being moved into now is not just dual diagnosis, which has by default been in the mental health court for a long time, but also pure substance use. This is a whole new area; current Commissioners will need to be as much up to speed as the new Commissioners. There is overlap but it is a whole new set of issues.

Steve Leoni stated they share the opinion with former Commissioner Khatera Tamplen that, in consumer communities, "recovery" as it is used in the mental health community by mental health consumers, even with the overlap in substance use as opposed to mental health, internally means something a bit different. Agreeing that everyone is doing recovery no longer will be so simple. The speaker noted that the Commission will have to deal with this too.

Steve Leoni agreed that many decisions will need to be made after the new Commissioners arrive because nothing would be worse than coming onto a Commission where they have already decided what the new Commissioners will do.

Commissioner Discussion

Chair Madrigal-Weiss stated the appointment opportunities have already been posted. She asked Executive Director Ewing to share additional detail for the record.

Executive Director Ewing stated the Governor's Office released a Press Release yesterday announcing new appointment opportunities for this Commission. The Governor's Office has asked the Commission to share widely that they are encouraging individuals who are interested and who meet the eligibility criteria to submit applications. He stated the Commission is sending out the Governor's Press Release through its LISTSERV and social media marketing channels. The application is on the Governor's website at gov.ca.gov under the appointments link. He noted that the Commission is not involved in the appointments process.

Chair Madrigal-Weiss thanked Deputy Director Zoller and Ms. Shah for sharing their knowledge. She stated the Commission looks forward to hearing more on the implementation efforts and next steps around the BHSA at future meetings.

10: Adjournment

Chair Madrigal-Weiss thanked everyone for their participation and engagement in today's meeting. She stated the next Commission meeting will take place in Los Angeles on September 26th. There being no further business, the meeting was adjourned at 2:22 p.m.

Mental Health Services
Oversight & Accountability Commission

Motions Summary
Commission Meeting
August 22, 2024

Motion #: 1 (Agenda Item 4 – July Minutes)

Date: August 22, 2024

Proposed Motion:

That the Commission approves the July 25, 2024 Meeting Minutes.

Commissioner making motion: Commissioner Bontrager

Commissioner seconding motion: Commissioner Robinson

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

Name	Yes	No	Abstain	Absent	On Leave
1. Bontrager	☒	☐	☐	☐	☐
2. Brown	☒	☐	☐	☐	☐
3. Bunch	☐	☐	☐	☒	☐
4. Carnevale	☒	☐	☐	☐	☐
5. Carrillo	☐	☐	☐	☒	☐
6. Chambers	☒	☐	☐	☐	☐
7. Chen	☐	☐	☐	☐	☒
8. Cortese	☐	☐	☐	☒	☐
9. Gordon	☒	☐	☐	☐	☐
10. Mitchell	☐	☐	☒	☐	☐
11. Robinson	☒	☐	☐	☐	☐
12. Rowlett	☒	☐	☐	☐	☐
13. VACANT	☐	☐	☐	☐	☐
14. VACANT	☐	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐
Totals:	**9**	**0**	**1**	**3**	**1**

Mental Health Services
Oversight & Accountability Commission

Motions Summary
Commission Meeting
August 22, 2024

Motion #: 2 (Agenda Item 5 – Consent Calendar)

Date: August 22, 2024

Proposed Motion:

That the Commission approve the Consent Calendar that includes:
(1) Funding for Orange County to join Phase 2 of the Psychiatric Advance Directive (PADs) Multi-County Collaborative Innovation Project for up to $4,980,470; and
(2) Funding for Orange County's Extension of the Community Program Planning Innovation Project for an additional amount of up to $1,000,000, for a total project amount of $1,950,000.

Commissioner making motion: Commissioner Rowlett

Commissioner seconding motion: Commissioner Carnevale

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

Name	Yes	No	Abstain	Absent	On Leave
1. Bontrager	☒	☐	☐	☐	☐
2. Brown	☒	☐	☐	☐	☐
3. Bunch	☐	☐	☐	☒	☐
4. Carnevale	☒	☐	☐	☐	☐
5. Carrillo	☐	☐	☐	☒	☐
6. Chambers	☐	☐	☒	☐	☐
7. Chen	☐	☐	☐	☐	☒
8. Cortese	☐	☐	☐	☒	☐
9. Gordon	☒	☐	☐	☐	☐
10. Mitchell	☒	☐	☐	☐	☐
11. Robinson	☒	☐	☐	☐	☐
12. Rowlett	☒	☐	☐	☐	☐
13. VACANT	☐	☐	☐	☐	☐

14. VACANT	☐	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐
Totals:	**9**	**0**	**1**	**3**	**1**

Mental Health Services
Oversight & Accountability Commission

Motions Summary
Commission Meeting
August 22, 2024

Motion #: 3 (Agenda Item 6 FSP Technical Assistance and Capacity Building)

Date: August 22, 2024

Proposed Motion:

That the Commission approve the allocation of $10 million in Mental Health Wellness Act funds to support the capacity building and technical assistance efforts as specified in the enclosed FSP Funding Proposal.

Commissioner making motion: Commissioner Rowlett

Commissioner seconding motion: Commissioner Alvarez

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

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

Totals:	**9**	**0**	**0**	**4**	**1**

Mental Health Services
Oversight & Accountability Commission

Motions Summary
Commission Meeting
August 22, 2024

Motion #:

Date: August 22, 2024

Proposed Motion:

Commissioner making motion:

Commissioner seconding motion:

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

Name	Yes	No	Abstain	Absent	On Leave
1. Bontrager	☐	☐	☐	☐	☐
2. Brown	☐	☐	☐	☐	☐
3. Bunch	☐	☐	☐	☐	☐
4. Carnevale	☐	☐	☐	☐	☐
5. Carrillo	☐	☐	☐	☐	☐
6. Chambers	☐	☐	☐	☐	☐
7. Chen	☐	☐	☐	☐	☒
8. Cortese	☐	☐	☐	☐	☐
9. Gordon	☐	☐	☐	☐	☐
10. Mitchell	☐	☐	☐	☐	☐
11. Robinson	☐	☐	☐	☐	☐
12. Rowlett	☐	☐	☐	☐	☐
13. VACANT	☐	☐	☐	☐	☐
14. VACANT	☐	☐	☐	☐	☐
15. Vice-Chair Alvarez	☐	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☐	☐	☐	☐	☐
Totals:					

Mental Health Services
Oversight & Accountability Commission

Motions Summary
Commission Meeting
August 22, 2024

Motion #:

Date: August 22, 2024

Proposed Motion:

Commissioner making motion:

Commissioner seconding motion:

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

Name	Yes	No	Abstain	Absent	On Leave
1. Bontrager	☐	☐	☐	☐	☐
2. Brown	☐	☐	☐	☐	☐
3. Bunch	☐	☐	☐	☐	☐
4. Carnevale	☐	☐	☐	☐	☐
5. Carrillo	☐	☐	☐	☐	☐
6. Chambers	☐	☐	☐	☐	☐
7. Chen	☐	☐	☐	☐	☒
8. Cortese	☐	☐	☐	☐	☐
9. Gordon	☐	☐	☐	☐	☐
10. Mitchell	☐	☐	☐	☐	☐
11. Robinson	☐	☐	☐	☐	☐
12. Rowlett	☐	☐	☐	☐	☐
13. VACANT	☐	☐	☐	☐	☐
14. VACANT	☐	☐	☐	☐	☐
15. Vice-Chair Alvarez	☐	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☐	☐	☐	☐	☐
Totals:					

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date September 11, 2024

Time 10:00 a.m.

Location MHSOAC
1812 9th Street
Sacramento, California 95811 and Virtual

Members Participating:

Mara Madrigal-Weiss, M.Ed., Chair
Mayra Alvarez, M.A., Vice Chair
Mark Bontrager, J.D., M.S.W.
Sheriff Bill Brown, M.P.A.
Keyondria Bunch, Ph.D.
Steve Carnevale*
Rayshell Chambers, M.P.A.
David Gordon, Ed.M.
Gladys Mitchell. M.S.W.
Jay Robinson, Psy.D., M.B.A.
Alfred Rowlett, M.B.A., M.S.W.

*Participated remotely

Members Absent:

Assembly Member Wendy Carrillo, M.A.
Shuo Chen, J.D.
Senator Dave Cortese, J.D.

MHSOAC Meeting Staff Present:

Sandra Gallardo, Chief Counsel
Tom Orrock, Deputy Director, Program Operations
Norma Pate, Deputy Director, Administration and Performance Management
Kendra Zoller, Deputy Director, Legislation
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 approximately 10:00 a.m. and thanked everyone for attending today's special meeting. The meeting was held on Zoom, via teleconference, and at the MHSOAC headquarters, located at 1812 9th Street, Sacramento, California 95811.

Chair Madrigal-Weiss asked to pause for a moment of silence to honor the memory of those lost on 9/11.

Chair Madrigal-Weiss noted for the record that the Commission is required by the Bagley-Keene Open Meeting Act to have a minimum of eight Commissioners in person to establish a quorum to conduct business today.

Sandra Gallardo, Chief Counsel, called the roll and confirmed the presence of a quorum. Attending in Person: Chair Madrigal-Weiss, Vice Chair Alvarez, and Commissioners Bontrager, Brown, Bunch, Chambers, Gordon, Mitchell, Robinson, and Rowlett. Attending Remotely: Commissioner Carnevale.

Amariani Martinez, Commission staff, reviewed the meeting protocols.

2: General Public Comment

There was no public comment.

3: Bagley-Keene Special Meeting Requirement

Chair Madrigal-Weiss stated the Commission will consider if circumstances exist to make a finding which requires the Commission to hold a special meeting to discuss a personnel matter pursuant to Government Code § 11125.4(c).

Commissioner Comments & Questions

Commissioners asked questions about the Bagley-Keene Open Meeting Act rules.

Public Comment

There was no public comment.

Action: Chair Madrigal-Weiss asked for a motion to approve meeting in closed session. Commissioner Chambers made a motion, seconded by Commissioner Robinson, that:

- *The Commission approves moving forward with the special meeting to address the personnel matter in closed session pursuant to Government Code § 11125.4(c).*

Motion passed 11 yes, 0 no, and 0 abstain, per roll call vote as follows:

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

4: Closed Session – Personnel Matter

Closed Session – Government Code § 11126(a)(1) and § 11125.4(a)(4) related to a personnel matter.

The Commission met in closed session to discuss confidential personnel matters as permitted by law.

5: Report Back from Closed Session

Chair Madrigal-Weiss reconvened the meeting and stated during closed session the Commission moved to put the Executive Director on paid administrative leave. She stated the closed session meeting will continue at the next full Commission meeting on September 26, 2024.

6: Adjournment

There being no further business, the meeting was adjourned at approximately 1:30 p.m.

Mental Health Services
Oversight & Accountability Commission

Motions Summary
Commission Meeting
September 11, 2024

Motion #: 1 (Agenda Item 3 – Bagley-Keene Special Meeting Requirements)

Date: September 11, 2024

Proposed Motion:

Pursuant to Government Code 11125.4(c), that the Commission move forward with this special meeting to address a personnel matter in closed session.

Commissioner making motion: Chambers

Commissioner seconding motion: Robinson

Motion carried _11_yes, __ no, and __ abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	On Leave
1. Bontrager	☒	☐	☐	☐	☐
2. Brown	☒	☐	☐	☐	☐
3. Bunch	☒	☐	☐	☐	☐
4. Carnevale	☒	☐	☐	☐	☐
5. Carrillo	☐	☐	☐	☐	☐
6. Chambers	☒	☐	☐	☐	☐
7. Chen	☐	☐	☐	☐	☒
8. Cortese	☐	☐	☐	☐	☐
9. Gordon	☒	☐	☐	☐	☐
10. Mitchell	☒	☐	☐	☐	☐
11. Robinson	☒	☐	☐	☐	☐
12. Rowlett	☒	☐	☐	☐	☐
13. VACANT	☐	☐	☐	☐	☐
14. VACANT	☐	☐	☐	☐	☐
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐
Totals:	**11**				**1**

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date September 26, 2024

Time 9:00 a.m.

Location MHSOAC
1812 9th Street
Sacramento, California 95811 and Virtual

Members Participating:

Mara Madrigal-Weiss, M.Ed., Chair
Mayra Alvarez, M.A., Vice Chair*
Sheriff Bill Brown, M.P.A.
Keyondria Bunch, Ph.D.
Steve Carnevale
David Gordon, Ed.M.
Gladys Mitchell. M.S.W.
Jay Robinson, Psy.D., M.B.A.
Alfred Rowlett, M.B.A., M.S.W.
Gary Tsai, M.D., DFAPA, FASAM*

*Participated remotely

Members Absent:

Mark Bontrager, J.D., M.S.W.
Assembly Member Wendy Carrillo, M.A.
Rayshell Chambers, M.P.A.
Senator Dave Cortese, J.D.

MHSOAC Meeting Staff Present:

Sandra Gallardo, Chief Counsel
Norma Pate, Deputy Director,
Administration and Performance
Management
Maureen Reilly, Retired Annuitant
Amariani Martinez, Administrative Support

1: <u>Call to Order, Roll Call, and Announcements</u>

Chair Mara Madrigal-Weiss called the Meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at approximately 9:00 a.m. and welcomed everyone. The meeting was held on Zoom, via teleconference, and at the MHSOAC headquarters, located at 1812 9th Street, Sacramento, California 95811.

Chair Madrigal-Weiss introduced Gary Tsai, M.D., DFAPA, FASAM, to the Commission.

Chair Madrigal-Weiss noted for the record that the Commission is required by the Bagley-Keene Open Meeting Act to have a minimum of eight Commissioners in person to establish a quorum to conduct business today.

Sandra Gallardo, Chief Counsel, called the roll and confirmed the presence of a quorum. Attending in Person: Chair Madrigal-Weiss and Commissioners Brown, Bunch, Carnevale, Gordon, Mitchell, Robinson, and Rowlett. Attending Remotely: Vice Chair Alvarez and Commissioner Gary Tsai.

Amariani Martinez, Commission staff, reviewed the meeting protocols.

Announcements

September is Suicide Prevention Month. It is a time to raise awareness of this urgently important crisis. This month is used to shift public perception, spread hope, and share vital information to people affected by suicide. The Commission strives to ensure that individuals, friends, and families have access to the resources they need to discuss suicide prevention and seek help.

2: General Public Comment

There was no public comment.

3: Closed Session – Personnel Matter

Closed Session – Government Code § 11126(a)(1) related to a personnel matter.

Commissioner Tsai recused himself from the discussion and decision-making with regard to this agenda item pursuant to California law.

The Commission met in closed session to discuss confidential personnel matters as permitted by law.

4: Report Back from Closed Session

Chair Madrigal-Weiss reconvened the meeting and stated during closed session the Commission voted to extend the Executive Director's paid administrative leave. The Commission voted to open an investigation using a third-party consultant.

5: Adjournment

Chair Madrigal-Weiss stated the next Commission meeting will take place on October 24th. There being no further business, the meeting was adjourned at approximately 1:30 p.m.

AGENDA ITEM 5

Information

October 24, 2024 Commission Meeting

Transformation Change in Behavioral Health: Early Intervention and Full Service Partnerships

Summary:
The Commission will hear a presentation from the Department of Health Care Services (DHCS) about its plan for implementing the Behavioral Health Services Act (BHSA) components on Early Intervention and Full Service Partnerships (FSP). Following the presentation the Commission will discuss opportunities for supporting DHCS and other partners in identifying funding priorities and best practices for Early Intervention and FSPs.

Background:
In March 2024, voters passed Proposition 1, establishing the Behavioral Health Services Act. The BHSA aims to transform California's behavioral health system by expanding services to include treatment for people with substance use disorders, prioritize care for individuals with the most serious mental health challenges, provide ongoing resources for housing interventions and workforce. The new law also retains and restructures investments in prevention, early intervention, and innovation strategies to prevent mental health and substance use challenges from becoming severe and disabling.

Under the BHSA, counties are required to devote 35 percent of allocated funds to implement local Behavioral Health Services and Supports, the majority (51 percent) of which must be used to administer a local Early Intervention program. Early Intervention, as defined by the BHSA, includes outreach strategies, access and linkage for early psychosis intervention, and services proven to prevent mental health and substance use disorders from becoming severe and disabling. At least 51 percent of local Early Interventions funds must be used for strategies targeting youth 25 years of age and younger.

An additional 35 percent of local BHSA funds will be used by counties to implement Full Service Partnership (FSP) programs, which are the most effective model of comprehensive and intensive care for people at any age with the most complex behavioral health needs (also known as the "whatever it takes" model).

The BHSA requires the Commission to provide consultation to DHCS to support the establishment of evidence-based practices, funding priorities, and a reporting strategy for local FSP and Early Intervention programs.

Presenter: Marlies Perez, Behavioral Health Transformation Project Executive and Division Chief, will present to the Commission on the State's vision and strategy for Early Intervention and FSP under the BHSA. The presentation will inform a discussion on opportunities for the Commission to support DHCS and other partners through its statutory consultive role under the BHSA.

Enclosure (2): Excerpts from the Behavioral Health Services Act on Early Intervention and Full Service Partnerships.

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

Behavioral Health Services Act (BHSA)

Early Intervention Component

(Excerpt taken from California Senate Bill 326, Eggman. The Behavioral Health Services Act)

SEC. 50. Section 5840 is added to the Welfare and Institutions Code, to read:

5840. (a) (1) Each county shall establish and administer an early intervention program that is designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health.

(2) Early intervention programs shall be funded pursuant to clause (ii) of subparagraph (A) of paragraph (3) of subdivision (a) of Section 5892.

(b) An early intervention program shall include the following components:

(1) Outreach to families, employers, primary care health care providers, behavioral health urgent care, hospitals, inclusive of emergency departments, education, including early care and learning, T-12, and higher education, and others to recognize the early signs of potentially severe and disabling mental health illnesses and substance use disorders.

(2) (A) Access and linkage to medically necessary care provided by county behavioral health programs as early in the onset of these conditions as practicable.

(B) Access and linkage to care includes the scaling of, and referral to, the Early Psychosis Intervention (EPI) Plus Program, pursuant to Part 3.4 (commencing with Section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs.

(3) (A) Mental health and substance use disorder treatment services, evidence-based practices and community-defined evidence practices for similar to those provided under other programs that are effective in preventing mental health illnesses and substance use disorders from becoming severe, and components similar to programs that have been successful in reducing the duration of untreated serious mental health illnesses and substance use disorders and assisting people in quickly regaining productive lives.

(B) Mental health treatment services may include services to address first episode psychosis.

(C) Mental health and substance use disorder services shall include services that are demonstrated to be effective at meeting the cultural and linguistic needs of diverse communities.

(D) Mental health and substance use disorder services may be provided to the following eligible children and youth:

(E) Mental health and substance use services may include services that prevent, respond, or treat a behavioral health crisis.

(i) Individual children and youth at high risk for a behavioral health disorder due to experiencing trauma, as evidenced by scoring in the high-risk range under a trauma screening tool such as an adverse childhood experiences (ACEs) screening tool, involvement in the child welfare system or juvenile justice system, or experiencing homelessness.

(ii) Individual children and youth in populations with identified disparities in behavioral health outcomes.

(4) Additional components developed by the State Department of Health Care Services.

(c) (1) The State Department of Health Care Services, in consultation with the Behavioral Health Services Oversight and Accountability Commission, counties, and stakeholders, shall establish a biennial list of evidence-based practices and community-defined evidence practices that may include practices identified pursuant to the Children and Youth Behavioral Health Initiative Act set forth in Chapter 2 (commencing with Section 5961) of Part 7.

(2) Evidence-based practices and community-defined evidence practices may focus on addressing the needs of those who decompensate into severe behavioral health conditions.

(3) Local programs utilizing evidence-based practices and community-defined evidence practices may focus on addressing the needs of underserved communities, such as BIPOC and LGBTQ+.

(4) Counties shall utilize the list to determine which evidence-based practices and community-defined evidence practices to implement locally.

(5) The State Department of Health Care Services may require a county to implement specific evidence-based and community-defined evidence practices.

(d) The early intervention program shall emphasize the reduction of the likelihood of:

(1) Suicide and self-harm.

(2) Incarcerations.

(3) School, including early childhood 0 to 5 years of age, inclusive, TK-12, and higher education, suspension, expulsion, referral to an alternative or community school, or failure to complete.

(4) Unemployment.

(5) Prolonged suffering.

(6) Homelessness.

(7) Removal of children from their homes.

(8) Overdose.

(9) Mental illness in children and youth from social, emotional, developmental, and behavioral needs in early childhood.

(e) For purposes of this section, “substance use disorder” shall have the meaning as defined in subdivision (c) of Section 5891.5.

(f) For purposes of this section, “community-defined evidence practices” is defined as an alternative or complement to evidence-based practices, that offers culturally anchored interventions that reflect the values, practices, histories, and lived-experiences of the communities they serve. These practices come from the community and the organizations that serve them and are found to yield positive results as determined by community consensus over time.

(g) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

5840.6. For purposes of this chapter, the following definitions shall apply:

(a) “County” includes a city receiving funds pursuant to Section 5701.5.

(b) “Early intervention funds” means funds from the Behavioral Health Services Fund allocated for early intervention services and programs pursuant to clause (ii) of subparagraph (A) of paragraph (3) of subdivision (a) of Section 5892.

(c) “Childhood trauma early intervention” refers to a program that targets eligible children and youth exposed to, or who are at risk of exposure to, adverse and traumatic childhood events and prolonged toxic stress in order to deal with the early origins of mental health and substance use disorder needs and prevent long-term mental health and substance use disorder concerns. This may include, but is not limited to, all of the following:

(1) Focused outreach and early intervention to at-risk and in-need populations, including youth experiencing homelessness, justice-involved youth, LGBTQ+ youth, and child welfare-involved youth.

(2) Implementation of appropriate trauma and developmental screening and assessment tools with linkages to early intervention services to eligible children and youth who qualify for these services.

(3) Collaborative, strengths-based approaches that appreciate the resilience of trauma survivors and support their parents and caregivers when appropriate.

(4) Support from peer support specialists, wellness coaches, and community health workers trained to provide mental health and substance use disorder treatment services with an emphasis on culturally and linguistically tailored approaches.

(5) Multigenerational family engagement, education, and support for navigation and service referrals across systems that aid the healthy development of children and youth and their families.

(6) Collaboration with county child welfare agencies and other system partners, including Medi-Cal managed care plans, as defined in subdivision (j) of Section 14184.101, and homeless youth service providers, to address the physical and behavioral health-related needs and social needs of child-welfare-involved youth.

(7) Linkages to primary care health settings, including, but not limited to, federally qualified health centers, rural health centers, community-based providers, school-based health centers, school-linked providers, and school-based programs and community-based organizations specializing in serving underserved communities.

(8) Leveraging the healing value of traditional cultural connections and faith-based organizations, including policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served and recognition of historical trauma.

(9) Blended funding streams to provide individuals and families experiencing toxic stress comprehensive and integrated supports across systems.

(10) Partnerships with local educational agencies and school-based behavioral health professionals to identify and address children exposed to, or who are at risk of exposure to, adverse and traumatic childhood events and prolonged toxic stress.

(d) “Early psychosis and mood disorder detection and intervention” has the same meaning as set forth in paragraph (2) of subdivision (b) of Section 5835 and may include programming across the age span.

(e) “Youth outreach and engagement” means strategies that target out-of-school youth and secondary school age youth, including, but not limited to, all of the following:

(1) Establishing direct linkages for youth to community-based mental health and substance use disorder treatment services.

(2) Participating in evidence-based practices and community-defined evidence programs for mental health and substance use disorder treatment services.

(3) Providing supports to facilitate access to services and programs, including those utilizing community-defined evidence practices, for underserved and vulnerable populations, including, but not limited to, members of ethnically and racially diverse communities, members of the LGBTQ+ communities, victims of domestic violence and sexual abuse, and veterans.

(4) Establishing direct linkages for students to community-based mental health and substance use disorder treatment services for which reimbursement is available through the students’ health coverage.

(5) Reducing racial disparities in access to mental health and substance use disorder treatment services.

(6) Providing school employees and students with education and training in early identification, intervention, and referral of students with mental health and substance use disorder needs.

(7) Strategies and programs for youth with signs of behavioral or emotional problems or substance misuse who are at risk of, or have had, contact with the child welfare or juvenile justice system.

(8) Integrated youth mental health and substance use disorder programming.

(f) “Culturally competent and linguistically appropriate intervention” refers to a program that creates critical linkages with community-based organizations, including, but not limited to, clinics licensed or operated under subdivision (a) of Section 1204 of the Health and Safety Code and clinics exempt from clinic licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code. The community-based organizations include facilities and providers licensed or certified by the State Department of Health Care Services, including, but not limited to, residential substance use disorder facilities licensed pursuant to Section 11834.01 of the Health and Safety Code or certified pursuant to Section 11830.1 of the Health and Safety Code and narcotic treatment programs licensed pursuant to Section 11839 of the Health and Safety Code. Community-based organizations may also include those organizations that provide community-defined evidence practices.

(1) “Culturally competent and linguistically appropriate” means the ability to reach underserved cultural populations and address specific barriers related to racial, ethnic, cultural, language, gender, age, economic, or other disparities in mental health and substance use disorder treatment services access, quality, and outcomes.

(2) “Underserved cultural populations” means those who are unlikely to seek help from providers of traditional mental health and substance use disorder services because of stigma, lack of knowledge, or other barriers, including members of ethnically and racially diverse communities, members of the LGBTQ+ communities, victims of domestic violence and sexual abuse, and veterans, across their lifespans.

(g) “Strategies targeting the mental health and substance use disorder needs of older adults” means, but is not limited to, all of the following:

(1) Outreach and engagement strategies that target caregivers, victims of elder abuse, and individuals who live alone.

(2) Outreach to older adults who are isolated.

(3) Programs for early identification of mental health disorders and substance use disorders.

(h) “Community-defined evidence practices” is defined as an alternative or complement to evidence-based practices, that offer culturally anchored interventions that reflect the values, practices, histories, and lived-experiences of the communities they serve. These practices

come from the community and the organizations that serve them and are found to yield positive results as determined by community consensus over time.

(i) This section shall become operative on July 1, 2026, if amendments to the Mental Health Service Act are approved by the voters at the March 5, 2024, statewide primary election.

5840.7. (a) The State Department of Health Care Services, in consultation with the Behavioral Health Services Oversight and Accountability Commission, shall establish priorities for the use of early intervention funds. These priorities shall include, but are not limited to, the following:

(1) Childhood trauma early intervention to deal with the early origins of mental health and substance use disorder treatment needs, including strategies focused on eligible children and youth experiencing homelessness, justice-involved children and youth, child welfare-involved children and youth with a history of trauma, and other populations at risk of developing a mental health disorder or condition as specified in subdivision (d) of Section 14184.402 or substance use disorders. Childhood trauma early intervention services shall not be limited to individuals enrolled in the Medi-Cal program.

(2) Early psychosis and mood disorder detection and intervention and mood disorder programming that occurs across the lifespan.

(3) Outreach and engagement strategies that target early childhood 0 to 5 years of age, inclusive, out-of-school youth, and secondary school youth. Partnerships with community-based organizations and college mental health and substance use disorder programs may be utilized to implement the strategies.

(4) Culturally competent and linguistically appropriate interventions.

(5) Strategies targeting the mental health and substance use disorder needs of older adults.

(6) Strategies targeting the mental health needs of eligible children and youth, as defined in Section 5892, who are 0 to 5 years of age, including, but not limited to, infant and early childhood mental health consultation.

(7) Strategies to advance equity and reduce disparities.

(8) Programs that include community-defined evidence practices and evidence-based practices and mental health and substance use disorder treatment services similar to those provided under other programs that are effective in preventing mental illness and substance

use disorders from becoming severe and components similar to programs that have been successful in reducing the duration of untreated severe mental illness and substance use disorders to assist people in quickly regaining productive lives.

(9) Other programs the State Department of Health Care Services identifies that are proven effective in preventing mental illness and substance use disorders from becoming severe and disabling, consistent with Section 5840.

(10) Strategies to address the needs of individuals at high risk of crisis.

(b) (1) (A) The portion of funds in the county plan relating to early intervention shall focus on the established priorities and shall be allocated as determined by the county with stakeholder input.

(B) (i) A county may include other priorities, as determined through the stakeholder process, in addition to the established priorities.

(ii) If a county chooses to include other programs, the plan shall include a description of why those programs are included and metrics by which the effectiveness of those programs is to be measured.

(2) Counties may act jointly to meet the requirements of this section.

(c) This section shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

(3) (A) Thirty-five percent of the funds distributed to counties pursuant to subdivision (c) of Section 5891 shall be used for the following Behavioral Health Services and Supports:

(i) Services pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care, excluding those services specified in paragraphs (1) and (2).

(ii) Early intervention programs in accordance with Part 3.6 (commencing with Section 5840).

(iii) Outreach and engagement.

(iv) Workforce education and training.

(v) Capital facilities and technological needs.

(vi) Innovative behavioral health pilots and projects.

(B) (i) A county shall utilize at least 51 percent of Behavioral Health Services and Supports funding for early intervention programs.

(ii) A county shall utilize at least 51 percent of the county's funding allocated for early intervention programs to serve individuals who are 25 years of age and younger.

Behavioral Health Services Act (BHSA)

Full Service Partnership Component

(Excerpt taken from California Senate Bill 326, Eggman. The Behavioral Health Services Act)

SEC. 86.

Part 4.1 (commencing with Section 5887) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 4.1. Full-Service Partnership

5887.

(a) Each county shall establish and administer a full service partnership program that include the following services:

(1) Mental health services, supportive services, and substance use disorder treatment services.

(2) Assertive Community Treatment and Forensic Assertive Community Treatment fidelity, Individual Placement and Support model of Supported Employment, high fidelity wraparound, or other evidence-based services and treatment models, as specified by the State Department of Health Care Services. Counties with a population of less than 200,000 may request an exemption from these requirements. Exemption requests shall be subject to approval by the State Department of Health Care Services. The State Department of Health Care Services shall collaborate with the California State Association of Counties and the County Behavioral Health Directors Association of California on reasonable criteria for those requests and a timely and efficient exemption process.

(3) Assertive field-based initiation for substance use disorder treatment services, including the provision of medications for addiction treatment, as specified by the State Department of Health Care Services.

(4) Outpatient behavioral health services, either clinic or field based, necessary for the ongoing evaluation and stabilization of an enrolled individual.

(5) Ongoing engagement services necessary to maintain enrolled individuals in their treatment plan inclusive of clinical and nonclinical services, including services to support maintaining housing.

(6) Other evidence-based services and treatment models, as specified by the State Department of Health Care Services.

(7) The service planning process pursuant to Sections 5806 or 5868 and all services identified during the applicable process.

(8) Housing interventions pursuant to Section 5830.

(b) (1) (A) Full-service partnership services shall be provided pursuant to a whole-person approach that is trauma informed, age appropriate, and in partnership with families or an individual's natural supports.

(B) These services shall be provided in a streamlined and coordinated manner so as to reduce any barriers to services.

(2) Full-service partnership services shall support the individual in the recovery process, reduce health disparities, and be provided for the length of time identified during the service planning process pursuant to Sections 5806 and 5868.

(c) Full-service partnership programs shall employ community-defined evidence practices, as specified by the State Department of Health Care Services.

(d) (1) Full-service partnership programs shall enroll eligible adults and older adults, as defined in Section 5892, who meet the priority population criteria specified in subdivision (c) of Section 5892 and other criteria, as specified by the State Department of Health Care Services.

(2) Full-service partnership programs shall enroll eligible children and youth, as defined in Section 5892.

(e) Full-service partnership programs 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, as specified by the State Department of Health Care Services, in consultation with the Behavioral Health Services Oversight and Accountability Commission, counties, providers, and other stakeholders.

(f) All behavioral health services, as defined in subdivision (j) of Section 5891.5, and supportive services provided to a client enrolled in a full-service partnership shall be paid from the funds allocated pursuant to paragraph (2) of subdivision (a) of Section 5892, subject to Section 5891.

(g) (1) The clinical record of each client participating in a full service partnership program shall describe all services identified during the service planning process pursuant to Sections 5806 and 5868 that are provided to the client pursuant to this section.

(2) The State Department of Health Care Services may develop and revise documentation standards for service planning to be consistent with the standards developed pursuant to paragraph (3) of subdivision (h) of Section 14184.402.

(3) Documentation of the service planning process in the client's clinical record pursuant to paragraph (1) may fulfill the documentation requirements for both the Medi-Cal program and this section.

(h) For purposes of this part, the following definitions shall apply:

(1) "Community-defined evidence practices" means an alternative or complement to evidence-based practices, that offer culturally anchored interventions that reflect the values, practices, histories, and lived-experiences of the communities they serve. These practices come from the community and the organizations that serve them and are found to yield positive results as determined by community consensus over time.

(2) "Substance use disorder treatment services" means those services as defined in subdivision (c) of Section 5891.5.

(3) "Supportive services" means those services necessary to support clients' recovery and wellness, including, but not limited to, food, clothing, linkages to needed social services, linkages to programs administered by the federal Social Security Administration, vocational and education-related services, employment assistance, including supported employment, psychosocial rehabilitation, family engagement, psychoeducation, transportation assistance, occupational therapy provided by an occupational therapist, and group and individual activities that promote a sense of purpose and community participation.

(i) This section shall be implemented only to the extent that funds are provided from the Behavioral Health Services Fund for purposes of this section. This section does not obligate the counties to use funds from any other source for services pursuant to this section.

5887.1.

This part shall become operative on July 1, 2026, if amendments to the Mental Health Services Act are approved by the voters at the March 5, 2024, statewide primary election.

AGENDA ITEM 8

Action

October 24, 2024 Commission Meeting

Consent Calendar

Summary:
The Commission will consider approval of the Consent Calendar which contains the following items:

1) Innovation project funding request from Shasta County – Level Up
2) Alameda and Tri-City: Multi County Collaborative – Psychiatric Advance Directive (PADs)
3) Information Technology Contract Update
4) Reallocation of unencumbered MHWA funds - EmPATH

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.

1) **Innovation project funding request from Shasta County: Level-Up, Supporting Community-Defined Practices for Health Equity**

Shasta County is requesting up to $999,977.52 of Innovation spending authority to partner with Level Up NorCal to provide case management and wrap-around supports for low income and underserved residents of the Hispanic/Latino and Asian communities that are traditionally difficult to reach. Level Up NorCal is a community-based organization whose mission is to improve and promote health and well-being of ethnic minorities through education, support, and advocacy. Level Up NorCal staff have a combined 30+ years of experience providing outreach and information to bicultural and bilingual community members and have built trust and rapport with individuals throughout Shasta County.

This proposed project will implement a community-driven and culturally based approaches to address Shasta County's underserved communities through methods previously proven effective in public health settings. This project will use the promotoras model to reach unserved and underserved communities, scaling these methods beyond the public health setting and into the behavioral health space. Case management services utilizing bilingual/bicultural staff will ensure

culturally and linguistically responsive services through enhanced understanding and comprehension between providers and those seeking assistance, as well as increase awareness of and access to services.

Behavioral Health Services Act (BHSA) Alignment and Sustainability:

The BHSA aims to expand the behavioral health workforce to reflect and connect with California's diverse population by focusing on outcomes, accountability, and equity. Shasta County's proposed plan aligns with and furthers that purpose through its culturally and linguistically diverse approach at reaching its community members who have typically been unserved, underserved, and/or inappropriately served. By implementing promotoras, this project will foster supports and services from within its local community through a workforce that addresses specific behavioral health needs for its Hispanic/Latino and Asian community members. Since translation services and cultural and linguistic competency has been a major challenge for Shasta County's Hispanic/Latino and Asian communities, this project will provide translation services to promote shared understanding of vital behavioral health concepts between community members and providers through use of staff who speak the language of the individuals being served and represent the community being served. The primary languages that will be utilized for provision of services will include Spanish, Mien, and Hmong.

Participants will also receive wrap-around case management with a whole-person approach to focus on the unique needs of those who require culturally and linguistically tailored assistance in areas such as housing, food, and economic insecurities. Addressing these basic immediate needs permits individuals to focus more on their behavioral health. If successful, the county plans on sustaining this project through BHSA funding allocated for early intervention efforts, such as outreach, case management support, referrals, and family and individual skill building.

Community Planning Process:

Local Level

During the County's community planning process, the main priority populations identified as being in most need of behavioral health services and supports were the Hispanic/Latino and Asian communities who face cultural and linguistic barriers that prevent them from receiving timely access to appropriate care. In April 2023, a community-wide survey was sent out to the public to identify ideas for potential innovation projects. Community members expressed the need for improvements in culturally appropriate services, and thus, this project was created.

Between August 7, 2023 and September 6, 2023, the plan underwent its 30-day public comment period. During that time, the proposed project received large support from community-based organizations and local community members, with the County receiving over a dozen letters of support. Some of the organizations who voiced their support of the plan included the Shasta Equal Justice Coalition, the National Alliance on Mental Illness (NAMI) Shasta branch, SEIU Local

2015, community members representing the target populations, and numerous other residents of Shasta County.

Many of the public comments centered around the pressing need for culturally and linguistically appropriate services for the Hispanic/Latino and Asian/Pacific Islander populations, who make up a large portion of the County's demographic but who often find it difficult to trust, access, and receive services that meet their specific needs. These comments also noted how beneficial the proposed services would be in promoting health equity and diversity within the behavioral healthcare space. Education and advocacy efforts that account for language barriers were called out as important strategies to advance the health and wellbeing of ethnic minorities, with some sharing their first-hand experiences witnessing the challenges and lack of supports available for the Hispanic/Latino and Asian communities.

An overwhelming portion of community comments vouched for the skills and efficacy of the Level Up NorCal organization, which has previously worked alongside other community-based organizations in Shasta County during the COVID-19 pandemic to promote vaccine awareness and education. Through their past efforts, Level Up NorCal increased vaccine equity among underserved communities by breaking down cultural and linguistic barriers. The trust in Level Up NorCal's ability to connect community members with much needed services is highly evident among the letters of support.

Shasta County's local mental health board approved the plan on September 6, 2023. Local Board of Supervisor approval is pending.

Commission Level

Commission staff shared this project's initial plan with its community partners and the Commission's listserv on August, 15, 2024, and comments were directed to Commission staff. An updated project plan was shared with the Commission's community partners and listserv on September 3, 2024.

2) <u>PADs Multi-County Innovation project funding request by Alameda and Tri-City:</u>

Alameda and Tri-City are requesting approval to participate in Phase Two of the Psychiatric Advance Directives (PADs) multi-county collaborative, joining Fresno, Shasta, and Orange Counties who have received previous approvals. Alameda is requesting up to $3,070,005 and Tri-City is requesting up to $1,500,000 in Innovation funding.

The first cohort of the Psychiatric Advance Directive (PAD) project was approved by the Commission on June 24, 2021, for a total of four years and is set to conclude on June 25, 2024.

Partnering counties consisted of Fresno, Contra Costa, Mariposa, Monterey, Orange, Shasta, and Tri-City.

Phase Two will focus heavily on the training and "live" use of PADs. At this time, Fresno and Shasta County are ready to pilot Phase Two; however, up to fifteen counties may join Phase Two by the end of the year.

Phase Two goals include engagement for new counties, collaboration amongst stakeholders, training and accessibility, testing in a live environment, evaluation, and transparency through www.padsCA.org.

Behavioral Health Services Act Alignment (BHSA) and Sustainability

This project will focus on individuals with behavioral health needs who may be unhoused and need housing and supportive services, who receive services from Full-Service Partnerships, and other individuals who are in the behavioral health system of care including veterans, justice-involved, recently hospitalized in emergency room departments or inpatient units, and those with co-occurring substance use disorders.

The project also aligns with the Commission's Strategic Plan goals of advocacy for system improvement, supporting universal access to mental health services, participation in the change in statutes, and promoting access to care and recovery.

On April 23, 2024, The Commission was asked to support Assembly Bill 2352 (Irwin) which will seek to build out a legal framework for PADs in California that will work the Counties who are currently participating in Phase One of this project. Support of AB 2352 was granted with the stipulation that this bill continues to work with disability rights groups and ensures that the bill empowers peers and supports recovery. *PADs Phase Two has outlined efforts to collaborate and partner with Peer Support Specialists, Painted Brain, Disability Rights of California, NAMI California (for complete list of collaborating partners, see page 4-5).*

Regarding sustainability, PADs has received support from current legislative action (AB2353, Irwin) for Phase One efforts. It is the hope that continued funding through legislation will support the work in Phase Two. Part of the goal within Phase Two is to show the need and the utility of PADs with the hope that it will secure ongoing funding from various agencies.

Discussion of County Specific Community Planning Process:

Alameda

In Phase Two, Alameda County is continuing to prioritize their focus on individuals who access crisis support services, individuals experiencing homelessness and those who are justice-involved.

Alameda County proposes to spend $3,070,005 in Innovation funding towards this multi-county collaborative.

Tri-City

In Phase Two, Tri-City has identified two priority populations: transitional aged youth (18-25) and individuals who are homeless/at risk of homelessness.

Tri-City reports that 24% of all crisis calls during Fiscal Year 2022/2023 involved transitional aged youth (TAY). Other data provided indicates the need for additional interventions specific for this population.

For individuals experiencing housing instability, PADs can help identify emergency contact information, treatment plans and tools to help in a time of crisis.

Tri-City Mental Health Authority proposes to spend up to $1,500,000 in Innovation funding towards this multi-county collaborative.

This final projects for Alameda and Tri-City to join the PADs Collaborative was shared with the Commission's community partners and listserv on September 25, 2024. No comments were received in response to this sharing.

3) Information Technology Contract Update

Requesting the approval of a contract in the amount of $215,550 to support updating the Commission's best practices in Information Technology security as mandated by the State of California Department of Justice (DOJ). The goals of this project are to ensure the Commission meets or exceeds the updated requirements as mandated by DOJ and follows appropriate best practices for data security.

Background

The Commission offers data transparency as part of a continuous commitment to support improved public access to and understanding of California's mental health services. Data for these analyses are obtained through data sharing agreements with other state entities. The DOJ requires the Commission as a non-law enforcement agency (NJCA) to demonstrate compliance

with Federal Bureau of Investigation Criminal Justice Information Services Security Policy (FBI CJIS SP) to receive Criminal Justice Offense Record Information (CORI). DOJ and FBI CJIS regularly update their requirements, which requires the Commission to review and update our policies regularly.

The Commission was first required to document CJI Compliance in 2020. The Commission received 3 bids for assistance, and the vendor Flank, now Centris, was contracted for compliance assistance. This contract was approved by the Commission in 2020 and the Commission successfully completed FBI CJIS SP 5.9 compliance on 6/30/21. Cost $114,625.00 - 20MHSOAC018.

In 2022 the Commission moved their data center to a new environment and the DOJ updated their security policies to FBI CJIS SP 5.9.1. The Commission contracted with the same vendor for compliance assistance. The Commission successfully completed the second compliance effort for FBI CJIS SP 5.9.1on 10/1/22. Cost $98,625.00 - 22MHSOAC024.

The DOJ has now updated security requirements to FBI CJIS 5.9.3. There are significant updates to the requirements from the prior version the Commission completed. The Commission requested five bids and received four. Three of the bids were accepted. Centris was the most competitive bid and chosen as the vendor. The current effort is proposed to be completed by June 2025 for FBI CJIS SP 5.9.3 at a cost of $215,550.00.

The bids were:

Illumant, LLC	$96,000	Unacceptable: Could not provide support for all items required in our request for proposal.
Centris	$215,550	Acceptable
Arlington, LLC	$373,000	Acceptable
MorganHill Consulting Group, LLC	$454,000	Acceptable

4) <u>Reallocation of unencumbered MHWA funds – EmPATH</u>

The Community Engagement and Grants Team is seeking approval to reallocate a total of $4 million in Mental Health Wellness Act Funding to current EmPATH grantees. Excess funds were made available as the result of two grant refusals. Ventura County was an applicant for a $1 million grant relative to our Older Adults program and Riverside University Health System was an applicant for a $3 million grant in our EmPATH program. Neither applicant entered contracts, and these funds are available to be directed to current EmPATH grantees. Both RFAs include language that permits the reallocation to other programs if additional funds become available.

The additional funding would assist hospitals cover higher than anticipated building costs and program sustainability while licensing approvals and county behavioral health agreements are negotiated.

Current EmPATH grantees include:

Community Regional Med Ctr - Fresno, CA
Henry Mayo Newhall - Valencia, CA
Loma Linda UCH - Loma Linda, CA
Loma Linda UMC (Children) - Loma Linda, CA
Sutter Coast - Crescent City, CA
Twin Cities - Templeton, CA
Pacifica Hospital - Sun Valley, CA
Sharp Chula Vista - San Diego, CA
College Med Center - Long Beach, CA
Mercy Med Ctr - Redding, CA

Presenter(s): None

Enclosures (4): (1) Commission Community Engagement Process; (2) Shasta County Analysis: Level Up - Supporting Community-Driven Practices for Health Equity; (3) Alameda and Tri-City Joint Analysis: Psychiatric Advance Directives (PADs) Multi-County Collaborative; (4) Reallocation Proposal for MHWA Funding

Handouts: None

Additional Materials (1): Links to the final Innovation projects are available on the Commission's website at the following URLs:

Shasta County: Supporting Community-Defined Practices for Health Equity
https://mhsoac.ca.gov/wp-content/uploads/Shasta_INN-Plan_Level-Up.pdf

Alameda and Tri-City: Psychiatric Advance Directive (PADs) Multi-County Collaborative
https://mhsoac.ca.gov/wp-content/uploads/Multi-County-Collab_PADS_Phase-2_Alameda-and-Tri-City_09132024_Final.pdf

Proposed Motions:
That the Commission approve the Consent Calendar that includes:

(1) Funding for Shasta County's Supporting Community-Driven Practices for Health Equity Innovation Project for up to $999,977.52; and
(2) Funding for Alameda County to join the Psychiatric Advance Directive (PADs) Multi-County Collaborative Innovation Project for up to $3,070,005; and
(3) Funding for Tri-City to join the Psychiatric Advance Directive (PADs) Multi-County Collaborative Innovation Project for up to $1,500,000.
(4) Authorization for the Interim Executive Director or the Commission Chair to enter one or more contracts not to exceed $225,000 to support the Commission in updating its best practices in Information Technology security as mandated by the State of California, Department of Justice.
(5) Reallocation of $4 million in Mental Health Wellness Act funds to existing EmPATH grantees.

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—Shasta County

Innovation (INN) Project Name:	**Supporting Community-Driven Practices for Health Equity**
Total INN Funding Requested:	**$999,977.52**
Duration of INN Project:	**24 months (2 years)**
MHSOAC consideration of INN Project:	**October 24, 2024**

Review History:

Public Comment Period:	August 7, 2023 – September 6, 2023
Mental Health Board Hearing:	September 6, 2023
Approved by the County Board of Supervisors:	Pending Commission Approval
County submitted INN Project:	September 9, 2024
Dates Project Shared with Commission Community Partners:	August 15, 2024 and September 3, 2024

Project Introduction

Shasta County ("County") is requesting up to $999,977.52 of Innovation spending authority to partner with Level Up NorCal to provide case management and wrap-around supports for low income and underserved residents of the Hispanic/Latino and Asian communities that are often difficult to reach. Level Up NorCal is a community-based organization whose mission is to improve and promote health and well-being of ethnic minorities through education, support, and advocacy. Level Up NorCal staff have a combined 30+ years of experience providing outreach and information to bicultural and bilingual community members and have built trust and rapport with these communities throughout Shasta County.

In line with the California Reducing Disparities Project's Strategic Plan, originally developed for the California Department of Public Health, this proposed project will implement a community-driven and culturally based approaches to address Shasta County's underserved communities through methods previously proven effective in public health settings. This project will use the promotoras model to reach unserved and underserved communities, scaling these methods beyond the public health setting and into the behavioral health space.

Case management services utilizing bilingual/bicultural staff will ensure culturally and linguistically responsive services through enhanced understanding and comprehension between providers and those seeking assistance, as well as increase awareness of and access to services.

What is the Problem?

Shasta County is one of the most diverse communities in the Superior Region. According to the 2020 US Census, people of Hispanic or Latino, Asian, Pacific Islander, and bicultural ancestry make up nearly a quarter of the county's population; however, these groups are not being effectively reached. A lack of behavioral health education, cultural stigmas, linguistic barriers, and socioeconomic hardships have contributed to health disparities. To address these challenges, the County is proposing a plan with a heavy focus on outreach and engagement to connect with diverse populations, which directly aligns with the goals of the Behavioral Health Services Act (BHSA).

Research shows that people of color are less likely than their white counterparts to engage in behavioral health services due to stigma, distrust, and lack of culturally appropriate providers. In particular, the Hispanic/Latino and Asian communities in Shasta County have been historically underrepresented. Within these groups, there is a general lack of trust in government entities and limited access to linguistically appropriate lines of communication to effectively meet culturally specific needs.

Appropriate translation services are largely in demand. Current translation services sourced from outside the community are not well-received, with families preferring to use their own children as translators; however, children are often limited in their language skills and lack the behavioral health-related knowledge to serve as effective and appropriate translators. Comparatively, some staff who are appropriately trained in behavioral health may not have the background or understanding of cultural nuances to provide culturally competent services. It is more common for people to seek out and receive services from someone who comes from their own community and culture. This project plans to marry together the two skillsets of both cultural relatability and subject matter expertise through outreach that best reaches these traditionally hard-to-reach communities.

How this Innovation project addresses this problem

This project seeks to increase access to mental health programs and services to underserved groups by applying a promising community driven practice or approach that has been successful in a non-mental health context.

Proposition 1: BHSA aims to expand the behavioral health workforce to reflect and connect with California's diverse population by focusing on outcomes, accountability, and equity. Shasta County's proposed plan aligns with and furthers that purpose through its culturally and linguistically diverse approach at reaching its community members who have typically

been unserved, underserved, and/or inappropriately served. By implementing promotoras, this project will foster supports and services from within its local community through a workforce that addresses specific behavioral health needs for its Hispanic/Latino and Asian community members.

Language barriers can adversely affect access to appropriate behavioral health services and supports. Since translation services and cultural and linguistic competency has been a major challenge for Shasta County's Hispanic/Latino and Asian communities, this project will provide translation services to promote shared understanding of vital behavioral health concepts between community members and providers through use of staff who speak the language of the individuals being served and represent the community being served. The primary languages that will be utilized for provision of services will include Spanish, Mien, and Hmong.

Participants will also receive wrap-around case management with a whole-person approach to focus on the unique needs of those who require culturally and linguistically tailored assistance in areas such as housing, food, and economic insecurities. Addressing these basic immediate needs permits individuals to focus more on their behavioral health.

In development of this project, Shasta County researched other innovation plans from other counties. Contra Costa County implemented a project that focuses on a similar target population; however, that project uses external agencies to provide services, whereas this proposed project plans to utilize culturally and linguistically competent staff from Level Up NorCal, a direct part of their community, to provide client- and family-driven practices.

Modeling the Promotores de Salud program, this project will provide the following activities:

- Culturally appropriate outreach and education to target populations to increase awareness of behavioral health concepts and early identification of behavioral health challenges, leveraging Level Up NorCal's extensive network within immigrant communities
- Case management supports in a culturally and linguistically appropriate manner to increase access to services and available programming by removing language barriers
- Culturally appropriate services to families, addressing not only the needs of individuals seeking services, but also empowering and bolstering their familial support system across multiple generations through both written and verbal communication and translations

Additionally, this project also aligns with the Commission's strategic goal of advocacy and universal access to mental health services by elevating the perspectives of diverse communities.

Community Planning Process

Local Level

During the County's community planning process, the main priority populations identified as being in most need of behavioral health services and supports were the Hispanic/Latino and Asian communities who face cultural and linguistic barriers that prevent them from receiving timely access to appropriate care. In April 2023, a community-wide survey was sent out to the public to identify ideas for potential innovation projects. Community members expressed the need for improvements in culturally appropriate services, and thus, this project was created.

Between August 7, 2023 and September 6, 2023, the plan underwent its 30-day public comment period. During that time, the proposed project received large support from community-based organizations and local community members, with the County receiving over a dozen letters of support. Some of the organizations who voiced their support of the plan included the Shasta Equal Justice Coalition, the National Alliance on Mental Illness (NAMI) Shasta branch, SEIU Local 2015, community members representing the target populations, and numerous other residents of Shasta County.

Many of the public comments centered around the pressing need for culturally and linguistically appropriate services for the Hispanic/Latino and Asian/Pacific Islander populations, who make up a large portion of the County's demographic but who often find it difficult to trust, access, and receive services that meet their specific needs. These comments also noted how beneficial the proposed services would be in promoting health equity and diversity within the behavioral healthcare space. Education and advocacy efforts that account for language barriers were called out as important strategies to advance the health and wellbeing of ethnic minorities, with some sharing their first-hand experiences witnessing the challenges and lack of supports available for the Hispanic/Latino and Asian communities.

An overwhelming portion of community comments vouched for the skills and efficacy of the Level Up NorCal organization, which has previously worked alongside other community-based organizations in Shasta County during the COVID-19 pandemic to promote vaccine awareness and education. Through their past efforts, Level Up NorCal increased vaccine equity among underserved communities by breaking down cultural and linguistic barriers. The trust in Level Up NorCal's ability to connect community members with much needed services is highly evident among the letters of support.

Shasta County's local mental health board approved the plan on September 6, 2023. Local Board of Supervisor approval is pending.

Commission Level

Commission staff shared this project's initial plan with its community partners and the Commission's listserv on August, 15, 2024, and comments were directed to Commission staff. An updated project plan was shared with the Commission's community partners and listserv on September 3, 2024.

A total of three (3) comments were received in response to the Commission's final request for feedback.

One (1) commenter stated:

> *"After reviewing the INN for Shasta County, it appears to be lacking a 'training component' for CHW and/or Peer Support Specialists."*
>
> The commenter later added: "*As Californians continue to grow and expand on HEALTHCARE access and services, it's very important to keep sustainability in mind. With that said, this link: https://www.dhcs.ca.gov/community-health-workers addresses some of those areas. California has been working on establishing CHW and PSS [as] health care career pathways, I hope all Counties work toward this goal."*

In response, the County added the following information to their plan:

> *"While our program is modeled on the CHW/PSS model, it builds and expands it to focus on addressing cultural and linguistic barriers to health equity. Staff will be bicultural and bilingual with shared lived experiences with the communities of focus and will be trained on understanding the mental health and behavioral health resources available to community members and how to access those resources to better support and improve health equity for these underserved communities. The proposed program is a more expansive wraparound program that addresses the whole needs of the individual. Training will vary and depends on the program and service needs of each specific individual. Training will include working with providers to understand their programs so that we can effectively educate and communicate the services available to community members. We are not clinicians; we do not treat or provide care for any behavioral or mental health concerns. We help connect community members to the mental health and behavioral experts and clinicians so that appropriate services can be provided to those who would otherwise not receive the support they need. Our role is to connect them to services that will provide them this care by providing cultural and linguistic support for clients that will enable them to seek and receive such services. We are filling a gap in services that tele translators or providers without the cultural or linguistic capacity are not able to meet. With populations who have been historically underserved or unserved, the proposed program builds a bridge towards health equity by offering culturally and linguistically appropriate support for the communities of focus to understand and receive the services they need.*
>
> *Below are the trainings we currently provide to staff:*
> - *HIPAA*
> - *Mandated Reporter*
> - *Sexual Harassment*
> - *Cultural Competency*
> - *Translation/Interpretation For Services*

- *Working with Providers*
- *Person Centered Training*
- *Youth Mental Health First Aid*
- *Adult Mental Health First Aid*
- *Applied Suicide Intervention Skills*

We are also open to adding other trainings as needed."

In addition to this comment, two (2) other comments were received in support of the plan:

"I am writing to support Shasta County Health and Human Services (HHSA) and Level Up for the Innovation project entitled, Supporting Community Driven Practices for Health Equity. This is an important project that will increase access to mental health and substance use disorder treatment for members of marginalized communities in Shasta County, namely immigrant communities with limited English ability. Shasta County has a predominantly English speaking population of European descent, with small populations of immigrants with limited English ability. These mainly include Mien, Hmong, and Latin American populations. These individuals struggle to access behavioral health services due to the fact that most services are provided in English. Shasta County HHSA has some bilingual staff, but the number is not sufficient to adequately provide behavioral health services for everyone who needs then in languages other than English. For this reason, the department relies heavily on language line services, which is poorly received by the immigrant communities. This program would provide an innovative solution to this problem by providing translation and case management
services in native tongues, which is more effective and culturally competent. This program will directly affect existing disparities in behavioral health access."

"I want to comment that I happy to see Shasta County is finally help our people. We do not get help or assistance now. Glad to see them do this. I support for our Asian community."

Learning Objectives and Evaluation

The County has identified the following learning objectives for this project:

1. Will offering culturally and linguistically appropriate case management increase utilization of programs and services among the target population?
2. Will offering culturally and linguistically appropriate outreach and engagement opportunities increase knowledge of available resources among the target population?
3. Will offering culturally and linguistically appropriate wraparound services to participants and their families promote overall mental health and wellness?

To determine project success and evaluate the desired goals and objectives outlined above, the County will collect and measure both qualitative and quantitative data including, but not limited to, the following:

- Number of individuals served based on enrollment in the project
- Participant demographic information, including race, ethnicity, and primary/preferred language
- Select outcome measures from SAMHSA's National Outcome Measures (NOMs)
    - Overall mental health
    - Handling daily life
    - General wellbeing
    - Social connectedness
- Access to programs and services
    - Number of programs and services community members were connected with
    - Types of programs or services
    - Language assistance needs by program and service
- Satisfaction surveys collected upon entry/middle/exit of services
- Narratives from individuals and families participating in the program

Success will be shown through increased utilization and awareness of programs, services, and/or resources. Increased number of referrals from providers and follow through will also help determine whether the project goals have been met. Additionally, surveys collected upon entrance and exit of programs will gauge whether the project has resulted in improved mental health and wellness.

Shasta County will be contracting with Level Up NorCal to provide services and collect data for this project and will receive monthly reports covering the aforementioned measures and information. "After Action Reviews" (AARs) will also be conducted following program activities, such as outreach events, to identify potential areas of improvements as the project progresses.

The BHSA heavily emphasizes health equity and aims to advance effective planning, services, and data to meet the needs of the diversity of Californians' geographic and demographic communities. In direct alignment with those objectives, Shasta County's Supporting Community-Defined Practices for Health Equity project intends on reducing disparities in their unserved and underserved communities. This project also focuses on early intervention, outreach, and engagement, which are some of the primary elements of the BHSA. The above proposed measures and evaluation plan will determine the success of culturally and linguistically diverse outreach and early intervention strategies on the Hispanic/Latino and Asian communities in Shasta County.

Upon completion of the project, and if determined successful, the County plans to continue services for clients through the Behavioral Health Services and Supports (BHSS) funding category.

The Budget and Budget Narrative

EXPENDITURES	Year 1 (FY 25-26)	Year 2 (FY 26-27)	TOTAL
Personnel Costs	$ 410,126.32	$ 431,496.90	**$ 841,623.22**
Operating Costs	$ 42,343.40	$ 45,010.90	**$ 87,354.30**
Non-Recurring Costs	$ 15,000.00	$ -	**$ 15,000.00**
Other (stipends)	$ 28,000.00	$ 28,000.00	**$ 56,000.00**
TOTAL	**$ 495,469.72**	**$ 504,507.80**	**$ 999,977.52**

FUNDING SOURCE	Year 1 (FY 25-26)	Year 2 (FY 26-27)	TOTAL
Innovation Funds	$ 495,469.72	$ 504,507.80	**$ 999,977.52**
TOTAL	**$ 495,469.72**	**$ 504,507.80**	**$ 999,977.52**

The County is requesting authorization to spend up to $999,977.52 in MHSA Innovation funding for this project over a period of 24 months (2 years). One hundred percent (100%) of the project will be supported by Innovation funding.

The budget allocates $841,623 (approximately 84% of the total budget) for Personnel wages and benefits. Additionally, community conversations have highlighted the importance of a workforce representative of the community's bicultural and bilingual needs; in response, the wages and benefits for project staff are to include a bilingual differential. Personnel for this project will include the following:

- 0.5 FTE Program Manager
- 1.0 FTE Project Manager
- 1.0 FTE Promotora (Spanish)
- 1.0 FTE Promotora (Mien)
- 0.66 FTE Promotora (Hmong)

The Level Up NorCal Program Manager will be responsible for evaluation of the innovation project, with 5% of the total budget ($49,998.88) reserved for evaluation of the project.

Approximately $87,354 (about 9% of the total budget) has been allocated for operating costs. These costs include expenses related to day-to-day operational needs, such as administrative support, rent, supplies, travel for outreach and engagement, and software to support data collection and tracking.

Non-recurring costs total $15,000 (approximately 2% of the total budget) and will cover office and workstation equipment.

Other expenses totaling $56,000 (about 6% of the total budget) will provide $200 stipends for community participants to help pay for fees that might otherwise be a barrier to accessing a service or program (i.e., application fees). These stipends will comprise 6% of the requested budget.

The County provides additional budget details on pages 13-16 of their plan.

Conclusion

The proposed project, Supporting Community-Defined Practices for Health Equity, appears to meet the minimum requirements listed under MHSA Innovation regulations; however, if this project is approved, the County must receive and inform the MHSOAC of certification of approval from the Shasta County Board of Supervisors before any Innovation Funds can be spent.

Additionally, this project is in alignment with the Behavioral Health Services Act and has provided information regarding sustainability.

STAFF ANALYSIS – ALAMEDA & TRI-CITY

Psychiatric Advance Directive Multi-County Collaborative

Innovation (INN) Project Name: **Psychiatric Advance Directives (PADs) – Phase 2**

MHSOAC consideration of INN Project: **October 24, 2024**

Review History

New Counties Joining PADs Phase 2:

County	Total INN Funding Requested	Duration of INN Project	30-day Public Comment	MH Board Hearing	BOS Approval (or calendared date to appear)
Alameda	$3,070,005	3 Years	4/1/2024-5/15/2024	3/20/2024	9/17/2024
Tri-City	$1,500,000	4 Years	9/6/2024-10/6/2024	10/8/2024	10/16/2024
TOTAL:	**$4,570,005**				

Previously Approved Counties:

County	Total INN Funding Requested	Duration of INN Project	30-day Public Comment	MH Board Hearing	Commission Approval Date
Fresno	$5,915,000	4 Years	2/16/2024-3/16/2024	3/20/2024	5/23/2024
Shasta	$1,000,000	4 Years	4/19/2024-5/19/2024	5/22/2024	5/23/2024
Orange	$4,980,470	4 Years	3/11/2024-4/15/2024	4/24/2024	8/22/2024
TOTAL:	**$ 11,895, 470**				

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, promote interagency and community collaboration related to Mental Health Services, supports for outcomes, and increases the quality of mental health services, including measured outcomes.*

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

Project Introduction:

Psychiatric Advance Directives (PADs) are used to support treatment decisions for individuals who may not be able to consent to or participate in treatment decisions because of a mental health condition. They generally are used to support individuals at risk of a mental health crisis where decision-making capacity can be impaired. PADs allow an individual's wishes and priorities to inform mental health treatment. Like their general health care counterpart, a PAD can also allow an individual to designate proxy decision-makers to act on their behalf in the event the individual loses capacity to make informed decisions.

Both Alameda and Tri-Cities are seeking approval to use innovation funds to join Fresno, Shasta, and Orange Counties in Phase Two of the Psychiatric Advance Directive (PADs) Multi-County Collaborative. This project will perform live testing and evaluation of the use of a digital Psychiatric Advance Directive utilizing the web-based platform. The overall goals of Phase Two will focus on engagement, collaboration, training, testing, evaluation, and transparency.

PADs Phase One Background:

The first cohort of the Psychiatric Advance Directive (PAD) project was approved by the Commission on June 24, 2021, for a total of four years and is set to conclude on June 25, 2024. Partnering counties consisted of Fresno, Contra Costa, Mariposa, Monterey, Orange, Shasta, and Tri-City.

The overarching goal of Phase One was for participating Counties to work in partnership with various contractors, stakeholders, peers with lived experience, consumers, and advocacy groups to provide resources relative to PADs training, a toolkit, as well as the creation of a standardized PAD template and a PADs technology-based platform to be utilized voluntarily by participating Counties.

Phase One will culminate with the following goals being achieved:

- Standardized PAD template language for incorporation into an online and interactive cloud-based webpage, created in partnership with Peers and first responders
- Creation of a PADs facilitator training curriculum that will utilize a training-the trainer model for facilitation
- Creation of easily reproducible technology that can be used across California while maintaining sustainability
- Legislative and policy advocacy to create a legal structure to recognize PADs
- Evaluation of the development and adoption of PADs, the understanding of PADs, and the user-friendliness of PADs with measured outcomes

The goals for Phase Two are to take achievements from Phase One and test them in a live environment following training on the use and completion of PADs.

Behavioral Health Services Act Alignment and Sustainability:

This project will focus on individuals with behavioral health needs who may be unhoused and need housing and supportive services, who receive services from Full-Service Partnerships, and other individuals who are in the behavioral health system of care, including but not limited to: Veterans, justice-involved, recently hospitalized in emergency room departments or inpatient units, and those with co-occurring substance use disorders.

The project also aligns with the current Commission Strategic Plan goals of advocacy for system improvement, supporting universal access to mental health services, participation in the change in statutes, and promoting access to care and recovery (see Appendices for Alameda and Tri-City, pages 56-69, for detailed information).

On April 23, 2024, the Commission was asked to support Assembly Bill 2352 (Irwin) which will seek to build out a legal framework for PADs in California that will work the Counties who are currently participating in Phase One of this project. Support of AB 2352 was granted with the stipulation that this bill continues to work with disability rights groups and ensures that the bill empowers peers and supports recovery. *PADs Phase Two has outlined efforts to collaborate and partner with Peer Support Specialists, Painted Brain, Disability Rights of California, NAMI California (for complete list of collaborating partners, see pages 18-22).*

Regarding sustainability, PADs has received support from current legislative action (AB 2353, Irwin) for Phase One efforts. It is the hope that continued funding through legislation will support the work in Phase Two. Part of the goal within Phase Two is to show the need and the utility of PADs with the overarching goal of securing ongoing funding from various agencies.

What is the Problem:

As outlined in Phase One of the PADs project, there is widespread support for the use of PADs to empower people to participate in their care, even during times of limited decision-making capacity. PADs can improve the quality of the caregiver-client relationship and improve health care outcomes. The Joint Commission on the Accreditation of Healthcare Organizations recognizes the value of psychiatric advance directives for treatment decisions when an individual is unable to make decisions for themselves (JCAHO, Revised Standard CTS.01.04.01).

While psychiatric advance directives were first put utilized in the United States in the 1990s, and have widespread support, research suggests their use is limited by lack of awareness, and challenges with implementation.

Although 27 states have passed laws recognizing PADs, most PADs are incorporated with the main emphasis on physical health. Adding to this is that there is not a standardized template for individuals, or their support systems, to access it when they might need it the most.

With the increasing rates of mental illness and high rates of recidivism, steps need to be taken so that directives are in in place in the event a person experiences a psychiatric episode.

Phase One explored the utility of PADs as a strategy to improve the effectiveness of community-based care for persons at risk of involuntary care, hospitalization, and criminal justice involvement. Phase Two will focus on the effectiveness of a PAD with training and live testing.

Innovation project overview:

Given the goals of Phase One have been achieved, Phase Two will focus heavily on the training and "live" use of PADs. At this time, Alameda and Tri-Cities are joining Fresno, Shasta, and Orange Counties.

Phase Two goals include the following (see pages 5-6 for details):

1. Engagement for new counties joining the project. Counties will work with first responders, behavioral health departments, courts, local NAMI chapter and peer organizations to better understand PADs and how to successfully utilize a PAD.
2. Collaboration amongst stakeholders will continue surrounding legislative efforts and to inform and enhance the use and access of a standalone PAD when tested in a "live" environment. Some of the groups that will partner include but are not limited to county staff, peer support specialists, Painted Brain, Cal Voices, Disability Rights of California, local NAMI chapters, California Professional Firefighters, California Sheriff's Association, California Hospital Association, Department of Justice, Patient Right's attorneys to name a few.
3. Training will be the main component within this project and the use and accessibility of a PAD will be closely monitored throughout the project. Training modules will be provided for first responders, crisis intervention teams, CARE Courts for judicial staff, Peer training for Peer Support Specialists and peer supports within the court system, and counties who have identified their own priority population.
4. Testing will occur after training has been provided. The testing phase will occur in a live environment to determine the ease of use, number of PADs that have been completed, and the disposition of law enforcement and hospitals to assess if there was a reduction in the number of 5150s requiring hospitalization due to the availability and use of a PAD.
5. Evaluation of Phase Two will continue from Phase One; however, emphasis will be on the intersectionality of the use of a PAD combined with the technology platform. Evaluation will include data obtained through interviews and observation and will meet all Institutional Review Board (IRB) requirements.

6. Transparency will be made available as Phase Two progresses on the project's website: www.padsCA.org.

The purpose of Phase Two will be to perform in-depth training, testing and evaluation of the tasks completed during Phase One.

Discussion of County Specific Regulatory Requirements

Alameda County (see Appendix, page 56)

In Phase Two, Alameda County is continuing to prioritize their focus on individuals who access crisis support services, individuals experiencing homelessness and those who are justice-involved.

The County believes this project will assist individuals by doing the following:

- Improve outcomes for individuals in crisis who are unable to advocate for themselves in a time of need
- Provide appropriate resources for first responders for the needs of the individual in crisis
- Will bring the County closer to compliance with Care Court legislation
- Will hopefully reduce recidivism within the criminal justice system and reduce visits to the emergency rooms during crisis
- Empower individuals with their own recovery and resilience by having a voice

The need for PADs was originally identified during the County's previous innovation project (Community Assessment Treatment Team – CATT). Local community efforts (23 listening sessions, 12 key informant interviews, and community surveys) held between October and December 2023 revealed the continued need for PADs. Strong community support led Alameda County Behavioral Health to join Phase 2 of this Multi-County Collaborative.

The County shared their intent to participate in this collaborative during their FY 2024/2025 Annual Update. The County's 30-day public comment period began on April 1, 2024 and held their public health board hearing on April 20, 2024. The County is calendared to appear before their Board of Supervisors on September 17, 2024.

Alameda County proposes to spend $3,070,005 in Innovation funding towards this multi-county collaborative.

Tri-City Mental Health Authority (see Appendix, page 61)

In Phase Two, Tri-City has identified two priority populations: transitional aged youth (18-25) and individuals who are homeless/at risk of homelessness.

Tri-City reports that 24% of all crisis calls during Fiscal Year 2022/2023 involved transitional aged youth (TAY). Other data provided indicates the need for additional interventions specific for this population.

For individuals experiencing housing instability, PADs can help identify emergency contact information, treatment plans and tools to help in a time of crisis.

Tri-City believes this project will assist individuals by doing the following:

- Empower individuals in crisis to select their preferred method of treatment
- Provide support for those in crisis by informing first responders and emergency room staff with resources, information, and options
- Allow individuals to take control and ownership of their own resiliency and recovery
- Enable peers to engage and build trust with consumers through outreach and promotion of PADs

Tri-City began their 30-day public comment period on September 6, 2024, followed by their local Mental Health Board hearing on October 8, 2024. Tri-Cities is expected to appear before their Board of Supervisors on October 16, 2024.

Tri-City Mental Health Authority proposes to spend up to $1,500,000 in Innovation funding towards this multi-county collaborative.

Commission Level

This final project for Alameda and Tri-City to join the PADs Collaborative was shared with the Commission's community partners and listserv on September 25, 2024. No comments were received in response to this sharing.

Learning Objectives and Evaluation (see pages 22-26):

Burton Blatt Institute will continue their work on this project and be the primary subcontractor, working in collaboration with other subcontractors, to perform the evaluation based on the established learning questions during this testing and implementation phase.

The following **individual and service-level** questions have been identified as follows:

(1) In the opinion of PADs county managers, did Phase 2 counties achieve the outcomes they specified in their work plans to test and implement the PADs web-based platform with their priority peer populations and community-based stakeholders?

(2) In the opinion of mental health legislative advocates, did PADs and its web-based platform address the county's goals for mental health treatment and recovery and for reducing the frequency of involuntary hospitalizations?

(3) In the opinion of peers, did accessing and using the PADs web-based platform positively affect their lives over the three-year evaluation period?

a. Did they experience increased feelings of empowerment, self-direction, and hope for the future by creating a web-based PAD?
b. Did they have better experiences with law enforcement, first responders, hospitals, and others when their web-based PAD was accessed and used when they were in crisis?
c. Did using a web-based PAD decrease the length of time when they were in crises and could not make their own decisions?
d. Did the use of a web-based PAD decrease the frequency of involuntary psychiatric commitments?
e. Did they feel that having a web-based PAD improved the quality of crisis response services they receive from their mental health, homelessness, criminal justice, and other agencies who work with them?
f. Was their crisis support system, including peers, family members, and stakeholder agency staff, strengthened by their use of a web-based PAD?

(4) In the opinion of community agency stakeholders, how did access and use of the PADs web-based platform positively affect how law enforcement, first responders, hospitals, and others serve peers when they are in crises over the three-year evaluation period?

a. Did orientation and training on PADs and its web-based platform improve their understanding, acceptance, and capacity to access and use web-based PADs on behalf of peers when they are in crisis situations?
b. Did they feel that accessing and using a peer's web-based platform improved their de-escalation, treatment, and support experiences when peers are in crisis situations?
c. Was the PADs web-based platform sufficiently customized to address the capacity and technology infrastructure of law enforcement, first responders, medical and mental health care providers, and other stakeholders including Care Courts in accessing and using a peer's PAD?
d. Did the PADs web-based platform affect the ways that Care Courts, law enforcement, first responders, medical and mental health care providers, and other stakeholders interact with and support peers in mental health crisis situations?
e. Was access and use of the PADs web-based platform integrated into the services that mental health agencies, including Full Services Partnerships, and community stakeholders provide to peers in crisis situations?
f. Were there indicators that access, and use of the PADs web-based platform could be sustainable and under what conditions?

The following **systems level** questions have been identified as follows:

1) Were Phase 2 counties successful in aligning services, partnerships, funding, and systems in testing and demonstrating the effectiveness of the PADs web-based platform, including its acceptance and use by Care Courts?

2) Did the knowledge and experiences of implementing the PADs web-based platform in Phase 1 counties inform and improve the design, marketing, and use of the PADs web-based platform among Phase 2 counties?
3) Were precepts of peer inclusion and methods of incorporating peer perspectives established during Phase 1 relevant and effective in accessing and using the PADs web-based platform by Phase 2 counties' priority populations?
4) Were Phase 2 counties able to establish a process and plan for sustaining and replicating the access and use of the PADs web-based platform by their priority populations, and community stakeholders?

For specific evaluation methods, please see page 22 and pages 24-26.

The Budget (see Appendices, pages 57-60 and pages 67-69):

Alameda County is seeking to contribute $3,070,005 of innovation dollars to fund the Psychiatric Advance Directives Phase Two project for three years:

- Personnel costs total $1,764,003 (57% of total budget) to cover staffing costs for this project, including benefits and salaries
- A total of $1,166,001 (38% of total budget) will cover consultant and evaluation costs
- Other costs total $140,001 (5% of total budget) to cover promotional materials for outreach and engagement, meeting/travel costs, and equipment/technology costs.

Tri-City is seeking to contribute a total of $1,500,000 of innovation dollars to fund the Psychiatric Advance Directives Phase Two project for four years:

- Personnel costs total $758,569 (51% of total budget) to cover staffing costs for this project, including benefits and salaries
- A total of $500,000 (33% of total budget) will cover consultant and evaluation costs
- Other costs total $241,431 (16% of total budget) to cover promotional materials for outreach and engagement, meeting/travel costs, equipment/technology costs and county administrative costs.

This project will partner with the following contractors for the implementation, training, testing and evaluation of this project (see pages 18-22 for listed Contractors in this project):

- Concepts Forward Consulting – will be the assigned Lead Project Manager and will provide case management, full project oversight, financial oversight of sub-contractors and will work closely with Commission staff
- Alpha Omega Translation – will over translation and interpretation services
- Burton Blatt Institute will perform the evaluation of this phase of the project
- Idea Engineering – will offer strategic consultation and creative direction as a full-service marketing agency (i.e. video direction and production, graphic design, translation, art production and coordination)

- Painted Brain - Peer Organization selected by counties who participated in Phase One to by providing input at stakeholder meetings representing the peer voice. Painted Brain will be instrumental in utilizing peers for this project, including outreach, education, peer representation, legislative advocacy, and training in the use of PADs platform.
- Chorus Innovations, Inc - this consultant will continue from building the secure, private, and voluntary platform where individuals can store their PADs to now testing the live platform

Conclusion

The proposed project appears to meet the minimum requirements listed under current MHSA Innovation regulations; **however**, if Innovation Project is approved, both Alameda and Tri-City must receive Board of Supervisor/Mental Health Authority (Tri-City) approval before any Innovation Funds can be spent. Additionally, this project is in alignment with the Behavioral Health Services Act and has provided information regarding sustainability (see pages 43-45).

Reallocation of Unspent Funds Proposal

October 24, 2024 Commission Meeting

The Community Engagement and Grants Team is seeking approval to reallocate a total of $4 million in Mental Health Wellness Act Funding to current EmPATH grantees. Excess Funds were made available as the result of two grant refusals. Ventura County was an applicant for a $1 million grant relative to our Older Adults program and Riverside University Health System was an applicant for a $3 million grant in our EmPATH program. Neither applicant entered into contracts and these funds are available to be directed to current EmPATH grantees. Both RFAs include language that permits the reallocation to other programs if additional funds become available.

AgeWise

In 2023, three awards were announced for the AgeWise program to serve the older adult population. Those awardees were Ventura County, Monterey County, and Korean Services Center (Anaheim). Prior to execution of their $1.3 million contract, Ventura County reached out to the Commission to refuse the award citing workforce capacity as the barrier to program implementation. Commission budget staff were able to revert $1 million of those funds for future allocation. There were no additional applicants for the AgeWise Grants. Commission staff have been in communication with the California Department of Aging to keep them informed about the status of the grants and Ventura's decision to decline the funding.

EmPath

In 2022, five awards were announced for the EmPATH program to create Behavioral Health Emergency units adjacent to existing hospital emergency rooms. Riverside University Health System was awarded $3 million to build an EmPATH unit but refused the award prior to execution. They cited complications with their construction and permitting process that will delay their project to Fiscal Year 2028/29, which is passed this grant term. There were three other EmPATH applicants, however, their applications were not substantive enough to receive an award. As a result, that $3million is also available for reallocation.

There are a total of 10 EmPATH grantees, nine of which were awarded $3 million contracts and one which received a $2 million contract (Sutter Coast Hospital). With the $4 million available (AgeWise and EmPATH), staff proposes to increase the contract for Sutter Coast Hospital to a level commensurate with the other grantees, then solicit other grantees to determine their need for additional funding. The remaining $3 million will be split equally between the interested grantees to support implementation and increased building costs. These additional funds would allow the EmPATH units to reach a level of implementation that would support long term sustainability. The Commission's EmPATH technical assistance provider, Dr. Scott Zeller, has recommended the allocation approach outlined above.

AGENDA ITEM 9

Action

October 24, 2024 Commission Meeting

Election of the Chair and Vice-Chair for 2025

Summary: Elections for the Mental Health Services Oversight and Accountability Commission Chair and Vice-Chair for 2024 will be conducted at the October 24, 2024 Commission meeting. The Commission's Rules of Procedure state that the Chair and the Vice-Chair shall be elected at a meeting held during the last quarter of the calendar year by a majority of the voting members of the Commission. The term for Commission Chair and Vice Chair is for one year and begins January 2025.

This agenda item will be facilitated by Chief Counsel, Sandra Gallardo.

Enclosures (1): Commissioner Biographies

Handout: None

Mental Health Services
Oversight & Accountability Commission

Commissioner Biographies
October 2024

Mayra Alvarez, Los Angeles

Current MHSOAC Vice Chair

Joined the Commission: December 2017

Mayra Alvarez is the President of the Children's Partnership, a nonprofit children's advocacy organization.

She also serves as a First 5 California Commissioner, appointed by Governor Newsom. Previously, she served in the U.S. Department of Health and Human Services (HHS), most recently as Director of the State Exchange Group for the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services.

She also served as the Associate Director for the HHS Office of Minority Health and was Director of Public Health Policy in the Office of Health Reform at HHS. Alvarez received her graduate degree from the University of North Carolina at Chapel Hill and her undergraduate degree from University of California, Berkeley. Commissioner Alvarez fills the seat of the Attorney General designee.

Mark Bontrager, Napa

Joined the Commission: November 2021

Mark Bontrager has been Behavioral Health Administrator for the Partnership HealthPlan of California since 2021. He was Director of Regulatory Affairs and Program Development for the Partnership HealthPlan of California from 2018 to 2021 and Executive Director of Aldea Children and Family Services from 2007 to 2018, where he was Deputy Director from 2005 to 2007. Commissioner Bontrager was an attorney in private practice from 2002 to 2006 and held multiple positions at the Villages of Indiana Inc. from 1996 to 2003, including Program Manager, Therapist and Social Worker. Commissioner Bontrager is vice chair of the Napa County Workforce Investment Board. He earned a Juris Doctor degree from the Indiana University School of Law and a Master of Social Work degree from the Indiana University School of Social Work. Commissioner Mark Bontrager fills the seat of representative of a health care service plan or insurer.

Sheriff Bill Brown, Lompoc

Joined the Commission: December 2010

Bill Brown was first elected as sheriff and coroner for Santa Barbara County in 2006, and reelected in 2010, 2014 and 2018. He had previously served as chief of police for the city of Lompoc from 1995-2007, and chief of police for the city of Moscow, Idaho from 1992-1995. He was a police officer, supervisor, and manager for the city of Inglewood Police Department from 1980-1992, and a police officer for the city of Pacifica from 1977-1980.

Prior to his law enforcement career, Sheriff Brown served as a paramedic and emergency medical technician in the Los Angeles area from 1974-1977. Sheriff Brown holds a master's degree in public administration from the University of Southern California and is a graduate of the FBI National Academy, the Delinquency Control Institute, the Northwest Command College, and the FBI National Executive Institute. Commissioner Brown fills the seat of a county sheriff.

Keyondria Bunch, Ph.D., Los Angeles

Joined the Commission: August 2017

Keyondria Bunch, Ph.D., is Supervising Psychologist for Los Angeles County Department of Mental Health. Dr. Bunch has been with Los Angeles County since 2008 and has worked in several positions including clinical psychologist and supervisor for the Emergency Outreach Bureau, clinical psychologist for the Specialized Foster Care Program, clinical psychologist for juvenile justice mental health quality assurance, and a clinical psychologist for Valley Coordinated Children's Services.

She has been an adjunct lecturer at Antioch University as well as worked within the mental health court system around issues of competency. Dr. Bunch is currently a supervising psychologist at West Valley Mental Health outpatient program. Commissioner Bunch fills the seat of a labor representative.

Assemblymember Wendy Carrillo, Los Angeles

Joined the Commission: February 2018

Wendy Carrillo was elected to represent California's 51st Assembly District in December 2017, which encompasses East Los Angeles, Northeast Los Angeles, and the neighborhoods of El Sereno, Echo Park, Lincoln Heights, Chinatown, and parts of Silver Lake.

She is a member of the Health, Appropriations, Utilities & Energy, Labor Privacy and Consumer Protections, and Rules Committees. Assemblymember Carrillo has advocated for educational opportunities, access to quality healthcare, living wage jobs, and social justice. She was host and executive producer of the community-based radio program "Knowledge is Power" in Los Angeles.

Her previous work with Service Employees International Union (SEIU) Local 2015 included better working conditions for caregivers. She arrived in the United States as an undocumented immigrant from El Salvador and became a U.S. citizen in her early 20s. Assemblymember Carrillo represents the member of the Assembly selected by the Speaker of the Assembly.

Steve Carnevale, San Francisco

Joined the Commission: April 2021

Steve Carnevale is the executive chairman of Sawgrass, a developer of digital industrial inkjet technologies and cloud-based mass customization software. He runs a family-owned wine business in the Napa Valley called Blue Oak and is the founder and chair of the advisory board for the UCSF Dyslexia Center which is translating cutting edge neuroscience to enable precision learning. In addition to other education non-profit board service, Carnevale is a founder and co-chairs Breaking-Barriers-by-8, where he works with other non-profits, schools, corporations, and foundations toward achieving 100 percent literacy for all by age 8. He is also an advisor to ESO Ventures, a social venture fund in Oakland for community workforce development of unrepresented populations and is the former President and Emeritus Chair of The Olympic Club Foundation, whose mission is to support disadvantaged youth sports programs that develop future community leaders. Commissioner Carnevale represents an employer with fewer than 500 employees.

Rayshell Chambers, Los Angeles

Joined the Commission: May 2022

Rayshell Chambers has been Co-Executive Director and Chief Operations Officer at Painted Brain since 2016. She was Program Analyst III at Special Service for Groups from 2011 to 2018. Chambers held several positions at the City of Los Angeles Human Services Department and Commission on the Status of Women from 2006 to 2010, including Legislative Coordinator and Community Outreach Coordinator. She earned a Master of Public Administration degree in public policy and administration from California State University, Long Beach. Commissioner Chambers represents clients and consumers.

Shuo Chen, Berkeley

Joined the Commission: April 2021

Shuo Chen is General Partner at IOVC, an early-stage venture capital fund based in Silicon Valley focused on enterprise and SaaS, where she has invested in dozens of startups now unicorns or acquired by Fortune 50 companies. She is a Lecturer at the University of California, Berkeley, and Faculty at Singularity University, where she teaches entrepreneurship and emerging technologies. Chen is a co-author to one of the leading books on financial regulations published by Cambridge University Press. In addition to her investing and teaching roles, Chen is the CEO of Shinect, a Silicon Valley-based non-profit community of 5,000+ engineers passionate about entrepreneurship. She is also a Board Member of Decode, the largest tech and entrepreneurship community co-hosted with UC Berkeley and Stanford student organizations, alumni networks, and entrepreneurship centers, as well as an Advisory Board Member of Yale School of Medicine's Center for Digital Health and Innovation. Commissioner Chen fills the seat of a family member.

Senator Dave Cortese, Santa Clara

Joined the Commission: September 2021

California Senator Dave Cortese represents District 15 in the California State Senate which encompasses much of Santa Clara County in the heart of Silicon Valley. Along with his accomplished career as an attorney and business owner, the Senator previously served on the Santa Clara County Board of Supervisors, the San Jose City Council, and the East Side Union High School District Board. Senator Cortese was a major architect of School Linked Services, a program that connects students and families to behavioral health services and counseling in Santa Clara County. Commissioner Cortese fills the seat of a member of the Senate selected by the President pro Tempore of the Senate.

Gary Tsai, M.D., Los Angeles

Joined the Commission: August 2024

Dr. Gary Tsai is the Director of the Substance Abuse Prevention and Control, a bureau 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 residents of Los Angeles County. Tsai is physician board-certified in both general psychiatry and addiction medicine.

Tsai serves on the Board of Directors of NAMI California, and the California Health and Human Services Agency’s Behavioral Health Task Force. Tsai completed his medical training at the University of California, Davis School of Medicine and his residency training at the San Mateo County Psychiatry Residency Training Program. Commissioner Tsai fills the seat of a physician specializing in substance use disorder treatment, including the provision of medications for addiction treatment.

David Gordon, Sacramento

Joined the Commission: January 2013

David W. Gordon is the Superintendent of the Sacramento (CA) County Office of Education. He holds a B.A. from Brandeis University and an Ed.M. and Certificate of Advanced Study in Educational Administration from Harvard University.

David has dedicated his career to education with a focus on Special Education. He has served on the President's Commission on Excellence in Special Education, the Governor's Advisory Committee on Education Excellence, and a visiting scholar at Stanford University. Commissioner Gordon fills the seat of a superintendent of a school district.

Mara Madrigal-Weiss, San Diego

Current MHSOAC Chair

Joined the Commission: September 2017

Mara Madrigal-Weiss is the Executive Director of Student Wellness and School Culture, Student Services and Programs Division, San Diego County Office of Education.

Her experience includes working with school communities as a Family Case Manager, Protective Services Worker and Family Resource Center Director.

Madrigal-Weiss received her M.A. in Human Behavior from National University, a M.Ed in School Counseling, and a M.Ed in Educational Leadership from Point Loma Nazarene University. Madrigal-Weiss has been dedicated to promoting student mental health and wellness for over 19 years. She is a past president of the International Bullying Prevention Association (IBPA) the only international association dedicated to eradicating bullying worldwide.

Madrigal-Weiss is a member of the California Department of Education's Student Mental Health Policy Workgroup. Commissioner Madrigal-Weiss fills the seat of the State Superintendent of Public Instruction designee.

Gladys Mitchell, Sacramento

Joined the Commission: January 2016

Gladys Mitchell served as a staff services manager at the California Department of Health Care Services from 2013-2014 and at the California Department of Alcohol and Drug Programs from 2010-2013 and from 2007-2009.

She was a health program specialist at California Correctional Health Care Services from 2009-2010 and a staff mental health specialist at the California Department of Mental Health from 2006-2007. She was interim executive officer at the California Board of Occupational Therapy in 2005 and an enforcement coordinator at the California Board of Registered Nursing from 1996-1998 and at the Board of Behavioral Science Examiners from 1989-1993.

She is a member of the St. Hope Public School Board of Directors. Mitchell earned a Master of Social Work degree from California State University, Sacramento. Commissioner Mitchell fills the seat of a family member of a child who has or has had a severe mental illness.

James (Jay) Robinson, Sacramento

Joined the Commission: May 2023

James L. (Jay) Robinson III, PsyD, MBA is the hospital administrator for Kaiser Permanente (KP) hospital Sunnyside and Westside Medical Centers and leads operations for the three ambulatory surgery centers for Kaiser Permanente Northwest.

In 2018, Jay was recognized as one of the 100 great leaders in health care by Becker's Healthcare. He holds bachelor and doctorate degrees in clinical psychology and has MBA from Concordia University Chicago. Jay has served as a Baldrige examiner for the State of Tennessee and is trained in Lean Six Sigma. He is an Adjunct Professor at the University of Tennessee Health Sciences Center in the school of Preventative Medicine and lecturer for the Kaiser Permanente Bernard J Tyson School of Medicine.

Jay brings 27 years of experience as a leader in hospital administration and clinical operations. Trained as a clinical psychologist, Jay focuses on employee engagement — teamwork and collaboration — to build community, drive quality, improve the patient care experience, and achieve high employee satisfaction. Jay's background includes serving as president of AMITA Saint Joseph Hospital, a 321-bed teaching hospital in Chicago; serving as CEO of Methodist South Hospital, a 145-bed community hospital in Memphis; and 20 years working within the Department of Veterans Affairs, where he worked at 5 different medical centers in roles of progressive complexity.

Al Rowlett, Sacramento

Joined the Commission: November 2021

Al Rowlett was named Turning Point Community Programs' Chief Executive Officer in 2014. Commissioner Rowlett has been with the agency since 1981 and today provides leadership and guidance to over 40 programs in several Northern and Central California counties. He holds a Bachelor of Arts degree from Ottawa University, a Master's in Business Administration in Health Services Management from Golden Gate University and in Social Work from California State University, Sacramento (CSUS). He is also a Licensed Clinical Social Worker.

Rowlett was appointed as a trustee to the Elk Grove Unified School District in 2009 serving through 2012. He is currently a Volunteer Clinical Professor at the University of California Davis Department of Psychiatry co-directing the Community Psychiatry seminar for residents and formerly served as an adjunct professor for the CSUS Mental Health Services Act cohort. In 2020, Assembly Speaker Anthony Rendon re-appointed Al to the California Institute for Regenerative Medicine Board. Commissioner Rowlett fills the seat of a mental health professional.

AGENDA ITEM 10

Action
October 24, 2024 Commission Meeting

Mental Health Student Services Act Report

Summary: The Commission will receive and consider approval of the draft biennial progress report to the legislature on the Mental Health Student Services Act (MHSSA) and a contract up to $4 million for phase 2 of the MHSSA evaluation.

Background: The Mental Health Student Services Act (MHSSA), authorized by Senate Bill 75 as part of the State's 2019 Budget Act, incentivizes partnerships between county behavioral health departments and local education agencies (LEAs) to deliver school-based mental health services to young people and their families. The goals of MHSSA are to provide highly accessible, comprehensive, and effective services in schools where students spend a great deal of time. A key tenet is preventing mental health conditions from developing and intervening early when students show signs of risk, to reduce the need for higher-level, more intensive services. The Commission has awarded MHSSA grant funding (as funding became available) to 57 county behavioral health departments, including two city municipalities, and their LEA partners.

MHSSA Progress Report to the Legislature

The Commission is required to provide a biennial progress report to the fiscal and policy committees of the Legislature on implementation of the MHSSA. The first progress report was submitted to the Legislature in May 2022. The second progress report is due in 2024.

At the August Commission meeting, Commissioners received a presentation on a draft progress report for 2024 and discussed the report's findings and recommendations. Since the August Commission meeting, Commission staff have worked with Commissioners to refine the report.

The revised draft MHSSA Progress Report for 2024 is included in this packet and presented to the Commission for review and approval.

MHSSA Phase 2 Evaluation Contract

The MHSSA Evaluation Project was designed to be conducted in two phases: (1) Phase 1 entails a robust planning process grounded in community engagement that results in a feasible and meaningful plan to evaluate the MHSSA; and (2) Phase 2 involves implementation of the plan to evaluate the MHSSA and dissemination of findings and lessons learned as they become available.

The Commission issued a request for proposal in August 2022 to conduct an evaluation of the MHSSA. The Commission awarded the contract to WestEd, a national leader in research, development, and service with headquarters in San Francisco. For Phase 1, WestEd developed a plan to evaluation the MHSSA and is poised to begin implementing the plan in Phase 2 with the Commission's approval.

Presenter: Melissa Martin-Mollard, Chief of Research and Evaluation

Enclosures (1): 2024 MHSSA Progress Report to the Legislature

Handouts (2): PowerPoint Presentation, MHSSA Evaluation Planning and Implementation Summary

Motion: That the Commission approve: (1) the biennial progress report to the legislature on the Mental Health Students Service Act (MHSSA), and (2) a contract for up to $4 million for WestEd to begin Phase 2 of the MHSSA evaluation.

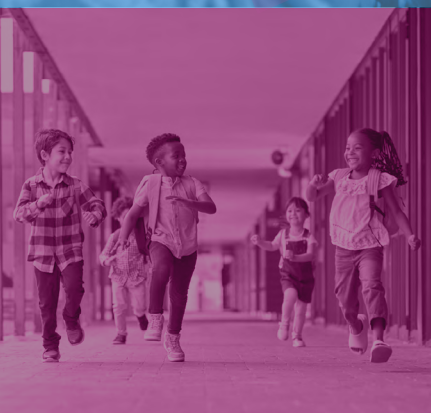
MHSOAC
Mental Health Services
Oversight & Accountability Commission

Report to the Legislature on the Mental Health Student Services Act

by the Mental Health Services Oversight and Accountability Commission

Submitted to the Fiscal and Policy Committees of the Legislature

DRAFT



CONTENTS

EXECUTIVE SUMMARY

In testimony before the Commission in July 2024, a presenter shared a story about a high school student in San Diego who recently brought a weapon to school. That day, a trusted teacher recognized that something was amiss with the student. When the teacher checked in with the student, the student disclosed having a weapon. Having received training in mental health literacy, the teacher expressed care and concern rather than disciplining the student. She worked with the student to secure the weapon and asked why they brought it to school. The student answered that they were hearing voices telling them that someone was trying to hurt them.

The school mental health team was able to refer the student to behavioral health services to address the psychosis that led to him being armed on a school campus. Without the trust and training the teacher and the school mental health team brought to school that day, the scenario of a student bringing a weapon to school could have resulted in a very different outcome.

As reflected in this example, California's behavioral health and education leaders are making significant progress in developing, strengthening, and scaling strategies to ensure that schools represent robust opportunities to serve the behavioral health needs of students. Teachers and educational staff are being provided with training to understand and recognize mental health challenges. School mental health funding is supporting on-campus wellness centers and on-site behavioral health services and supports. State investments are supporting stigma reduction, youth engagement, suicide prevention, social-emotional learning, and more.

These recent investments in school mental health have relied heavily on one-time funds, including one-time funds from the Mental Health Student Services Act (MHSSA). Under the Child and Youth Behavioral Health Initiative, the Department of Health Care Services (DHCS) is leading efforts to shift reliance on short-term grant funding to durable financing strategies that tap into health care insurance resources.

These investments recognize that the peak and median age of onset for any mental health disorder are 14.5 years and 18 years. Unmet mental health needs can disrupt learning and lead to negative student academic outcomes such as chronic absenteeism, poor grades, and eventually failure to graduate from high school.

Strong partnerships between education and community behavioral health can increase access to a continuum of behavioral health services, with an emphasis on prevention and early intervention services to reduce the risk of a child developing a mental health disorder and improve educational outcomes.

California's K-12 schools are an essential access point to these services, particularly for underserved communities. Education in partnership with community behavioral health can increase access to a continuum of behavioral health services including critical prevention and early intervention supports to reduce the risk of a child developing a mental health disorder and improve educational outcomes. Effective partnerships can engage students and families to improve understanding and awareness of what constitutes mental health, promote wellbeing, and create pathways to care through referrals and behavioral health services on campus.

The MHSSA incentivizes partnerships between county behavioral health departments and local education agencies to bring an array of behavioral health services to California's K-12 schools.

The Commission's implementation of the MHSSA within the broader work of the Child and Youth Behavioral Health Initiative has reached 57 out of 58 counties – only Alpine County, which has the smallest population of any county in California, is not represented in the grants. California's $280 million in MHSSA grants have reached approximately 45 percent of districts across the state and just under 25 percent of all California schools (see MHSSA at-a-Glance graphic).

The Commission is aware that these investment dollars did not reach all students in all schools across the state of California. Instead, grant partners prioritized the highest-need districts/schools and tailored MHSSA activities and services to meet local needs. Some grant partners focused on capacity building and training at the county and district levels. Others have directed their dollars toward universal, schoolwide prevention efforts, such as suicide prevention and social-emotional learning curricula. Some have prioritized hiring behavioral health staff to provide intensive services to students including individual counseling and crisis services.

There have been many successes reported at the local level. New and strengthened partnerships between education and county behavioral health have expanded access to services for students. However, access to universal prevention, early intervention, and treatment for all students has not yet been achieved. These efforts need to be expanded to include all of California's 9,997 K-12 schools so that all students benefit from a comprehensive statewide strategy for school mental health.

Building from youth perspectives and MHSSA implementation successes and lessons learned, the Commission identified a set of recommendations to ensure that California's school mental health efforts can be scaled and sustained.

MHSSA at-a-Glance[i]

$280 million

invested in MHSSA to build and strengthen partnerships between county behavioral health, education, and other partners

MHSSA activities and services are tailored to meet local needs and include:

TIER 3
intensive interventions

TIER 2
targeted and early interventions

TIER 1
universal or schoolwide (all students) prevention

IMPLEMENTATION SUPPORT
(teaming, capacity building, and training)

Approximately

242,000
students received Tier 1 services

12,000
students received Tier 2/3 services

through MHSSA in 2022-23, according to grant partner reports

57 of 58

California counties are served by MHSSA, as well as the city municipalities of Berkeley and Tri-City

57
county behavioral health departments

50
county offices of education/superintendent of schools

Approximately

45%
of school districts

25%
of schools and charter schools

39
community-based organizations

480

staff hired by grant partners to provide direct services and support administration, partnership development, and coordination through MHSSA

To support quality improvement and evaluation, the Commission:

Established an MHSSA Learning Collaborative that meets quarterly and has grown to over 300 members since its inception in 2020

Partnered with WestEd to develop a plan to evaluate the MHSSA informed by robust community engagement

Is implementing a statewide school mental health technical assistance strategy to support MHSSA grant partners in achieving sustainability

[i] Information contained in this report comes from several sources of data that the Commission collects from MHSSA grant partners in each of the 57 participating counties and city municipalities: grant summaries, monthly update reports, quarterly hiring reports, annual fiscal reports, site visits, and data on services and students served.

What Youth Are Saying About School Mental Health

The Commission works across its initiatives to elevate youth voices. The school mental health initiative has leveraged the Commission's youth advocacy work designed to increase youth voices and participation through targeted conversations about school-based mental health. Listening sessions with youth were held in Fresno, Humboldt, Sacramento, San Bernardino, and adjacent counties.

In conversations with these youth about school mental health, they indicate wanting:

A school climate that supports wellbeing (e.g., low stress, no bullying, and everyone getting along)

"A school that centers wellbeing looks like no kids fighting and arguing in schools, no one running down the halls screaming. Just everyone going to class doing what they need to do."

Having trusted adults provide safe spaces at school

"It is important that school staff exhibit safe space behavior – that they practice inclusivity and open-mindedness and promote students to speak respectfully and thoughtfully and [have] open-door policies."

Increased mental health awareness training and resources for seeking help

"[It is good] if more students are reaching out to get resources. If there are a lot of resources, it's not always very effective, because students either aren't aware of their own mental health to know they need help or are otherwise hesitating to reach out."

Increased access to peer services (services provided by youth for youth)

"Kids who are considered 'bad kids' or are causing trouble need support. They often are misunderstood and are for the most part going through a lot, feel alone, and feel like outcasts. School may not resolve these issues. Students need to be heard. Peer counseling can reach kids more successfully than adults who often seem like they are lecturing."

MHSSA Implementation Successes

MHSSA grant partners report successes in building strong partnerships, transforming schools into centers of wellness by expanding a continuum of school-based mental health services and providing students and families with access to services that are making a difference in their lives. The following themes emerged as successes of MHSSA from the grantee perspective.

MHSSA deepens partnerships at the local level

Local county partners report that MHSSA funding has deepened and enhanced partnerships between K-12 education and county mental health. This includes greater trust and collaboration, improved service coordination for students and families, and leveraging Medi-Cal and private insurance to cover the cost of services.

MHSSA expands the continuum of mental health services in schools

Local MHSSA partners have expanded prevention, early intervention, treatment, and crisis services on school campuses. These are services that would not have been available otherwise, with over 250,000 students served.

MHSSA increases awareness and destigmatizes mental health

By providing outreach/training and expanding the continuum of services and supports, grant partners report increasing mental health awareness and the normalization of students seeking services on school campuses.

MHSSA services are making a difference in the lives of students and families

MHSSA grant partners regularly share with Commission staff stories about how MHSSA is making a difference in the lives of students and families. Anecdotal reports from grant partners demonstrate the different ways that MHSSA services are improving student outcomes.

MHSSA services engage and educate parents and caregivers

Grant partners report that providing individual counseling to students on school campuses has enabled them to involve families in treatment and provide them with education to help them better understand and support their child.

Lessons Learned

The following are key lessons the Commission has learned from grant and community partners during MHSSA implementation:

1. **Local MHSSA activities and services are heterogeneous and tailored to meet local needs and gaps in services.** Allowing MHSSA grant partners the flexibility to respond to local needs has been a successful feature of the MHSSA grant program but has also presented challenges for conducting a statewide evaluation and establishing consistent metrics for monitoring and reporting.

2. **MHSSA partners have built and strengthened partnerships but need additional guidance to support local success.** Sustainability is a key concern among MHSSA grant partners. Partners report needing additional funding and sustainability planning to meet local needs, particularly since grants are scheduled to end as early as 2025.

3. **The need for school mental health services often exceeds local capacity.** Partners report that the demand for services is often higher than the availability of services. Hiring and retaining staff continues to be a challenge for MHSSA grant partners, especially in rural counties with more severe mental health professional shortages.

4. **School mental health standards are needed in California to drive quality improvement.** MHSSA grant partners have asked the Commission for guidance in building their local school mental health systems. In California, there are currently no agreed-upon guidelines or standards to support local communities in designing their school mental health systems, monitoring implementation, and measuring outcomes.

5. **Alignment of California's school mental health initiatives is important for local success.** Multiple youth and school mental health funding initiatives in California have benefited local communities but also created stress and overburdened staff who prepare grant proposals, manage different grant programs, track different funding streams, and meet different reporting requirements.

These lessons learned provide a roadmap for what California should prioritize next to continue moving closer toward a vision of schools as centers for wellness. Achieving this vision will require effective and sustainable comprehensive school mental health systems that promote a positive school climate and support the mental health and wellness needs of students and school staff. Through MHSSA, the Child and Youth Behavioral Health Initiative, and other school mental health initiatives, California has made tremendous strides in building the capacity of schools to develop comprehensive school mental health systems. However, there is work to be done to promote this model and its core features across the state.

Recommendations

The MHSSA is part of a broader investment in California's children and youth behavioral health system. To support long-term local success in comprehensive school mental health systems will require a shared understanding across California agencies of both the systems change goals California is working toward and the metrics to measure progress. It is imperative that the state look toward the future and ensure that its investments are efficient, effective, and sustainable.

Based on community feedback and lessons learned during MHSSA implementation, the Commission offers the following three recommendations for the State to consider:

1

LEADERSHIP

The State should establish a leadership structure for youth behavioral health to coordinate and align school mental health initiatives and develop a long-term strategy for building sustainable, comprehensive school mental systems in every K-12 school in California. That strategy should design effective ways for the health and education systems and their partners to collaborate with youth and families to deliver a continuum of behavioral health services and supports in schools.

2

ADEQUATE AND RELIABLE FUNDING

As California builds the necessary capacity and infrastructure for comprehensive school mental health services, the State should make additional investments to fill the gap between implementation and long-term sustainability. Funding should be adequate, consistent, aligned, and incentivized to achieve desired outcomes.

3

ACCOUNTABILITY

The State, as part of its strategy to build comprehensive school mental health systems, should develop an accountability structure including school mental health standards and metrics that reports back to youth, parents, teachers, leaders, and other invested partners to show progress toward established goals. This accountability system should include a heavy emphasis on reducing disparities and promoting educational equity.

INTRODUCTION

The Imperative for School Mental Health

The mental health crisis of youth is well documented, particularly in light of the COVID-19 pandemic. The 2023-24 California Healthy Kids Survey of California's 11th graders found that:

45%
report feelings of optimism about their life

31%
report chronic sadness and hopelessness

28%
report experiencing social and emotional distress

12%[4]
report having considered suicide

Although the mental health of California's youth has slightly improved since the COVID-19 pandemic, the seriousness of the crisis continues, particularly for LBGTQIA students, students in the foster care and juvenile justice systems, students from communities of color, and students living in rural settings.

Unmet mental health needs can disrupt learning and lead to negative student academic outcomes such as chronic absenteeism, poor grades, and eventually failure to graduate from high school. Schools are a primary location for promoting wellbeing, supporting early identification of student mental health needs and access to services.

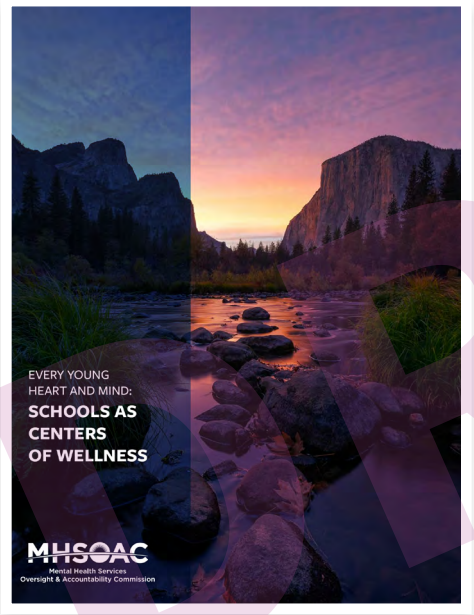
Improved access to mental health services is foundational to supporting children and youth as they develop into healthy, resilient adults. Comprehensive school mental health models and integrated services that are tailored to individual and family needs have the best chance of improving health and academic outcomes.

The Mental Health Student Services Act (MHSSA) is intended to foster stronger partnerships between education and health systems to leverage resources to help students succeed. The MHSSA incentivized counties and local education agencies to enter into partnerships to provide a continuum of behavioral health services to students, with an emphasis on prevention and early intervention. These partnerships offer an opportunity to reach children and youth in an environment where they are comfortable and that is accessible.

[4]California Healthy Kids Survey, 2023-24: Mental Health Report Card, https://calschls.org/docs/sample_sec_district_mhr_2324.pdf.

Schools as Centers of Wellness

The Commission works to transform systems by engaging diverse communities and employing relevant data to advance policies, practices, and partnerships that generate understanding and insights, develop effective strategies and services, and grow the resources and capacity to improve positive behavioral health outcomes for every Californian. The Commission, with support from the Governor and the Legislature, has developed the distinct roles required to shape policies and drive practices and system-level improvements. As part of its role, the Commission seeks to drive transformational change in school mental health so that every child can succeed and thrive.



In 2020, the Commission released its report "Every Young Heart and Mind: Schools as Centers of Wellness," and recommended that the State make a significant multi-year investment to build and enhance partnerships between county behavioral health departments and local education agencies. The Mental Health Student Services Act (MHSSA) realized this vision.

To achieve the vision of schools as centers for wellness requires effective, comprehensive school mental health systems that promote a positive school climate and support the mental health and wellness needs of students and school staff. As illustrated below, the National Center for School Mental Health identified eight core features of comprehensive school mental systems. These core features are interrelated and essential to the success of implementing comprehensive school mental health systems. For example, schools and their partners (in collaboration) should regularly conduct needs assessments to identify student needs and map existing resources to assess gaps in services and support.

Core Features of a Comprehensive School Mental Health System*

California has made considerable progress in building the capacity of schools to develop comprehensive school mental health systems. Governor Gavin Newsom's office released the Master Plan for Kids' Mental Health (California for All, 2023), supporting the vision of schools as centers of wellbeing. The core of CYBHI is a five-year, $4.6 billion investment that reimagines how California supports youth mental health. Several CYBHI workstreams are designed to offer school-linked services, such as the Statewide Multi-Payer School-Linked Fee Schedule, School-Linked Partnerships and Capacity Grants, and the Student Behavioral Health Incentive Program, to name a few. In addition, through the California Community Schools Partnership Act, the state has invested $4.1 billion to establish community schools that connect youth and families to essential services including behavioral health services.

* Adpated from Hoover, S., Lever, N., Sachdev, N., Bravo, N., Schlitt, J., Acosta Price, O., Sheriff, L. & Cashman, J. (2019). Advancing Comprehensive School Mental Health: Guidance from the Field. Baltimore, MD: National Center for School Mental Health. University of Maryland School of Medicine.

MENTAL HEALTH STUDENT SERVICES ACT

The Mental Health Student Services Act (MHSSA), authorized by Senate Bill 75 as part of the State's 2019 Budget Act, provides grants for partnerships between county behavioral health departments and local education agencies (LEAs) to deliver school-based mental health services to young people and their families. The goals of MHSSA are to provide highly accessible, comprehensive, and effective services in schools, which are central to the lives of families and where children spend almost one-third of their lives (180 days a year). A key tenet is preventing mental health conditions from developing and intervening early when students show signs of risk to reduce the need for higher-level, more intensive services.

The Commission awarded MHSSA grant funding in three phases (as funding became available) to 57 county behavioral health departments, including two city municipalities, and their LEA partners. The table on the next page provides a description of the grant phases and total funding amounts. See Appendix A for more information about the history of each phase and the source of funding.

PHASE 1	PHASE 2	PHASE 3
18 partnership grants awarded in 2020, totaling	19 partnership grants awarded in 2021, totaling	20 partnership grants awarded in 2022, totaling
$74,849,047	**$77,553,078**	**$54,910,420**

Grant awards are generally for four years, with Phase 3 grants scheduled to end in December 2026. In 2023, the Commission made available additional MHSSA funding to existing MHSSA grant partners through a request for applications (RFA). Forty-one MHSSA grantees were awarded additional MHSSA funds to expand their capacity, activities, and services.

In May 2024, the Commission issued a request for applications to award additional MHSSA funds, totaling $25 million. To identify the best use of these funds, the Commission held community listening sessions and conducted surveys of MHSSA grant partners. The Commission learned of specific needs and gaps that informed the targeted use of MHSSA funds in four categories: (1) services for vulnerable or marginalized youth; (2) universal screening learning community; (3) quality improvement and sustainability; and (4) other areas to be identified by the grant applicant. Fifty-one grants across the four categories were awarded in August 2024 to 29 counties.

To date, the Commission has awarded a total of $280 million in MHSSA grant funding.

Mental Health Student Services Act Grant Program Timeline

	2020	2021	2022	2023	2024
PHASE	Phase 1	Phase 2	Phase 3	Additional funding	New targeted grants*
GRANTEES	18 grantees	19 grantees	20 grantees	41 existing grantees	29 grantees
TOTAL FUNDING	$74,849,047	$77,553,078	$54,910,420	$47,687,455	$25,000,000
Total $ Awarded to County/School Partners = $280,000,000					

* Four categories: (1) services for vulnerable or marginalized youth; (2) universal screening learning community; (3) quality improvement and sustainability; and (4) other areas to be identified by the grant applicant.

MHSSA operates in 57 of California's 58 counties, as well as in the city municipalities of Berkeley and Tri-City.

Grants partners were given the flexibility to design school mental health activities and services that were responsive to local needs. To support local implementation of MHSSA, the Commission established an MHSSA Learning Collaborative that meets quarterly to share best practices and provide implementation support. The Commission, in consultation with MHSSA grant partners, is currently implementing a statewide Technical Assistance (TA) strategy to respond to implementation barriers and challenges and support ongoing learning and quality improvement.

MHSSA grant partners report local successes.

MHSSA is deepening partnerships at the local level by building greater trust and collaboration across sectors, improving service coordination, and leveraging Medi-Cal and private insurance to cover the cost of services. MHSSA also has expanded the availability of a continuum of services in K-12 schools, including crisis services. Grant partners report that the increase of mental health services on school campuses has increased awareness of student mental health needs and led to less fear and stigma in seeking services. Lastly, grant partners report that MHSSA is making a difference in the lives of students by engaging parents and caregivers to increase their mental health knowledge and ability to emotionally support their child. Grant partners are reporting positive student outcomes such as increased school engagement, attendance, and high school graduation.

BUILDING AND STRENGTHENING LOCAL PARTNERSHIPS

MHSSA grants build and strengthen partnerships across behavioral health, education, and the community.

As the figure below illustrates, MHSSA grant partners include county behavioral health departments, county offices of education or superintendent of schools, school districts and schools, charter schools, community-based organizations, and other partners. The list of MHSSA partners continues to grow as counties expand their partnerships to meet the needs of students and families in their local communities. It is anticipated that in the next round of MHSSA funding (August 2024), new partners such as those from the child welfare and juvenile justice systems will be added to MHSSA partnerships to better serve system-involved youth.

> *"This partnership is helping to break down communication barriers and build partnerships not only across districts but also between district and behavioral health partners."*
>
> **– MHSSA GRANTEE**

MHSSA Partnerships

57 county behavioral health departments

50 county offices of education/county superintendents of school out of 58 counties

440 districts

2,161 K-12 schools

221 charter schools

39 community-based organizations and other partners

MHSSA funded both established and new partnerships. As a result, there is variation across grant partners in their history of working together and degree of collaboration.

Prior to MHSSA, some partners had established inter-agency relationships and agreements; some are using MHSSA dollars to deepen those relationships and address an unmet need and/or service gap in their local schools and communities. For example, prior to the passage of MHSSA, Fresno County Department of Behavioral Health and Fresno County Superintendent of Schools established the All 4 Youth partnership program to provide services to youth and their families in schools, in the community, or in the home. To expand the reach of All 4 Youth, Fresno County used their MHSSA dollars to build and operate four Wellness Centers in four schools in areas of the county where there was a high concentration of underserved students and families.

Other MHSSA grant partners are in the process of building new relationships and strengthening existing relationships. For example, San Benito partners include the San Benito County Behavioral Health Department, San Benito County Office of Education, and local school districts. Together they have established a Mental Health Provider Network and are developing protocols and routines that establish sustainable coordination of services between entities. For example, the San Benito County partners have developed a universal referral form and process that all partners have agreed to use to better serve students and coordinate services.

An evaluation of MHSSA will examine in more detail its impact on cross-system partnerships, and specifically how relationships are built and strengthened to provide a coordinated and sustainable continuum of mental health services and supports to students and their families.

EXPANDING ADMINISTRATIVE CAPACITY AND DIRECT SERVICES

MHSSA grant dollars are primarily used to fund the hiring of staff to provide administrative oversight and direct mental health services on school campuses. In total, MHSSA funds more than 480 staff in 57 California counties. Approximately 73 percent of these staff provide direct mental health services and supports and include licensed clinicians, case managers, and paraprofessionals such as parent advocates and mentors. Since MHSSA partnerships require dedicated staff time and ongoing cultivation, the other 27 percent of staff provide grant administration and support MHSSA partnership development and coordination.

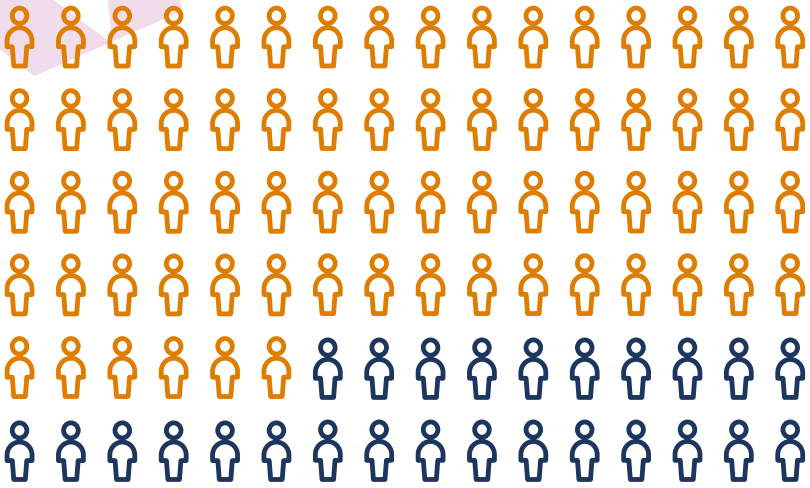
Staff Funded Under MHSSA

483
staff currently funded under MHSSA

353
staff providing direct mental health services and supports

\+

130
staff providing administration, partnership development, and coordination



One figure represents five funded staff members

LOCAL MHSSA SPOTLIGHT

Kern County

Kern County uses MHSSA funds to hire mental health teams that provide direct services on school campuses. These teams include licensed clinical social workers, licensed marriage and family therapists, case managers, substance use specialists, and AmeriCorps mentors. Mental health teams provide the following services to students:

- Screen foster and homeless youth for adverse childhood experiences (ACEs).
- Pilot universal screening for all students.
- Provide check-in/check-out rapid response intervention to support academics, behavior, and social and emotional health.
- Provide school-based therapeutic services for youth during and after school.
- Provide families with community referrals and resources.
- Provide substance use counseling and case management services.

CREATING TAILORED SOLUTIONS

MHSSA legislation allowed for flexibility in grant programs if they meet MHSSA goals (citation). Thus, local partners use MHSSA grant dollars to create solutions tailored to the needs of students, communities, and gaps in service delivery. In other words, there is variation in MHSSA activities and services, target populations, and reach across the county.

To begin to categorize the heterogeneity of MHSSA grant services and activities, the Commission's evaluation partner WestEd conducted a thematic analysis of grant summaries that included for each county its total MHSSA funding, a list of partners, and a high-level narrative of proposed activities and services.

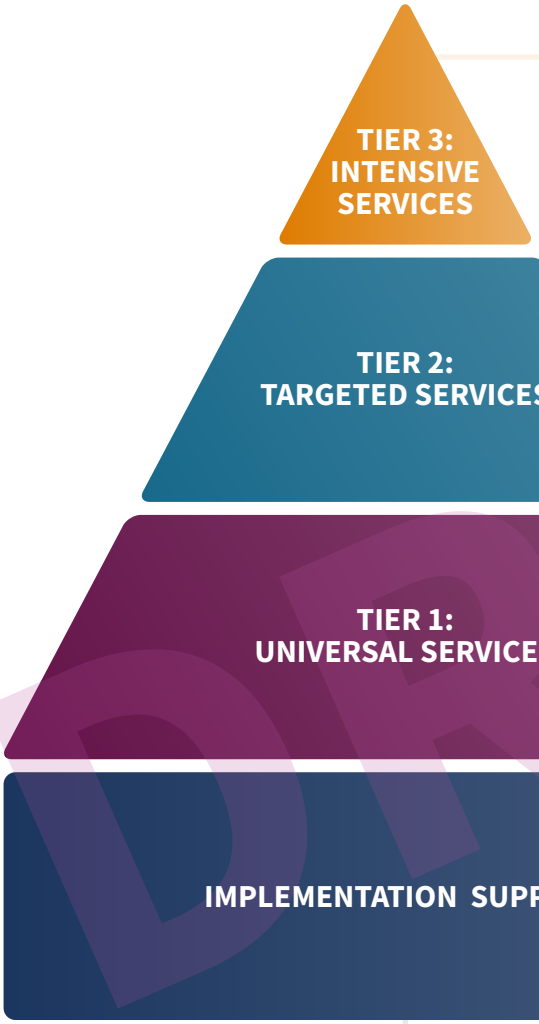
> *"[We] identify gaps and work to find ways to expand services to meet those needs."*
>
> **– MHSSA GRANTEE**

Based on an analysis of the grant summaries, local MHSSA activities and services can be categorized into four broad categories:

- Implementation support (e.g., teaming, capacity building, and training)
- Tier 1 universal prevention and wellness promotion
- Tier 2 targeted, early intervention
- Tier 3 intensive intervention

The figure on the following page illustrates the types of activities and services that fall into each category. All counties report MHSSA activities and services that span at least two of the four categories, with many touching on all four. One of the key investigations of the statewide MHSSA evaluation will be to learn what activities and services ultimately resulted from the partnerships in each county, and if, how, and why these changed over time.

Categories of MHSSA Activities and Services



- Individual counseling and treatment
- Case management
- Referral and system navigation
- Telehealth
- Behavioral support
- Substance use treatment
- Crisis services
- Psychiatric services

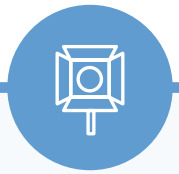
- Small group counseling and support
- Mentoring (e.g., peer-to peer, adult-student)
- Family/parent programs/training
- Youth leadership development
- Check-in/check-out interventions

- Mental health awareness/ literacy promotion
- Screening
- Social and emotional learning
- Behavior management/PBIS
- Trauma-informed and restorative practices
- School climate
- Bullying and violence prevention
- Dropout prevention

- Collaboration/partnering
- Teaming
- Staff training and professional development
- Coaching and consultation
- Culturally responsive and equity centered
- Systems capacity building and continuous improvement
- Procedure/protocol development
- Medi-Cal billing

Implementation Support

The vast majority of MHSSA grantees (95 percent) reported plans to use MHSSA funds to support systems implementation (i.e., to facilitate capacity building and sustainable systems change). The most common implementation support activities were collaboration and partnering, building teams and teaming, and staff training and professional development.



LOCAL MHSSA SPOTLIGHT

San Diego County

San Diego County expands suicide prevention policies and practice through the Creating Opportunities for Preventing & Eliminating Suicide (COPES) Initiative. To build capacity, 31 COPES local education agencies (LEAs) provided 675 mental health and suicide prevention trainings and events in their school communities that engaged over 60,000 students, 850 staff, and 3,000 parents and caregivers.

All participating COPES local education agencies (LEAs) currently:

- Use an evidence-based screening tool.
- Collect data on suicide risk screenings.
- Receive formal training on conducting risk screenings and providing suicide intervention.

In addition, 84% of participating schools have current resources and information about suicide prevention on their website and 56% offer training to families/caregivers on suicide prevention.

Between July 2022–June 2023, COPES LEAs conducted 3,387 suicide risk screenings.

675

mental health and suicide prevention trainings and events in school communities that engaged over 60,000 students, 850 staff, and 3,000 parents and caregivers

3,387

suicide risk screenings conducted*

84%

of participating schools have current resources and information about suicide prevention on their website

56%

offer training to families/caregivers on suicide prevention

* between July 2022–June 2023

Providing a Continuum of Services and Supports: Tiers 1, 2, and 3

MHSSA grantees report transforming schools into centers of wellness by providing a continuum of services and supports to elementary, middle, and high school students. The most common framework that grantees use for organizing and delivering services in schools is a Multi-Tiered System of Support (MTSS): Tiers 1, 2, and 3. The following provides the percentage of grantees that reported plans to provide a specific tier of service or support using MHSSA grant dollars.

81%

reported plans to provide Tier 1 or universal services and activities.

68%

reported plans to provide Tier 2 or targeted group services and activities.

98%

reported plans to provide Tier 3 or intensive individual services and activities.

46% reported plans to provide crisis intervention services, including general crisis intervention, suicide crisis intervention, and mobile crisis services.

LOCAL MHSSA SPOTLIGHT

Sacramento County

Sacramento County places a mental health clinician in every school. A partnership between the Sacramento County Office of Education and the Sacramento County Department of Health Services established an innovative way to address children and youth mental health – placing a mental health clinician in every school in the county to work within a continuum of care at the school site, transforming the schools into centers of wellness. The clinicians provide direct mental health services while also working with school staff to integrate social emotional and relationship-building strategies into the entire school community.

In Sacramento County, currently 40 schools in 13 school districts have an onsite mental health clinician that provides services to the school community. Since October 2021 – September 2023, 770 students have received mental health sessions. Of the 7,959 therapy sessions provided, 90% are reimbursable by Medi-Cal.

40 SCHOOLS & **13** SCHOOL DISTRICTS
are provided with services

770 STUDENTS
received direct mental health services since October 2021

90% OF THERAPY SESSIONS
are reimbursable by Medi-Cal

Wellness Centers

Approximately one in four MHSSA grantees report planning to establish wellness centers on school campuses to provide a continuum of mental health services and supports (often using an MTSS framework) to students and families. Wellness centers provide safe and supportive environments for students to step out of the stresses of a school day, seek mental health support and information, and connect with others. The Commission facilitated student-led discussions on preferred strategies to meet student mental health needs and wellness centers represented the most student-friendly proposal under discussion. The Commission has supported cross-partnership collaboration on how to best design and implement student wellness centers to meet student mental health needs.

LOCAL MHSSA SPOTLIGHT

Santa Clara County

Santa Clara County partners established wellness centers and programs on 18 school campuses. Wellness center activities and services:

- Are informed by Youth Advisory Boards
- Adapt to meet the culture and climate of the school community
- Provide a full continuum of services and support (MTSS)

In the 2022-2023 school year, wellness centers supported over 10,000 student visits. Students reported feeling calmer and less anxious after visiting a wellness center, and over 97 percent said they would like to return for a visit.

Santa Clara Office of Education published "An Introduction to the Wellness Center Model" to support local education agencies and their partners in planning and implementing wellness centers.

STUDENTS RECEIVING MHSSA SERVICES AND SUPPORTS

The Commission collects data on a biannual basis from MHSSA grantees on services provided, the number of students served and their demographic characteristics to meet legislative reporting requirements. To develop a data reporting tool for MHSSA, the Commission conducted extensive engagement with grantees to understand what data are available and feasible to collect/report.

The Commission learned that grant partners vary in their capacity to collect, store, and report MHSSA data. Thus, the data the Commission receives varies in terms of completeness, accuracy, and quality. Thus, the student numbers presented below are approximations of students served and are likely an undercount. The Commission is in the process of establishing MHSSA technical assistance to improve the grant partner's ability to collect and report school mental health data.

The Commission conducted a survey on technical assistance (TA) needs and found that more than 80 percent of MHSSA grant partners reported needing TA for data collection and reporting, and specifically:

- **Setting up data collection systems.**
- **Navigating HIPAA and FERPA laws to share data across partners.**
- **Utilizing data to inform program planning and decision making.**

During the 2022-23 school year, the Commission received data submissions from 45 out of 57 grant partners. The table below presents the approximate number of students receiving Tiers 1, 2, and 3 services funded under MHSSA in 2022-23 by grade level. Other demographic variables such as race-ethnicity are not included in this report due to a lack of consistent reporting.

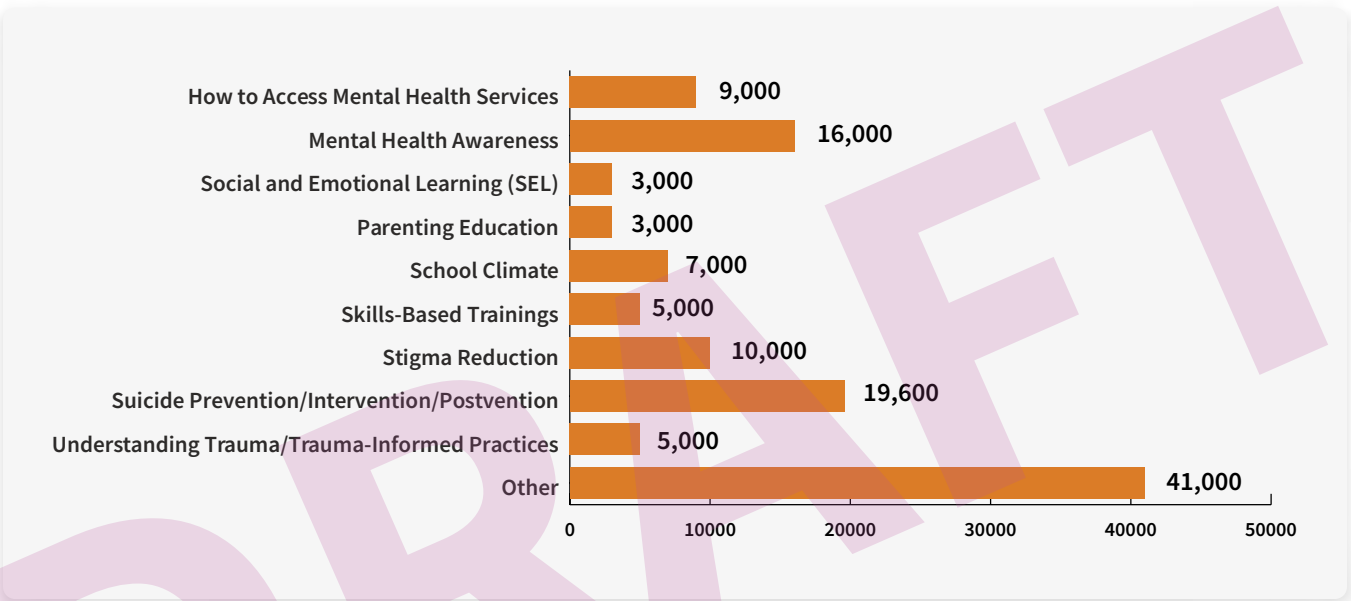
Twenty-one grantees reported providing Tier 1 services and 37 grantees reported providing Tier 2 and 3 services.

Approximate Number of Students Statewide Receiving MHSSA Services By Grade in 2022-23

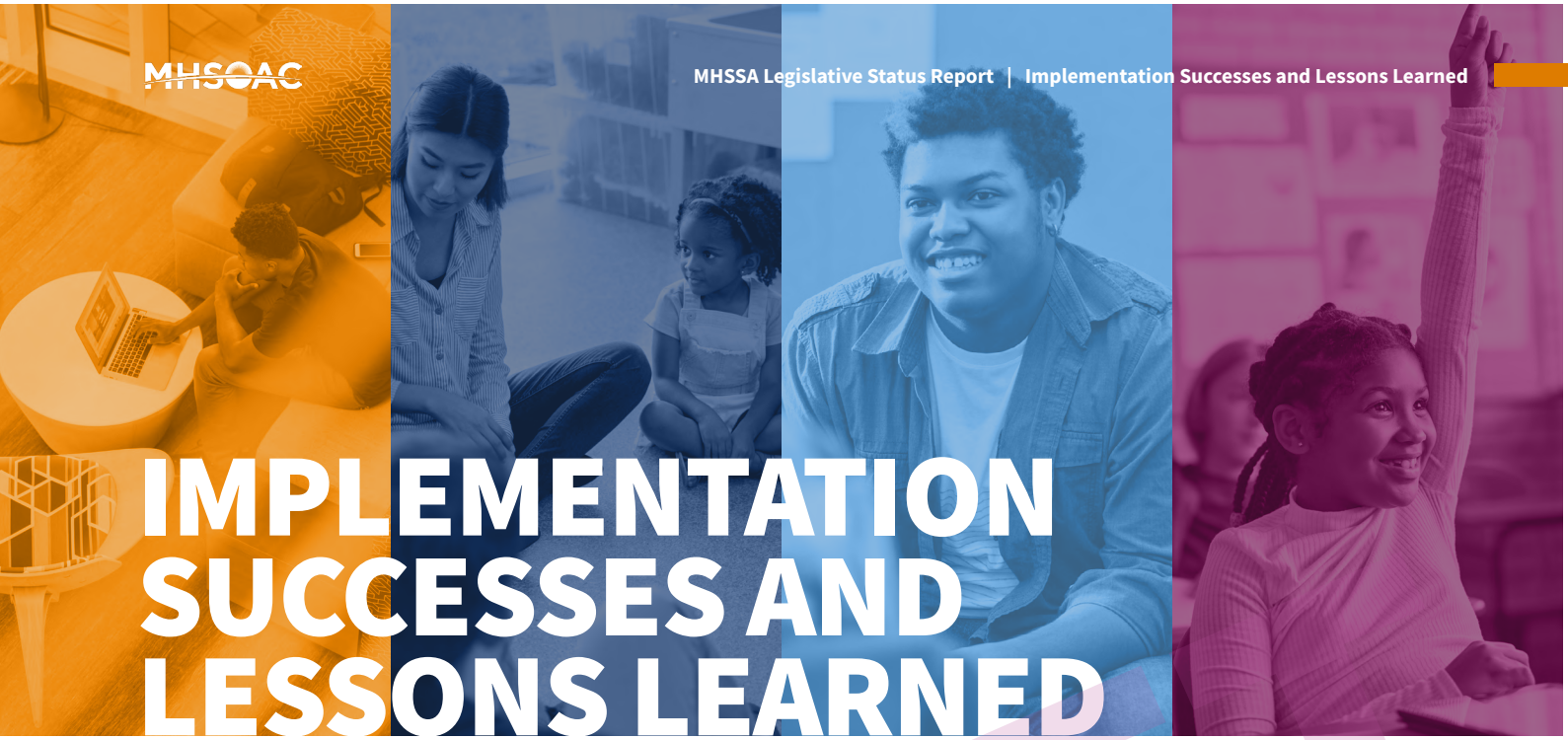
	TIER 1 SERVICES (21 grantees reporting)	TIERS 2 & 3 SERVICES (38 grantees reporting)
Elementary schools (grades PreK-6)	109,000	4,000
Middle schools (grades 7-8)	43,000	2,000
High schools (grades 9-12)	83,000	4,200
Other/Unknown	7,000	2,000
TOTAL	**242,000**	**12,200**

In addition to direct services, MHSSA grants support outreach and training for students, parents, staff, and others in the community. The figure below provides the approximate number of individuals trained in 2022-23 by type of training and outreach, as reported by 24 MHSSA grant partners. Please note individuals may have been trained across several training types. We will continue to work with state agencies, MHSSA grantees, students, parents, and other community partners to identify outcomes that matter for a wide range of perspectives.

Type of Training/Outreach and Approximate Number of Individuals Trained in 2022-23*



** 24 grantees reporting*



IMPLEMENTATION SUCCESSES AND LESSONS LEARNED

MHSSA grant partners report successes in building strong partnerships, transforming schools into centers of wellness by expanding a continuum of school-based mental health services and providing students and families with access to services that are making a difference in their lives. The following highlights a few of these successes and stories.

Implementation Successes

MHSSA Deepens Partnerships at the Local Level

Local county partners report that MHSSA funding has deepened and enhanced partnerships between K-12 education and county mental health. Specifically, MHSSA grants:

- **Build greater trust and collaboration across education and county mental health systems.** Grant partners report that MHSSA has been the impetus for bringing a diverse group of partners together to improve access to services in schools. By holding regular planning meetings, partners get to know each other, build trusting relationships, and establish common goals for working together.

> *"[For MHSSA] representatives from all five school districts, the County Office of Education, and the County Health and Human Services Agency (HHSA) have participated in the Project Implementation Workgroup and Steering Committee meetings. Within each Catchment area, representatives from the district, vendor, and HHSA attend regional committee meetings. A partnership/planning team consisting of the County HHSA and the Office of Education meet monthly to discuss implementation and ensure alignment."*
>
> **— STAFF/PROVIDER**

→ **Improve service coordination for K-12 students and their families.**
Grantees report that MHSSA partnerships are co-developing and implementing processes for improving the coordination of services, including improved referral pathways and closed referral loops.

> *"A high school student needing crisis services was evaluated using the Columbia Suicide Rating Scale. The tool called for referral to behavioral health for crisis services. This linkage was successful and demonstrated a seamless integration between [county name] Wellness Center sites and county mental health."*
>
> **— STAFF/PROVIDER**

→ **Leverage Medi-Cal and private insurance to cover the cost of services.**
Grantees report that their partners are working together to bill Medi-Cal and private insurance.

> *"The County's success continues to be the collaborative relationship that is being created between County Behavioral Health and the County Office of Education. This collaboration will help our students for years to come. We have a plan to Medi-Cal site certify all school campuses in [name] County."*
>
> **— STAFF/PROVIDER**

LOCAL MHSSA SPOTLIGHT

Sustainability

ALAMEDA COUNTY

The Alameda County of Education (ACOE) seeks to align MHSSA and the Student Behavioral Health Incentive Program (SBHIP) assessments, identify additional funding opportunities, and build the infrastructure to support insurance billing during the CalAIM transition.

ACOE is working to support local school districts in building out the infrastructure to bill for services and increase long-term sustainability and expansion of site-based mental health services, as part of SBHIP and CalAIM and the larger landscape. To support this work, ACOE hosts monthly "Funding Learning Exchange" meetings countywide.

NAPA COUNTY

Napa County is building sustainability through the intersection of MHSSA, and the Statewide Multi-Payer School-Linked Fee Schedule.

The Napa County Office of Education (COE) has begun working with Kaiser Permanente as a new partner in the region to provide mental health services to K-12 students in the county. Napa COE reported to the Commission that their school districts are excited to partner with Kaiser, look forward to interconnected support for school mental health services as the Fee Schedule launches across California, and greater coordination of closed-loop referrals, as the wait time for services can be long.

MHSSA Expands the Continuum of Mental Health Services in Schools

As detailed above, MHSSA through local partnerships has expanded a continuum of Tiers 1, 2, and 3 services, and crisis services on school campuses. These are services that would have not been available without MHSSA funding, with over 250,000 students served. MHSSA grant partners report that the increase of mental health services on school campuses has increased awareness of student mental health needs and led to less fear and stigma in seeking services. These efforts have been augmented by over 26,000 individuals receiving mental health awareness and stigma reduction training through MHSSA.

MHSSA INCREASES AWARENESS AND DESTIGMATIZES MENTAL HEALTH

By providing outreach/training and expanding the continuum of services and supports, grant partners report increasing mental health awareness and the normalization of students seeking services on school campuses.

Imperial County reported that staff and students at one of their schools have been enthusiastic about new mental health campaigns, events, and initiatives. For example, during May 2023, Imperial reported that over 500 students and staff participated in mental health campaign events, and 2,000 students attended a mental health resource fair. Imperial reported that these events have increased school staff mental health awareness and the motivation to look out for students and refer them to school-based mental health services if needed.

Ventura grant partners have observed that ninth-grade students have been the main population accessing high school wellness centers, noting that most of these ninth-graders came from a middle school that had a wellness center on campus. Ventura County reports that these students are extremely comfortable accessing the centers, resources, and services when needed. Many even bring in friends to introduce them to the center. Ventura concludes that the stigma around mental health and services is slowly decreasing due to the introduction of wellness centers across their county.

MHSSA Services Are Making a Difference in the Lives of Students and Families

> *"I started feeling very depressed, I had many absences and was going to get kicked out of school. I started going to therapy at school each week. I also learned that it is important to face my anxiety and all my fears and not avoid it. It helped that my therapist talked to my mom a lot because my mom also learned how to help me start feeling better. Today, I am a lot better."*
>
> **— YOUTH**

MHSSA grant partners regularly share with Commission staff stories about how MHSSA is making a difference in the lives of students and families. Anecdotal reports from grant partners demonstrate the different ways that MHSSA services are improving student outcomes. These outcomes include, but are not limited to:

- Increased student wellbeing and quality of life
- Improved ability to reach goals like graduating from high school
- Improved school engagement and ability to make friends
- Improved school attendance and grades
- Reductions in anxiety, depression, self-harm, and other trauma-related symptoms

MHSSA SERVICES HELP STUDENTS GRADUATE

MHSSA legislation identifies several outcomes for the grant programs to achieve, including the reduction of school failure. Across California, grant partners are sharing stories about how MHSSA services are enabling students at risk of school failure to graduate from high school.

In Humboldt County, a student was at risk of not graduating from high school due to poor grades. This student had been diagnosed with a chronic health condition that had impacted his academics and engagement with school and caused significant anxious and depressive symptoms that led to a mental health crisis. Support was provided to the student and family via teletherapy and in-person sessions. The student graduated from high school and began a paid community internship program, which has increased his wellbeing.

In Imperial County, a student's family had experienced a tragedy and were struggling to cope. The student was suffering, and they were at risk of not graduating. The student's goal for seeking services was to "feel okay" and be the first person in his family to graduate from high school. The school-based clinician worked together with the student allowing him space to process the loss and share his trauma for the first time. Talking about how he felt opened the door for him to share with his mom. Having each other's support in their grieving process helped them both. The student met his goal and became the first person in his family to graduate from high school.

Grant partners report that MHSSA services are engaging parents to improve student outcomes. Under the MHSSA grant program, local communities provide training and education to parents on a range of topics such as mental health awareness, and social and emotional learning.

MHSSA SERVICES ENGAGE AND EDUCATE PARENTS AND CAREGIVERS

Grant partners report that providing individual counseling to students on school campuses has enabled them to involve families in treatment and provide them with education to help them better understand and support their child.

In Riverside County, a student was barely attending school, struggling with anxiety and self-harm, and had no friends. She began receiving services at school and, with staff support and the involvement of her mother in her treatment plan, has made tremendous progress. She is no longer self-harming and has started making friends who she eats lunch with every day. A parent partner is also working with her mother to provide psychoeducation and parenting tips to bring more calmness and stability to the household. The student's younger sibling has significant behavioral issues, and the parent partner is providing support in accessing services for this child as well.

LOCAL MHSSA SPOTLIGHT

Solano County

SOLANO COUNTY SCHOOL-BASED MOBILE CRISIS RESPONSE SYSTEM

Solano County Behavioral Health and Solano County Office of Education (SCOE) have partnered with local education agencies to address increasing rates of Solano County youth requiring intervention for suicidal ideation. Solano County partners established a uniform school-based mobile crisis response system that responds to students experiencing a mental health crisis at school. Solano County provides crisis services to 79 local K-12 schools, which represents most schools in the county.

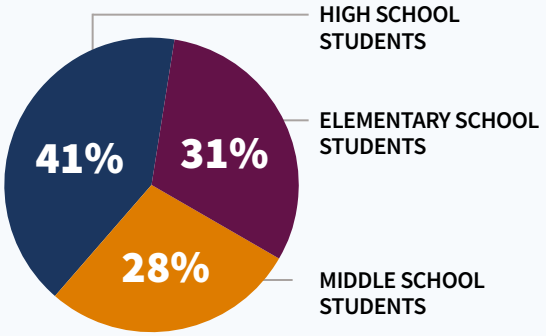
The Mobile Crisis Response team, housed at SCOE, provides the following services during school hours:

- Hotline crisis intake.
- In-person assessments and direct interventions (e.g., de-escalation, safety planning) to students in crisis at school.
- Brief case management to support students' successful integration back into school and linkage to additional services.

There are no insurance requirements for receiving these services. If there is an overt safety risk to students, SCOE responds to the crisis in partnership with local law enforcement.

Solano County partners use data to guide programming and serve their community. Since the beginning of the MHSSA grant, SCOE has responded to 697 student mental health crises (unduplicated students).

PERCENTAGE OF STUDENTS IN CRISIS BY SCHOOL LEVEL



40%

of mental health crises involved LGBTQ+ students

74%

of students (518 out of 697) were stabilized at their school site and did not require an emergency room visit or hospitalization

Lessons Learned

The following are key lessons the Commission has learned from grant and community partners during MHSSA implementation:

1. **Local MHSSA activities and services are heterogeneous and tailored to meet local needs and gaps in services.** Allowing MHSSA grant partners the flexibility to respond to local needs has been a successful feature of the MHSSA grant program but has also presented challenges for conducting a statewide evaluation and establishing consistent metrics for monitoring and reporting.

2. **MHSSA partners have built and strengthened partnerships but need additional guidance to support local success.** Sustainability is a key concern among MHSSA grant partners. Partners report needing additional funding and sustainability planning to meet local needs, particularly since grants are scheduled to end as early as 2025.

3. **The need for school mental health services often exceeds local capacity.** Partners report that the demand for services is often higher than the availability of services. Hiring and retaining staff continues to be a challenge for MHSSA grant partners, especially in rural counties with more severe mental health professional shortages.

4. **School mental health standards are needed in California to drive quality improvement.** MHSSA grant partners have asked the Commission for guidance in building their local school mental health systems. In California, there are currently no agreed-upon guidelines or standards to support local communities in designing their school mental health systems, monitoring implementation, and measuring outcomes.

5. **Alignment of California's school mental health initiatives is important for local success.** Multiple youth and school mental health funding initiatives in California have benefited local communities but also created stress and overburdened staff who prepare grant proposals, manage different grant programs, track different funding streams, and meet different reporting requirements.

These lessons learned provide a roadmap for what California should prioritize next to continue moving closer toward a vision of schools as centers for wellness. Achieving this vision will require effective and sustainable comprehensive school mental health systems that promote a positive school climate and support the mental health and wellness needs of students and school staff. Through MHSSA, the Child and Youth Behavioral Health Initiative, and other school mental health initiatives, California has made tremendous strides in building the capacity of schools to develop comprehensive school mental health systems. However, there is work to be done to promote this model and its core features across the state.

BARRIERS AND CHALLENGES TO IMPLEMENTATION

The Commission collects information from MHSSA grant partners on implementation barriers and challenges, successes, and lessons learned from several sources including monthly reports, site visits, and surveys.

Grant partners report five main barriers and challenges they have encountered (or are encountering) when implementing activities and services:

1. Developing partnerships across sectors
2. Hiring and retaining mental health providers and staff
3. Implementing activities and providing services
4. Collecting and reporting data to the Commission
5. Building fiscal sustainability to continue grant activities and services

These barriers have been consistent and ongoing for many grant partners, particularly in rural areas. One rural grant partner noted the difficulties are *"because rural aspects of living and the challenges that we face are extremely different than those in an urban setting. Isolation plays a huge factor, adequate transportation, poverty needs, everything is exacerbated in rural areas because of unique considerations."*

In response, the Commission is developing a technical assistance approach to provide guidance and support to MHSSA grant partners. Since California's Children Youth Behavioral Health Initiative workstreams (workforce training and capacity, developing ecosystem infrastructure and coverage) seek to address and rectify these common barriers, the Commission will collaborate with California's Health and Human Services Agency and other departments on how to best respond to local needs for capacity building and support.

1 Developing partnerships across sectors

Although MHSSA grant partners report success in building and strengthening local partnerships, some note that developing partnerships requires overcoming several challenges:

- Building trust and rapport with new partners, each of whom has their own unique culture, policies and procedures, etc.
- Overcoming the divide between different sectors to learn each other's language and terminology, systems and service delivery models, etc.
- Strategic planning and conducting needs assessments to set goals and priorities.
- Determining levels of administrative oversight and teaming structures.
- Engaging students and families for consultation and planning services.

2 Hiring and retaining staff mental health providers and staff

Grant partners report that hiring and retaining school mental health providers is a main barrier to implementing their school mental health activities and services. These barriers can include finding and hiring qualified mental health providers, particularly in rural areas, as well as retaining staff throughout the grant cycle.

3 Implementing activities and providing services

Grant partners report several barriers in establishing and providing a continuum of school mental health services on school campuses:

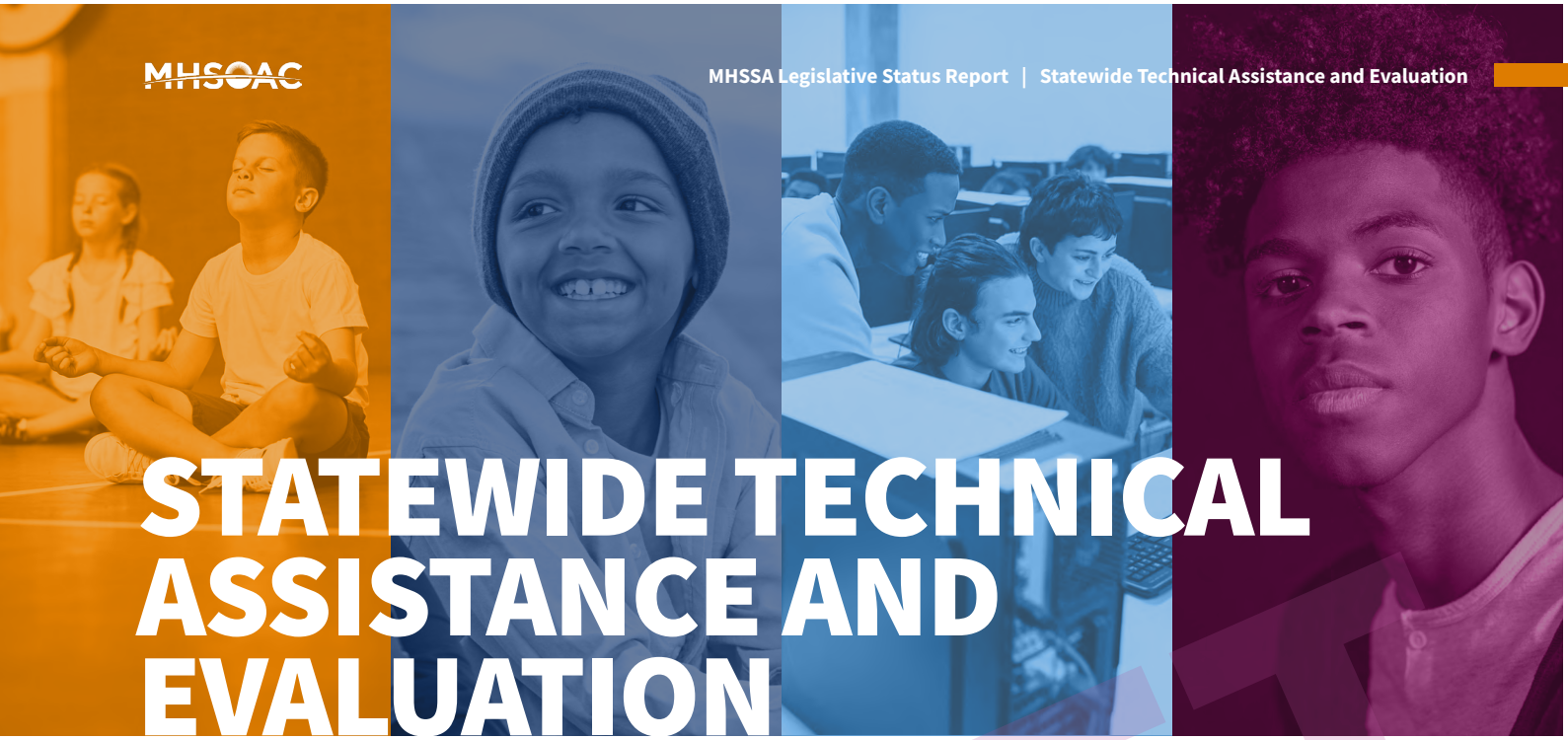
- Locating space on school sites to provide services or establish wellness centers.
- Responding to student and family needs for services, which often exceeds service availability and staff capacity.
- Managing multiple school mental health programs and initiatives makes implementation and coordination of activities and services difficult.
- Lack of community referral loops and providers.

4 Collecting and reporting data to the Commission

Although grant partners see the value in collecting data on MHSSA activities and services, they report several barriers to collecting and reporting data to the Commission, including lack of data systems and staff resources dedicated to data reporting, HIPAA/FERPA concerns around reporting individual-level data, and difficulty establishing memoranda of understanding with multiple partners.

5 Building fiscal sustainability to continue grant activities and services

MHSSA grant partners report concerns about how they will continue school mental health activities and services after MHSSA ends. In a survey of technical assistance needs, 86 percent of grant partners surveyed reported needing support to sustain their MHSSA activities and services after the grant ends. More than half of these grantees report needing support in establishing Medi-Cal billing, partnering with private health insurance companies, and blending and braiding these different funding streams.



STATEWIDE TECHNICAL ASSISTANCE AND EVALUATION

School Mental Health Technical Assistance

To address the technical assistance needs of MHSSA grant partners, the Commission partnered with the California School-Based Health Alliance in 2020 to produce the *California Student Mental Health Implementation Guide*.

The guide was recently updated in 2024 and includes resources designed to support local education agencies and county behavioral health departments as they work together to deliver comprehensive, high-quality school mental health.

Recently, the Commission established a Technical Coaching Assistance Grant to establish and implement Technical Coaching Teams to provide direct assistance to MHSSA grantees statewide. Three MHSSA grantees – Placer, Imperial, and Tehama – were awarded the grant to provide technical assistance support and direct consultation to other MHSSA grantees in four subject areas:

- **PARTNERSHIP DEVELOPMENT**
- **PROGRAM IMPLEMENTATION**
- **DATA COLLECTION AND REPORTING**
- **SUSTAINABILITY**

These four subject areas were identified by the Commission as creating barriers to success for MHSSA grant partners. In addition, a web-based information hub will be developed by a third-party statewide coordinator to be selected in 2024. The Technical Coaching Teams will begin providing support to MHSSA grantees in the summer/fall of 2024. The statewide coordinator will survey what technical assistance related to school mental health is being provided across the state, and work with those to providers to explore better coordination and alignment, so efforts are not duplicative.

MHSSA Evaluation

MHSSA legislation requires the Commission to develop metrics and a system to measure and publicly report on the performance outcomes of services provided using the grants. The Commission aims to conduct an evaluation that meets this legislative requirement and supports transformational change in school mental health. **In June 2023, the Commission partnered with WestEd to develop a framework and plan for evaluating the MHSSA.**

The Commission's primary goals for the evaluation are to:

1. Understand MHSSA implementation and successes, challenges, and lessons learned.
2. Understand the impact of MHSSA on different levels (a) cross-system partnerships; (b) services in schools and communities; and (c) student and family outcomes.
3. Understand the experiences of student subgroups and the provision of mental health services to close the equity gap.
4. Develop performance metrics that cut across systems to create a shared understanding of student success and wellbeing and close equity gaps.
5. Build capacity of school-county partnerships for data-driven approaches that inform continuous improvement toward effective and sustainable school mental health systems.

To evaluate the MHSSA, the Commission and its partner WestEd have engaged:

6 MHSSA Evaluation Workgroup meetings

24 listening sessions

16 youth from diverse backgrounds participating in a Youth Advisory Group

WestEd will submit a final evaluation plan to the Commission for approval in October 2024, after which implementation of the evaluation will begin. The MHSSA evaluation will be designed to promote systems change and a culture of learning for both MHSSA grant partners and the Commission which will be supporting technical assistance.

OPPORTUNITIES AND RECOMMENDATIONS

Under Governor Newsom's administration, California has made monumental investments to better support the mental health of its young population. Through initiatives such as the Children and Youth Behavioral Health Initiative, the Mental Health School Services Act, and its modernized public healthcare system known as CalAIM, California is building a full continuum of infrastructure and service systems that emphasize prevention and early intervention in mental health services.

Schools are an important access point for mental services in this continuum. To support long-term local success in school mental health will require a shared understanding across California agencies of both the systems change goals California is working toward and the metrics to measure progress.

California's historic investments in school mental health, including the Mental Health Student Services Act, have allowed for initial steps to be taken to develop school-based mental health services and supports across the state. However, many of these investments are one-time funds. In the next two to three years, MHSSA grant partners will be facing a "fiscal cliff" as their grants end, with many still in the process of building their partnerships and comprehensive school mental health systems. MHSSA grant partners are still learning to leverage Medi-Cal, private insurance, and blend and braid various funding streams. Grant partners need additional time and preparation to implement sustainability plans with the help of the Commission's statewide technical assistance team.

> *"Implementing new strategies for funding mental health in schools is not a sprint. It is a marathon and will take time and preparation. To be successful will require new partnerships, strategies, and staff collaborations."*
>
> **– COMMISSION PARTNER AND SUBJECT MATTER EXPERT**

Based on lessons learned during MHSSA implementation, the Commission offers the following three recommendations for the State to consider:

1 State School Mental Health Leadership

The State should establish a leadership structure for youth behavioral health to coordinate and align school mental health initiatives and develop a long-term strategy for building sustainable, comprehensive school mental systems in every K-12 school in California. The leadership structure would simplify the complex network of leadership, funding, and reporting under which counties currently operate, and foster collaborative leadership among state agencies, local governments, educational institutions, youth, and families. This will promote a unified approach to school mental health, enhance resource allocation, and enable the sharing of best practices across different regions and communities.

A long-term comprehensive school mental health strategy should design effective ways for the health and education systems and their partners to collaborate with youth and families to deliver a continuum of behavioral health services and supports in schools. To strengthen partnerships, the State should establish policies that codify these partnerships, create incentives to encourage collaborative behavior, and build metrics into an accountability system to monitor collaboration.

2 School Mental Health Funding

As California advances toward establishing a robust infrastructure for comprehensive school mental health services, it is crucial to secure additional funding to bridge the gap between initial implementation and long-term sustainability. The State should increase its investment through the Mental Health Services Act (MHSSA) to allow behavioral health and education partners more time to continue to strengthen partnerships, build capacity, and implement a continuum of services and support that began under the initial investment. The State should also invest in programs, services, and resources to support the mental health of teachers and school staff. If California makes a targeted investment, behavioral health and education partners will be able to address immediate funding needs, support the scalability of successful programs, and ensure that mental health services in schools are sustainable and able to adapt to evolving student needs over time.

3 State School Mental Health Standards and Metrics

The State, through the youth behavioral health leadership structure, should develop and implement robust mental health standards and metrics that establish clear guidelines for comprehensive school mental health systems. These standards should encompass essential components such as prevention, early intervention, crisis support, and school climate indicators to ensure a holistic approach to student wellbeing. Metrics should be designed to track progress, assess program effectiveness, and drive continuous improvement. As part of accountability, the State should establish a data collection and reporting system to collect consistent, school-wide data on mental health services and supports for students. By creating a shared framework and data system for evaluating and enhancing school mental health systems, the State can foster consistency in quality, promote accountability, and support schools in their efforts to deliver impactful mental health support.

APPENDIX A

Description of MHSSA Grant Award Phases

PHASE 1	PHASE 2	PHASE 3
18 partnership grants awarded in 2020, totaling	19 partnership grants awarded in 2021, totaling	20 partnership grants awarded in 2022, totaling
$74,849,047	**$77,553,078**	**$54,910,420**

Grant awards are generally for four years, with Phase 3 grants scheduled to end in December 2026. In 2023, the Commission made available additional MHSSA funding to existing MHSSA grant partners through a request for applications (RFA). Forty-one MHSSA grantees were awarded additional MHSSA funds to expand their capacity, activities and services.

PHASE 1 GRANTS WERE AWARDED TO 18 OUT OF 38 APPLICANTS IN 2020.

Phase 1 grants were awarded in two categories: (1) An existing history of partnership between county and local education agencies (n = 10); and (2) New and/or emerging partnerships between county and local education agencies (n = 8).

A total of $75 million was issued for the four-year MHSSA grants, with awards determined by county size (small, medium, and large). Phase 1 grantees were slated to begin their programs in Fall 2020 but many experienced significant delays in hiring staff and implementing their programs due to the COVID-19 pandemic. As a result, the four-year grants were amended to allow for a fifth year.

PHASE 2 GRANTS WERE AWARDED TO 19 APPLICANTS IN 2021.

The Budget Act of 2021 provided an additional $95 million to fund applicants who applied to the first round of MHSSA funding (Phase 1) but did not receive a grant. These applicants were approached by the Commission to see if they were still interested in the MHSSA grants and whether their proposal was still applicable. One original applicant chose not to participate. Phase 2 grant contracts were issued to 19 counties between August 2021 and March 2022. In addition, grantees were given additional time to make changes to their original proposal and submit a modified budget within 90 days after the contract was executed.

PHASE 3 GRANTS WERE AWARDED TO 17 APPLICANTS IN FEBRUARY 2022.

The Federal American Rescue Plan (ARPA) provided up to $100 million through the State Fiscal Recovery Fund (SFRF) to support the remaining 20 California counties in establishing an MHSSA program. The Commission surveyed the 20 eligible counties to understand why they did not apply for a Phase 1 grant and asked what their main barriers would be for submitting a proposal. Counties reported a lack of resources and staff to develop a plan and submit a proposal as the primary barrier to participating in the MHSSA program. It should be noted that most of these counties are small, rural counties, many of which had been significantly affected by natural disasters such as wildfires as well as the pandemic. The Commission offered one-on-one sessions, confidential guidance on plan development, and a four-month planning phase to overcome barriers. Phase 3 grant contracts were executed on March 1, 2022.

In addition, approximately $48 million dollars, which was not awarded in the previous RFAs, were distributed to the 41 grantees that applied for it to expand their capacity, activities, and services.

MHSSA Funding Table (as of January 2024)

COUNTY	SIZE	PHASE 1: 18 GRANTS (2020)	PHASE 2: 19 GRANTS (2021)	PHASE 3: 20 GRANTS (2022)	ADDITIONAL MHSSA FUNDS
Alameda	Large			$6,000,000	$1,619,403
Alpine	Small				
Amador	Small		$2,487,384		
Berkeley City	Small			$2,500,000	
Butte	Medium			$4,000,000	$1,079,602
Calaveras	Small	$2,500,000			$674,751
Colusa	Small			$2,500,000	
Contra Costa	Large		$5,995,421		$1,618,167
Del Norte	Small			$0	$2,500,000
El Dorado	Medium			$4,000,000	$1,044,665
Fresno	Large	$6,000,000			$1,619,403
Glenn	Small		$2,500,000		
Humboldt	Small	$2,500,000			$674,751
Imperial	Small		$2,500,000		$674,751
Inyo	Small			$2,499,444	
Kern	Large	$6,000,000			$1,619,403
Kings	Small			$2,500,000	$674,751
Lake	Small		$2,499,450		
Lassen	Small			$2,274,040	
Los Angeles	Large		$6,000,000		$1,619,403
Madera	Small	$2,499,527			$674,623
Marin	Medium		$4,000,000		$1,079,602
Mariposa	Small			$0	$2,500,000
Mendocino	Small	$2,500,000			$674,751
Merced	Medium			$4,000,000	$810,949
Mono	Small			$2,500,000	
Monterey	Medium		$3,999,979		
Napa	Small			$2,500,000	$454,476
Nevada	Small		$2,499,448		$674,602
Orange	Large	$6,000,000			$1,619,403

COUNTY	SIZE	PHASE 1: 18 GRANTS (2020)	PHASE 2: 19 GRANTS (2021)	PHASE 3: 20 GRANTS (2022)	ADDITIONAL MHSSA FUNDS
Placer	Medium	$4,000,000			$1,079,602
Plumas	Small			$1,749,800	
Riverside	Large		$5,862,996		$1,409,487
Sacramento	Large		$6,000,000		$1,619,403
San Benito	Small			$0	$2,500,000
San Bernardino	Large		$5,998,000		
San Diego	Large		$6,000,000		$1,111,133
San Francisco	Large		$6,000,000		
San Joaquin	Large			$6,000,000	$1,619,403
San Luis Obispo	Medium	$3,856,907			
San Mateo	Large	$5,999,999			
Santa Barbara	Medium	$4,000,000			$1,022,151
Santa Clara	Large	$6,000,000			$1,619,403
Santa Cruz	Medium		$4,000,000		$1,079,602
Shasta	Small		$2,500,000		$465,755
Sierra	Small			$1,566,204	
Siskiyou	Small			$2,500,000	$674,751
Solano	Medium	$4,000,000			$1,079,602
Sonoma	Medium		$4,000,000		$1,079,602
Stanislaus	Medium			$4,000,000	$1,079,602
Sutter-Yuba	Small		$2,215,438		$402,746
Tehama	Small	$2,500,000			$674,751
Tri-City	Medium			$3,820,932	$1,031,272
Trinity-Modoc	Small	$2,492,684			$453,146
Tulare	Medium	$4,000,000			$1,079,602
Tuolumne	Small		$2,494,962		
Ventura	Large	$5,999,930			$1,619,384
Yolo	Medium	$4,000,000			$1,079,602
TOTAL		**$74,849,047**	**$77,553,078**	**$54,910,420**	**$47,687,455**

MISCELLANEOUS ENCLOSURES

October 24th, 2024 Commission Meeting

Enclosures (4):

(1) Evaluation Dashboard

(2) Innovation Dashboard

(3) Department of Health Care Services Revenue and Expenditure Reports Status Update

MHSOAC Evaluation Dashboard October 2024
(Updated October 11, 2024)

Mental Health Services
Oversight & Accountability Commission

Summary of Updates

Contracts

New Contracts: 0

Total Contracts: 3

Funds Spent Since the September 2024 Commission Meeting

Contract Number	Amount
21MHSOAC023	$ 0.00
22MHSOAC025	$ 0.00
23MHSOAC018	$ 0.00
TOTAL	**$ 0.00**

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

MHSOAC Staff: Melissa Martin-Mallard
Active Dates: 07/01/21 - 06/30/27
Total Contract Amount: $7,544,350.00
Total Spent: $4,244,350

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis.

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Complete	09/30/21	No
Quarterly Progress Reports	Complete	12/31/21	No
Quarterly Progress Reports	Complete	03/31/2022	No
Quarterly Progress Reports	Complete	06/30/2022	No
Quarterly Progress Reports	Complete	09/30/2022	No
Quarterly Progress Reports	Complete	12/31/2022	No
Quarterly Progress Reports	Complete	03/31/2023	No
Quarterly Progress Reports	Complete	06/30/2023	No
Quarterly Progress Reports	Complete	09/30/2023	No
Quarterly Progress Reports	Complete	12/31/2023	No
Quarterly Progress Reports	Complete	03/31/2024	No
Quarterly Progress Reports	Complete	06/1/2024	No
Quarterly Progress Reports	Complete	9/30/2024	Yes
Quarterly Progress Reports	In Progress	12/31/2024	Yes
Quarterly Progress Reports	Not Started	3/21/2025	No
Quarterly Progress Reports	Not Started	6/30/2025	No
Quarterly Progress Reports	Not Started	9/30/205	No

Quarterly Progress Reports	Not Started	12/31/2025	No
Quarterly Progress Reports	Not Started	3/31/2026	No
Quarterly Progress Reports	Not Started	6/30/2026	No
Quarterly Progress Reports	Not Started	9/20/2026	No
Quarterly Progress Reports	Not Started	12/31/2026	No
Quarterly Progress Reports	Not Started	3/31/2027	No
Quarterly Progress Reports	Not Started	6/1/2027	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: $1,100,000.00

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	Complete	September 1, 2023	No
Community Engagement Plan Implementation (a, b and c)	Complete Complete In Progress	December 15, 2023 January 15, 2024 October 30, 2024	No
Evaluation Framework and Research Questions	Complete	December 15, 2023	No
School Mental Health Metrics	Complete	June 15, 2024	No
Evaluation Plan (draft and final)	In Progress	September 1, 2024 October 30, 2024	No
Consultation on Report to the California Legislature	Complete	March 1, 2024	No
Progress Reports (a, b, and c)	Complete Complete Complete	September 15, 2023 January 15, 2024 June 15, 2024	No

The Regents of the University of California, San Francisco: Universal Screening Project (23MHSOAC018)

MHSOAC Staff: Kali Patterson

Active Dates: 12/12/23 -12/31/24

Total Contract Amount: $160,000

Total Spent: $10,000

The project will support the Commission in conducting research on the subject of universal mental health screening for children and youth and conduct a landscape analysis to understand universal mental health screening policies and practices for children and youth in California. Doing so will allow the Commission, as part of its required legislative Report, to develop recommendations to improve universal screening of students in California schools.

Deliverable	Status	Due Date	Change
Survey Tool	Complete	02/01/2024	No
Literature Review Report	Complete	02/01/2024	No
Project Support and Consult			
a. Workplan	Complete	1/15/2024	No
b. Meetings and Interviews	Complete	1/15/2024	No
c. Analysis and Summary	Complete	4/30/2024	No
Landscape Analysis Report			
a. Draft Report	Complete	6/30/2024	No
b. Final Report	Complete	7/31/2024	No

Note. Invoices are pending payment.

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD

October 2024

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	3	2	**5**
Participating Counties (unduplicated)	3	2	**5**
Dollars Requested	$5,569,983	$36,365,000	**$41,934,983**

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	$354,562,909	26 (44%)
FY 2023-2024	15	15	$197,481,034	13 (22%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
2024-2025	3	3	$6,891,376	2

INNOVATION PROJECT DETAILS

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Shasta	Level Up Norcal: Supporting Community Driver Practices for Health Equity	$999,978	2 Years	7/25/2024	8/30/2024
Under Final Review	Alameda	Psychiatric Advance Directive (PADs) Phase 2 Multi County Collaborative	$3,070,005	3 Years	9/13/2024	10/10/2024
Under Final Review	Tri-City	Psychiatric Advance Directive (PADs) Phase 2 Multi County Collaborative	$1,500,000	4 Years	9/13/2024	10/10/2024

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	Nevada	BHSA Implementation Plan	$1,365,000	3 Years	9/4/2024	Pending
Under Review	Orange	PIVOT: Program Improvements for Valued Outpatient Treatment	$35,000,000	3 Years	9/19/2024	Pending

APPROVED PROJECTS (FY 24-25)			
County		Funding Amount	Approval Date
Sierra	Semi-Statewide Enterprise Health Record Multi County Collaborative	$910,906	7/25/2024
Orange	Community Program Planning – Extension Request	$1,000,000	8/22/2024
Orange	Psychiatric Advance Directive (PADs) Phase 2 Multi County Collaborative	$4,980,470	8/22/2024

DHCS Status Chart of County RERs Received
October 24, 2024, Commission Meeting

Below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated October 11, 2024. This Status Report covers FY 2021 -2022 through FY 2022-2023, all RERs prior to these fiscal years have been submitted by all counties.

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

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

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

DCHS MHSA Annual Revenue and Expenditure Report Status Update

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

DHCS Status Chart of County RERs Received
October 24, 2024, Commission Meeting

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

DHCS Status Chart of County RERs Received
October 24, 2024, Commission Meeting

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Sierra	1/27/2023	1/30/2023	2/16/2023	12/18/2023	12/27/2023	1/15/2024
Siskiyou	2/6/2023	2/7/2023	2/9/2023	2/2/2024	2/15/2024	2/15/2024
Solano	1/31/2023	1/31/2023	2/15/2023	1/31/2024	2/15/2024	2/20/2024
Sonoma	1/31/2023	2/2/2023	3/6/2023	1/31/2024	2/7/2024	2/14/2024
Stanislaus	1/31/2023	2/2/2023	2/3/2023	1/31/2024	2/6/2024	2/9/2024
Sutter-Yuba	1/31/2023	2/2/2023	3/6/2023	3/29/2024		4/2/2024
Tehama						
Tri-City	1/25/2023	1/25/2023	2/16/2023	1/31/2024	2/6/2024	2/9/2024
Trinity	7/18/2023	7/24/2023	8/24/2023	5/21/2024	5/29/2024	6/10/2024
Tulare	1/31/2023	1/31/2023	2/15/2023	1/30/2024	2/20/2024	5/1/2024
Tuolumne	3/29/2023	3/30/2023	4/5/2023	3/1/2024	3/4/2024	3/7/2024
Ventura	1/30/2023	1/30/2023	1/31/2023	1/31/2024	2/15/2024	2/15/2024
Yolo	1/31/2023	2/2/203	3/15/2023	4/4/2024	4/5/2024	4/19/2024
Total	**57**	**42**	**57**	**56**	**53**	**56**