WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Meeting
July 25, 2019

Hyatt Place Santa Cruz
407 Broadway
Santa Cruz, CA 95060

Call-in Number: 1-866-817-6550
Participant Passcode: 3190377

Mental Health Services
Oversight & Accountability Commission

Khatera Tamplen
Chair
Lynne Ashbeck
Vice Chair

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

July 25, 2019
9:00 AM – 4:00 PM

Hyatt Place Santa Cruz
407 Broadway
Santa Cruz, CA 95060

Call-in Number: 866-817-6550; Code: 3190377

Public Notice

The public is requested to fill out a "Public Comment Card" to address the Commission on any agenda item before the Commission takes an action on an item. Comments from the public will be heard during discussion of specific agenda items and during the General Public Comment period. Generally, an individual speaker will be allowed three minutes, unless the Chair of the Commission decides a different time allotment is needed. Only public comments made in person at the meeting will be reflected in the meeting minutes; however, the MHSOAC will also accept public comments via email, and US Mail. The agenda is posted for public review on the MHSOAC website http://www.mhsoac.ca.gov 10 days prior to the meeting. Materials related to an agenda item will be available for review at http://www.mhsoac.ca.gov. All meeting times are approximate and subject to change. Agenda items are subject to action by the MHSOAC and may be taken out of order to accommodate speakers and to maintain a quorum.

As a covered entity under Title II of the Americans with Disabilities Act, the Commission does not discriminate on the basis of disability and upon request will provide reasonable accommodation to ensure equal access to its meetings. Sign language interpreters assisted listening devices, or other auxiliary aids and/or services may be provided upon request. To ensure availability of services, please make your request at least three business days (72 hours) prior to the meeting by contacting (916) 445-8696 or by email at mhsoac@mhsoac.ca.gov.

Khatera Tamplen
Chair

AGENDA
July 25, 2019

Lynne Ashbeck
Vice Chair

Approximate Times

9:00 AM **Convene and Welcome**
Chair Khatera Tamplen will convene the Mental Health Services Oversight and Accountability Commission meeting and introduce the Transition Age Youth representative, Kalyn Jones**.** Roll call will be taken.

9:10 AM **Announcements**

9:20 AM **Consumer/Family Voice**
BJ North will open the Commission meeting with a story of recovery and resilience.

9:40 AM **Action**
1: Approve May 23, 2019 and June 10, 2019 MHSOAC Meeting Minutes.

The Commission will consider approval of the minutes from the May 23, 2019 meeting and the June 10, 2019 teleconference meeting.

- Public Comment
- Vote

9:45 AM **Information**
2: Criminal Justice Data Linkage Project Update
Presenter:

- Dawnté Early, M.S., Ph.D., Chief of Research & Evaluation, MHSOAC

The Commission will be presented with an update and relevant findings in the Commission's ongoing Criminal Justice data linkage efforts.

- Public Comment

10:30 AM **Action**
3: Legislative and Budgetary Priorities
Presenter:

- Norma Pate, Deputy Director, MHSOAC

The Commission will consider legislative and budgetary priorities, including consideration of AB 480 (Salas): Mental Health: Older Adults, SB 582 (Beall) Youth Mental Health and Substance Use Disorder Services and SB 665 (Umberg): Mental Health Services Fund: County Jails.

- Public Comment
- Vote

11:00 AM **Action**

4: MHSOAC Budget Overview

Presenter:

- Norma Pate, Deputy Director, MHSOAC

The Commission will consider approval of its final Fiscal Year 2018-19 Operations Budget and its proposed Fiscal Year 2019-20 Operations Budget.

- Public Comment
- Vote

11:45 AM **General Public Comment**

Members of the public may briefly address the Commission on matters not on the agenda.

12:00 PM **Lunch Break**

1:15 PM **Action**

5: MHSOAC New Funding and Programs

Presenter:

- Norma Pate, Deputy Director, MHSOAC

The Commission will hear an update on funding provided in the Budget Act to support school-mental health partnerships, Early Psychosis Programs, and Integrated Youth Drop in Centers.

- Public Comment
- Vote

2:15 PM **Action**

6: Children's Mental Health Funding Proposal

Presenter:

- Alex Briscoe, Principal, California Children's Trust

The Commission will hear a presentation and potential funding request to support increased access to care and service coordination for children and their families.

- Public Comment
- Vote

3:15 PM **Information**

7: Executive Director Report Out

Presenter:

- Toby Ewing, Ph.D., Executive Director, MHSOAC

Executive Director Ewing will report out on projects underway, on county Innovation plans approved through delegated authority and on other matters relating to the ongoing work of the Commission.

- Public Comment

3:45 PM **General Public Comment**
Members of the public may briefly address the Commission on matters not on the agenda.

4:00 PM **Adjourn**

AGENDA ITEM 1

Action

July 25, 2019 Commission Meeting

Approve May 23, 2019 and June 10, 2019 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from May 23, 2019 and June 10, 2019 Commission meetings. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None.

Enclosures (2): (1) May 23, 2019 Meeting Minutes; (2) June 10, 2019 Teleconference Meeting Minutes.

Handouts: None.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
May 23, 2019

We Rise 2019
Downtown Los Angeles Arts District
1262 Palmetto Street
Los Angeles, CA 90013

866-817-6550; Code 3190377

Members Participating:

Khatera Tamplen, Chair
Lynne Ashbeck, Vice Chair
Reneeta Anthony
Ken Berrick
John Boyd, Psy.D.
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
Mara Madrigal-Weiss
Gladys Mitchell
Tina Wooton

Members Absent:

Mayra Alvarez
Senator Jim Beall
Assemblymember Wendy Carrillo
David Gordon

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Technology
Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations

CONVENE AND WELCOME

Chair Khatera Tamplen called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:07 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Chair Tamplen reviewed the meeting protocols.

Announcements

Chair Tamplen provided the announcements:

- Youth Innovation Project Planning Committee members from Fresno and Monterey Counties presented last week at the California Mental Health Advocates for Children and Youth Conference.
- Many Youth Innovation Project Planning Committee members will attend the We Rise event and will host a focus group.

Youth Participation

Chair Tamplen stated the Commission made a commitment to include a young person around the table at every Commission meeting to learn the Commission process and to give their perspective on issues. Celeste Walley, Youth Advocate, Seneca Family of Agencies, introduced herself.

Meeting Calendar

The next Commission meeting will be a teleconference meeting on June 10th.

The July meeting will be held in Santa Cruz on July 25th.

Consumer/Family Voice

The Commission made a commitment to begin Commission meetings with an individual with lived experience sharing their story. Chair Tamplen invited Keris Jan Myrick to share her story of recovery and resilience.

Keris Jan Myrick, Discipline Chief for Peer Services, Los Angeles County Department of Mental Health, stated she calls stories of recovery and resilience “moments for mission” to remind everyone why they attend meetings and why these meetings occur. She stated no two stories of mental health and recovery are alike even though there may be common threads between many of them.

Ms. Myrick shared her story of living with schizophrenia, being shamed into silence, feeling isolated and unlovable, finding a therapist who focused on her goals, and the critical moment of being introduced to a peer who had been through what she had been through. This peer supporter gave Ms. Myrick the opportunity to see the possibilities in life, which helped her move forward with her life by returning to school and work while working on her symptoms. She gave credit to her family for their support during her recovery journey. She stated whole health care is important and discussed the support she received during a difficult physical illness.

Ms. Myrick ended her presentation with the poem “I rise” by Maya Angelou. She stated Los Angeles has decided that they, too, will rise and she asked that the MHSOAC rise with them.

Questions and Discussion

Chair Tamplen asked how to correct the notion that persons in recovery cannot possibly know what it is like to be seriously ill since they are recovered.

Ms. Myrick stated she does not use the term “recovered” because recovery is a journey. She stated no matter if she is experiencing symptoms or not, the thief, schizophrenia, is still here and continues to steal from her life. She stated she is not only on a journey for herself but for others who are still trying to find their way on this path.

Commissioner Mitchell thanked Ms. Myrick and honored her for sharing her story, which gives hope to consumers and family members.

Commissioner Boyd asked about the one thing Ms. Myrick would leave with Commissioners that should be woven into decision-making and the work of the Commission.

Ms. Myrick stated she would leave everyone with the importance of the work in helping individuals remain in community. Although it is helpful to be a part of community mental health, it would also be helpful to keep individuals connected to community with the supports surrounding them in order to remain in community. She stated the need to think about how to shore up the mental health system, communities, neighbors, and families to be a support to individuals where they are, when and how they need it, so that individuals do not need to seek support because the support is already there for them.

Celeste Walley thanked Ms. Myrick for sharing and stated she was moved by her story.

ACTION

1: <u>Approve April 25, 2019, MHSOAC Meeting Minutes</u>

Chair Tamplen asked for a motion to approve the minutes from the April 25, 2019, meeting.

Vice Chair Ashbeck moved approval of the April 25, 2019, meeting minutes. Commissioner Danovitch seconded.

Public Comment

Poshi Walker, LGBTQ Program Director, Mental Health America of Northern California (NorCal MHA), Co-Director, #Out4MentalHealth, referred to their second comment on page 17 and asked to change “NorCal MHA did their LGBTQ outreach with that in mind” to “the Subcommittee in general did their outreach with that in mind.”

Poshi Walker also referred to the first paragraph on page 23 and asked to remove the word “some” from “but the speaker has noticed that some stakeholders make a lot of public comment that is not reflected.”

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), referred to their request on page 11 for “the Commission to reconsider its decision to eliminate statewide advocacy for refugees and immigrants in this grant” and stated they had elaborated on that point. The speaker stated they have not asked in the past for their comments to be noted as verbatim or written down in full in other minutes; however, due to the importance of this subject and because it remains unresolved, the speaker would like the record for this subject to be complete.

Stacie Hiramoto asked that the written record reflect a more complete and accurate account of what they said. The speaker referred to the original notes from the testimony given at the April meeting and noted that, in addition to asking for reconsideration, they stated the following:

> "I would like to ask the Commission to reconsider your decision to eliminate state advocacy for refugees and immigrants in this grant. REMHDCO remains convinced that this was a vote that was misunderstood as somehow giving more power to local groups or local decision-makers. Nothing could be further from the truth. Integrated and coordinated efforts to advocate between state and local levels makes advocacy stronger and more informed at both levels.
>
> "Furthermore, this is the only grant of all the stakeholder advocacy grants that the OAC administers that omits state-level advocacy. This was a decision that not a single community stakeholder that we know of asked for or supported.
>
> "REMHDCO did want to thank Commissioner Ashbeck for her courageous and thoughtful vote and for listening to the voice of racial and ethnic communities as well as family members and consumers. We also wanted to thank Commissioner Anthony for also listening and considering testimony of community family members and consumers, although she was not present at that meeting.
>
> "A voice at the state level as well as at the local level, going back and forth, will be lacking."

Stacie Hiramoto respectfully requested that such testimony be added to the record.

Vice Chair Ashbeck amended her motion to include the requested changes to pages 11, 17, and 23, as noted. Commissioner Danovitch agreed.

Action: Vice Chair Ashbeck made a motion, seconded by Commissioner Danovitch, that:

The Commission approves the April 25, 2019, Meeting Minutes as revised.

Motion carried 8 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Anthony, Boyd, Bunch, Danovitch, Madrigal-Weiss, and Wooton, Vice Chair Ashbeck, and Chair Tamplen.

The following Commissioners abstained: Commissioners Brown and Mitchell.

ACTION

2: <u>Orange County Innovation Plan</u>

Presenters:

- Jeff Nagel, Ph.D., Behavioral Health Director, Orange County Health Care Agency

- Clayton Chau, M.D., Ph.D., Regional Executive Medical Director, Institute for Mental Health and Wellness, Providence St. Joseph Health
- Sharon Ishikawa, Ph.D., Orange County MHSA Coordinator
- Courtney Ransom, J.D., Family Member

Chair Tamplen stated the Commission will consider approval of $18,000,000 to support Orange County's Behavioral Health System Transformation Innovation Project. She asked the representatives from Orange County to present this agenda item.

Courtney Ransom, J.D., Family Member, shared the story of losing her son to suicide in 2016 and how her family was directly impacted by the fragmented behavioral health system in Orange County. She spoke in support of Be Well Orange County (Be Well OC), this innovation project, and the efforts to drive change to the behavioral health system of care.

Sharon Ishikawa, Ph.D., Orange County MHSA Coordinator, provided an overview, with a slide presentation, of the key challenges, community planning process, innovative solution, project activities and deliverables, learning objectives, evaluation approach, and budget of the proposed innovation project.

Clayton Chau, M.D., Ph.D., Regional Executive Medical Director, Institute for Mental Health and Wellness, Providence St. Joseph Health, spoke in support of the proposed innovation project.

Commissioner Questions

Commissioner Anthony reminded counties to have a full and robust community planning process. She asked, regarding the digital navigator, if the county representatives had ever called up the Medi-Cal line to apply for benefits.

Dr. Chau stated he used to work for Los Angeles Care Health Plan, which is the nation's largest nonprofit Medicaid plan.

Commissioner Anthony walked the county representatives through the process of calling the Medi-Cal line's automated system. She stated it is difficult to navigate and callers receive inconsistent answers to questions. She stated the proposed innovation project plans to use a digital navigator for the back end; however, the front end is a huge problem.

Jeff Nagel, Ph.D., Behavioral Health Director, Orange County Health Care Agency, stated this project has been iterative in development. The 30-day posting is at the end of a lot of participation by family members that preceded that and refined the proposal so that, by the time of the 30-day posting, the county already received a lot of input. Also, the digital navigation tool being developed is a tool that will be used by peers to help navigate the system. Peers will partner with clients who need services. The resource given to them will have embedded search capabilities that allows for meaningful searches but that will be just a tool that will then be used by individuals with lived experience who can help clients navigate the systems of care.

Dr. Chau stated there will be a number where clients will call in. They will get a live person who is a peer to help them. This navigation is the directory for the person who answers the phone. The problem with inconsistency when calling a health plan is that the directory is out of date the minute it is published so five different people that answer the phone give five different answers because they do not have a consistent directory to help them to support the individuals who call in. That is the goal of this project.

Commissioner Danovitch stated he shares Commissioner Anthony's concern about the difficulty consumers face when trying to navigate services. He stated the blending of the private and public is an essential and important innovation. He stated the need to learn from both the things that are successful and the challenges. He stated one thing he did not see in the meeting materials is a project plan with a timeline and milestones. Milestones could be critical points for learnings. A timeline with milestones is a mechanism for the Commission to monitor progress and learn from it. He stated his hope that there would be an opportunity to learn county-to-county.

Dr. Ishikawa stated the timeline with milestones will be provided. That is one of the first things that will be done to help flesh out and organize all the activities and entities involved in the project.

Dr. Chau stated a timeline is included on page 16 of the meeting materials.

Commissioner Wooton asked if the digital navigator's salary is included in the project office budget.

Dr. Ishikawa stated it depends. The subject matter expertise in terms of the computer programming would be involved under the Professional Consultation budget category, which she pointed out on the presentation slide. She stated there will be a series of community stakeholder meetings to determine the criteria to curate the list of programs and to determine the information that the community is most interested in seeing provided and regularly updated in this resource navigator. This will be included in the Local Community Consultation budget category.

Commissioner Wooton asked what would happen if the hospital and crisis residential programs were filled in the new system.

Dr. Nagel stated there are key bottlenecks in the system. Among them are adequate housing resources, crisis services, and residential treatment programs. Gaps needs to be located and addressed in the integrated system.

Vice Chair Ashbeck asked who would get paid as part of the digital navigator tool.

Dr. Ishikawa stated the professional consultation costs would be for the technology experts who would be developing the digital platform.

Vice Chair Ashbeck stated $18 million for no services is a lot of money. She asked for clarification on what the county is trying to improve with this project because some of this is happening already.

Dr. Chau stated the cartoon on the left side of the presentation slide is where the county is currently and the cartoon on the right is the future.

Dr. Nagel stated without cost the county has come together, Be Well has formed, and part of a blueprint of performance indicators has been developed as Appendix A on page 19 of the meeting materials. He reviewed the six key performance indicator goals that will be part of Be Well.

Commissioner Boyd asked about the role the payers have had so far in the dialogue in shaping this in concrete ways and what the barriers will be.

Dr. Chau stated all the major payers are at the table and innovative services provided for members will be reimbursed.

Commissioner Boyd asked if there have been concrete changes to the market and to their commitments as it relates to parity specifically as a result of having all major payers at the table.

Dr. Chau stated a full network is offered regardless of insurance.

Commissioner Boyd suggested that these payers present to the Commission about their work and what they hope to achieve with a full network.

Commissioner Boyd stated he would be interested in how this work will interface with the California Technology Suite. He stated the need to look at practice transformation and how that interplays in creating additional access.

Commissioner Brown stated $18 million seems like a tremendous amount of money for planning. The Stepping Up Initiative in Fresno and Santa Barbara Counties brings communities together to address ways to mitigate individuals with mental illness being involved in the justice system. He asked for clarification that the $18 million will not only cover the costs of meetings but that there will also be legal services, contracts, Memorandums of Understanding, and agreements between agencies.

Dr. Ishikawa stated that is absolutely the case. Part of the professional consultation includes legal fees as well as different subject matter expertise in contracting and procurement and representatives who will ensure compliance with regulations across the braided funding streams. Paying for meetings is not just renting space or providing light refreshments but also includes providing stipends to consumers and family members to attend the meetings in an effort to reach more consumers and family members in the hope that they will stay involved in the planning process.

Dr. Ishikawa stated the other large amount is for technical expertise for building the digital resource navigator. She stated the hope that the resource navigator will be built through the Technology Suite so it can be shared with other counties.

Dr. Nagel stated that is the one element that is not planning. A product will be delivered as a result of this project.

Commissioner Brown asked if there were letters of support from law enforcement and to what extent the county will partner with the sheriff’s office and with law enforcement agencies.

Dr. Chau stated the sheriff is fully onboard. He has been involved with the Be Well OC since day one before he was the sheriff. Also, the county works in collaboration with various city police departments as part of Be Well OC.

Commissioner Mitchell stated her concern about spending $18 million for a plan with no services. The funding should be transformative in terms of helping people. She stated the goals are anecdotal; she requested seeing more data or hands-on work that shows that the $18 million will touch lives such as mentally ill homeless individuals. She stated there are payers and partners involved in the planning process but she asked where the clients and family members are.

Dr. Chau stated the Commission is only seeing the application to ask for funding to do some of the work of Be Well. The goal of Be Well OC is not to provide services but how the siloed system can be stitched together to create an informative system. Everyone has data but that data is meaningless unless it is stitched together to reveal impacts in the community and how programs affect the system. He stated no one is left out of the conversation; the homeless community has been involved in the planning process.

Commissioner Berrick asked for clarification of the underlying contracting and payment mechanisms, particularly on the Medicaid/Medi-Cal side.

Dr. Ishikawa asked the consultant who has subject matter expertise in this area to address Commissioner Berrick's question.

John Freeman, Administrator, Dale Jarvis and Associates, stated he has been working with Be Well and helping to support Orange County in this effort. He stated the answer to the blending and braiding question also answers the $18 million question – it is a huge lift to address the legal and other contracting barriers in existence and to get the expertise to go through and identify the funding sources that can be blended and braided, including sources from the private sector. Digging into those things and exploring what can happen gets at the core of what will be addressed through that part of the project to understand what can and cannot happen.

Commissioner Berrick asked about the payment mechanism and if the county is envisioning a capitation or a case rate.

Mr. Freeman stated the clinical design is what needs to be identified through the planning process so the appropriate financial and fiscal design can be applied to it. Then, the funding streams can be identified that will support the clinical design that will deliver the care needed by the community.

Commissioner Berrick stated his understanding that the county is assuming some fairly radical state and/or federal waivers.

Mr. Freeman stated the county will be communicating with the state and the Department of Health Care Services (DHCS) and other involved stakeholders on what can be included in upcoming waivers in the future that could support this work going forward.

Commissioner Berrick asked if funding that is clearly identified and dedicated to mental health might get lost to the health care system.

Dr. Chau stated it will not because, when looking at mental health as the essential health and lifting with the parity care, providers are held responsible for the wellness of the entire individual.

Commissioner Bunch stated parts of this proposal are similar to the proposal to be heard later from Los Angeles County. She asked if Orange County has spoken with Los Angeles County about the similarities and differences in their proposals and whether the counties can work together.

Dr. Nagel stated Orange County has reached out to Los Angeles County and will be working together with them on shared learnings. This is an opportunity to look at what is possible.

Dr. Chau stated both counties want to achieve the same goal but approach it very differently. It would be interesting to have an entity that will evaluate the two counties at the same time.

Chair Tamplen asked Dr. Nagel about his vision for the county and the leadership of consumers and family members throughout the system including at the county behavioral health care services. It is inside and outside the county system that needs to empower and include the leaders.

Dr. Nagel stated he formed a peer employee advisory committee prior to becoming the behavioral health director. That committee, which is composed of individuals with lived experience, meets with him on a monthly basis, develops the vision, and looks at how to transform the system. He stated those meetings are what inspire him. Changes to the system are currently being driven by that peer advisory committee.

Chair Tamplen recommended the Los Angeles County model of bringing in a peer and family chief like Keris Myrick who reports directly to the director, not at a monthly meeting to hear the stories. Those are powerful but it is important to utilize the expertise and the ability of peers to get out into the streets where clinicians do not want to go to connect with the community. She stated Orange County needs someone in the department who reports to Dr. Nagel directly and is his go-to.

Commissioner Wooton stated the need to hire peers for this project who will be helping out as navigators or at the wellness center. She encouraged the county to hire a consumer empowerment manager and to include involvement with family members, as well.

Public Comment

Julia Ransom spoke in support of the proposed project.

Poshi Walker echoed concerns of the Commissioners. The speaker wanted to ensure that services are integrated for LGBTQ communities, particularly transgender individuals, and that there will be services specifically for LGBTQ communities. The speaker urged continued outreach to LGBTQ agencies in Orange County and offered #Out4MentalHealth as a resource for this endeavor. The speaker stated the need for individuals trained in LGBTQ issues to be part of the digital navigation tool.

Tiffany Carter, Statewide Advocacy Liaison, ACCESS California, NorCal MHA, stated ACCESS California is not in support of the proposed project for the following reasons:

- The $7.3 million being allotted to local community consultation mirrors what the CPP dollars should be investing in. It is concerning to see these dollars being spent in a consultation manner rather than in stakeholder engagement and evaluation.
- The mention of peers is present throughout the presentation but one of the main benefits of peers being engaged is that their experiences and their skills are utilized consistently and elevated throughout their services that they provide. This is not being reflected in this program.
- The MHSA is married to the recovery model. There has been references to the clinical design throughout the program, but the intent of the MHSA needs to be reflected through the entire program and not just bits and pieces of it.

Andrea Crook, Advocacy Director, ACCESS California, NorCal MHA, spoke in opposition to the proposed project. The speaker echoed the comments of the previous speaker. This plan is an opportunity to demonstrate the commitment of integrating, elevating, and marrying the recovery model with the historical medical model. The proposed project is heavily clinically-driven. To truly transform the system, the budgets need to reflect the meaningful integration of peers. The county only plans to give stipends to individuals with lived experience to facilitate meetings. The speaker stated the need to ensure that the plan is reflective of the values, philosophy, and intent of the MHSA.

Commissioner Boyd stated his comments will be made in the spirit of healing, collaboration, and doing the right thing. He stated there are various peer groups and they do not always agree, nor does one group reflect all peers or all activities that take place in a county and state. It is troublesome to hear global statements that peers are “not involved” or “not at the table” because, almost without exception, there have been other peers and other organizations that have stepped up and said they were there, and statements like these make them not feel valued, respected, or heard. He asked how ACCESS California navigates and coordinates to the extent possible to ensure that, when statements like that are made, there really are not other peers or peer groups at the table.

Commissioner Boyd asked if there is a statewide process where salaries of peers are approved – a market rate for peers – because this keeps coming up. Various ranges are seen in the counties and it is not fair or right to the Commission to weigh in one way or another without understanding the context for a market rate or community practice. That is a discipline for every other professional group.

Andrea Crook stated the way that ACCESS California ensures that peers from communities are being represented and can speak on behalf of Orange County is through the 30 ambassadors throughout the state. They are the boots on the ground. There are individuals that live in all five MHSA regions and are very active and leaders within the communities throughout the state. In addition, ACCESS California does

trainings and outreach to all five regions in the state with not only the leadership but also the stakeholder communities. The speaker stated what they are asking today and echoing is the sentiment conveyed, which is something that the clients throughout the state are unified on. There may be differences but, when it comes to elevating the voice of peers, that is a sentiment shared from clients throughout the state. In addition to ensuring that there are individuals represented, it would be helpful to hear from those client leaders and stakeholder groups as part of county presentations.

Andrea Crook stated, regarding the salaries, it would be nice to have more information but this was not even a salaried position. This particular plan only allotted stipends. The speaker stated they would love to see more budget detail.

Steve McNally, a member of the Orange County Mental Health Board, speaking as a consumer and family member, spoke in support of the proposed project.

Steve Leoni, consumer and advocate, stated concern about the community planning process and that the private sector has not been a part of it. The speaker cautioned against the tail wagging the dog with hospitals having more political clout than the mental health system, which will cause increased hospitalizations.

Debbie Innes-Gomberg, Deputy Director, Adult System of Care and MHSA, Los Angeles County Department of Mental Health, spoke in support of the proposed project.

Commissioner Discussion

Commissioner Wooton asked if there are funding and positions for consumers and family members within this project.

Dr. Ishikawa stated there are and they are separate and distinct from the stipends for individuals who participate and provide feedback during the community meetings. Consumers and family members will be paid at the same rate as other professionals filling those positions and duties.

Commissioner Boyd asked if there have been peers involved, engaged, and at the table with full participation and equal rights in this process.

Dr. Nagel stated peers have been and will continue to be a part of the process.

Commissioner Boyd stated the work in the health plans noted in the meeting materials cover the most disadvantaged populations around the state and those populations reside in Orange County. He stated the county could learn from Commissioner requests about how to make the project move forward more effectively.

Commissioner Boyd stated lives are lost every day due to the lack of coordination. The Commission is not an administrative body but is a body that helps individuals in their most desperate state more effectively navigate one of the worst systems that have been put together on the front end to help heal people. He encouraged the county to bring in human design expertise to help create a system where individuals can get help when they want it.

Commissioner Mitchell asked if the county will come back to the Commission to demonstrate successes and failures.

Dr. Ishikawa stated the fifth point from the bottom on page 16, Aligning Local Organizations, and the red section, third from the bottom in the meeting materials, are about giving progress updates to the Commission. She stated the county is hoping to work with the Commission on reporting intervals and content.

Chair Tamplen stated staff may ask the county to return with an update in one year.

Commissioner Danovitch made a motion to approve this proposal.

Commissioner Bunch seconded.

Vice Chair Ashbeck stated she was still struggling with the $18 million, $7 million of which is consultation in the first year. She echoed Commissioner Mitchell's comments. She stated she did not know of another plan approved by the Commission in the past with such a great amount of funding that will only produce a plan. There are no deliverables and individuals are not helped. She stated she has led a five-year collective impact project in the past that, at the end, determined they were going down the wrong path. She suggested that projects that are just plans be required to come back at the end of each year to share what has been learned as a check-in along the way.

Commissioner Danovitch amended his motion to include at least one annual report on the achievements around the milestones that are developed.

Commissioner Bunch agreed.

Action: Commissioner Danovitch made a motion, seconded by Commissioner Bunch, that:

The MHSOAC approves Orange County's Innovation Plan as presented with the requirement to include at least one annual report to the Commission on the achievements around the milestones that are developed as follows.

Name: Behavioral Health System Transformation

Amount: $18,000,000

Project Length: Three (3) Years

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

The following Commissioners voted "Yes": Commissioners Anthony, Berrick, Boyd, Brown, Bunch, Danovitch, Madrigal-Weiss, Mitchell, and Wooton, Vice Chair Ashbeck, and Chair Tamplen.

ACTION

3: <u>Ventura County Innovation Plan</u>

Presenters:

- Kiran Sahota, MA, Mental Health Services Act Senior Behavioral Health Manager, Ventura County Behavioral Health

- Hilary Carson, MSW, MHSA Administrator, Innovations, Ventura County Behavioral Health

Chair Tamplen stated the Commission will consider approval of $1,047,100 to support Ventura County's Conocimiento: Addressing ACEs through Core Competencies Innovation Project. She asked the representatives from Ventura County to present this agenda item.

Kiran Sahota, Mental Health Services Act Senior Behavioral Health Manager, Ventura County Behavioral Health, reviewed the background and county demographics. She stated this project is youth-created and 100 percent community-driven.

Hilary Carson, MHSA Administrator, Innovations, Ventura County Behavioral Health, provided an overview, with a slide presentation, of the need, proposed project to address the need, innovative components, evaluation, and budget of the proposed innovation project.

Commissioner Questions and Discussion

Celeste Walley stated she is behind anything that is trauma-informed and deals with adverse childhood experiences (ACEs). She asked how the county will ensure honesty with self-reported data. She asked how individuals will be comfortable and informed about what the surveys ask.

Ms. Carson stated the first six months will include staff hiring and development trainings including an ACEs training. The self-report will be anonymous. The project ensures that the staff know the youth in order to connect them to services rather than relying on the information provided in a survey.

Commissioner Brown asked about the origin of the title word and if it is a grassroots program developed from scratch.

Ms. Carson stated the name came from the individual who submitted the idea. Conocimiento means knowledge-sharing. The meetings begin with participants sharing where they currently are, how they are feeling, and what is going on. It is more about the way of starting meetings and bringing individuals together in a group rather than a preconceived concept or program.

Vice Chair Ashbeck asked if the family liaison will be a paid position and if that is included in the direct cost.

Ms. Carson stated they are included under the Consultant Costs and Contracts budget line item. The budget narrative includes a breakdown including a paid position for the family liaison.

Celeste Walley asked about the type of dinners that will be presented.

Ms. Sahota stated the youth at the centers will plan the dinners.

Public Comment

Melissa Hannah spoke in support of the proposed project.

Zachary Hixson spoke in support of the proposed project.

Onalyn Garman spoke in support of the proposed project.

Aubrey Bader spoke in support of the proposed project.

Sophia Skoe spoke in support of the proposed project.

Mark De Jesus spoke in support of the proposed project.

L. Ruiz spoke in support of the proposed project.

Poshi Walker encouraged the county to look at the Family Acceptance Project. The speaker spoke in support of the proposed project.

Kate English spoke in support of the proposed project.

Action: Commissioner Madrigal-Weiss made a motion, seconded by Commissioner Berrick, that:

The Commission approves Ventura County's Innovation Plan as follows:

Name: Conocimiento: Addressing ACEs through Core Competencies

Amount: Up to $1,047,100

Project Length: Four (4) Years

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

The following Commissioners voted "Yes": Commissioners Anthony, Berrick, Boyd, Brown, Bunch, Danovitch, Madrigal-Weiss, Mitchell, and Wooton, Vice Chair Ashbeck, and Chair Tamplen.

LUNCH BREAK

ACTION

4: <u>Los Angeles County Innovation Plan</u>

Presenters:

- Jonathan E. Sherin, M.D., Ph.D., Director, Department of Mental Health, Los Angeles County
- Anthony Ruffin, Community Center Director, Department of Mental Health, Los Angeles County
- Jesús Romero, Jr., LCSW, MPA, Program Manager, Hollywood Mental Health Center
- David Pilon, Ph.D., C.P.R.P., Mental Health Consultant

Chair Tamplen stated the Commission will consider approval of $116,750,000 to support Los Angeles County's The TRIESTE Project. She asked the representatives from Los Angeles County to present this agenda item.

Jonathan E. Sherin, M.D., Ph.D., Director, Department of Mental Health, Los Angeles County, discussed the need for payment reform.

Anthony Ruffin, Community Center Director, Department of Mental Health, Los Angeles County, discussed the inability to bill for needed services.

Jesús Romero, Jr., LCSW, MPA, Program Manager, Hollywood Mental Health Center, discussed the proposed project to address the need.

David Pilon, Ph.D., C.P.R.P., Mental Health Consultant, stated he was the lead author of the project proposal. He stated payment reform, accountability reform, and documentation reform are extremely important because they are barriers to recovery. He stated the ability to form a relationship has almost twice the effect of any specific practice a person might engage in and bureaucratic and regulatory environments get in the way of that relationship. He provided an overview, with a slide presentation, of the innovative components of the proposed innovation project.

Commissioner Questions

Commissioner Boyd stated this project involves a level of transformation from a cultural perspective. He asked how that kind of change management and cultural transformation is being done that will support this kind of effort.

Dr. Sherin stated if, from the trenches up, providers and consumers can be empowered, it will cultivate cultural change.

Commissioner Berrick stated the proposed project is important for California, not just for the country. The proposed project should have a 50 percent federal funding match. He asked how that can happen.

Dr. Sherin agreed. The goal is to get matching funds that will allow the county to push the new approach to delivering care.

Chair Tamplen asked about the proposed innovation of shifting the provision of wellbeing-focused services. The meeting materials state this creates an assigned health home for each member appropriate to their level of care, but she stated recovery is a journey. She asked what moving through the levels of care looks like.

Dr. Pilon stated level of care is related to how self-coordinating the person is. To some extent, their journey in recovery is a part of that, but individuals can be fairly far along in the journey of recovery and be unable to coordinate all their care themselves. The level of care is defined by the amount of staff support required for quality of life in the community. The proposal recognizes that individuals are at different levels of need and that some individuals may always need help in particular areas.

Chair Tamplen asked how individuals will move through the levels of care.

Dr. Pilon stated, as individuals learn to self-coordinate and manage their own care, they can be moved down to lower levels of care. It is up to the individual as to when they are ready to move to lower levels, based on their level of care.

Vice Chair Ashbeck stated the first year of funding is about planning. She asked about the stakeholder input process to date.

Dr. Sherin stated this has been an organic process since 2017, when a number of individuals went to Trieste, Italy, to study their mental health system. Since then, there have been a number of formal engagements with the community and, when the county hosted mental health experts from Italy and other locations around the world, there were intensive conversations about this type of project.

Dr. Sherin agreed that it is a lot of money and stated it will provoke many new challenges and will only succeed if a collective is created around it. Governments do not solve problems; collective problems require collective solutions. He stated the first year will be spent building the ecosystem, culture, and array of services needed to succeed and achieve outcomes. He stated, in addition to trying to push the envelope around the service array, this project will move the needle with respect to the engagement of every stakeholder and, ultimately, with the voice of consumers out in front.

Vice Chair Ashbeck stated her concern that there is not a presentation slide on the budget. She stated, for $116 million, there should at least be a discussion about the buckets of the funding and how it will be spent.

Dr. Pilon apologized for not including a budget slide in the presentation. He reviewed the basics of the budget plan.

Vice Chair Ashbeck asked if the planning year will include the development of the electronic health record (EHR).

Dr. Pilon stated it will.

Vice Chair Ashbeck asked about integrating the EHR with other systems. Creating another EHR is not helpful because it will not talk to existing EHRs, hospitals, or other mental health services.

Dr. Pilon stated there is nothing being suggested in the documents, accountability, or billing system that could not be done in a current EHR, although there will be improvements by using a cellphone-based technology to gather the data. The EHR will have to be linked to the existing data system but the technology already exists to capture the necessary information.

Dr. Sherin stated, in order to address the segregated medical record issue, there is a focus on systems that will allow communication as a network across all urgent care facilities and emergency departments with the Department of Mental Health. The proposed project is a part of that.

Vice Chair Ashbeck stated the Orange County innovation project is similar yet different from the proposed project. The system will never be transformed with counties working independent of each other. She stated her hope that Los Angeles and Orange Counties will share their learnings.

Commissioner Brown stated Trieste, Italy, and Los Angeles, California, are two very different communities and there is nowhere near the existing problem in Trieste that there is in Los Angeles in terms of mental illness and the co-occurring homelessness and substance abuse. Trieste has been flagged as a model program for many years. He asked why this model has not been tried before in the United States.

Dr. Sherin stated there have been things done in this country that are similar, such as The Village in Los Angeles and the Progress Foundation in San Francisco. He agreed that Trieste, Italy, is very different. The county is not trying to replicate Trieste but is taking fundamental principles from the Trieste model and importing them, such as hospitality and coproduction.

Commissioner Brown stated the biggest difference between the two areas is the economics of it, where the funding comes from, and the lack of bureaucracy in the Trieste version in trying to get services. That is indicative of the social safety net that exists in many European countries, along with the cultural and taxation differences. This project focuses on Hollywood, which has a population of approximately 100,000 individuals, which is approximately 1/40th of Los Angeles's population and can be extrapolated to be a cost of approximately $1.4 billion. Extrapolated out to the state as a whole, the question becomes if the proposed project is financially feasible or sustainable. He stated his concerns about the cost issues, the differences in the existing societal and social safety net systems, and if this is a realistic approach for the problems seen in Los Angeles, which, arguably, are far greater than in Trieste, Italy.

Dr. Sherin stated the budget was reverse-engineered based on the spending to ensure that this project was within the realm of the current fiscal system. He argued that a tremendous amount of funding will be saved by keeping individuals in community rather than having them cycle in and out of hospitals and emergency departments, getting through that system, and being in the streets and in the jail.

Dr. Sherin stated the biggest difference between Trieste and Los Angeles is addictions, which is a massive challenge. He stated the need to figure out how to incorporate the substance use disorder funding and service delivery system as a part of the proposed project. He stated the county does not have all the answers but this has to happen in order to advance and transform the mental health system.

Dr. Pilon agreed that Trieste is more an inspiration for the proposed project. It is anticipated that, through using the model's principles, the costs of hospitalization will be reduced. He stated the hope to provide better outcomes for at least the same amount of money that is currently being provided.

Celeste Walley asked about the model of care and what the intake and closing process would look like.

Mr. Romero stated it will look like providers getting out of their offices and into the street going to where the clients are and doing whatever it takes to help clients have a meaningful life. There will be no wrong door and no wrong way to access services. He stated there is an endless array of possibilities in terms of what it might look like for someone.

Commissioner Mitchell asked who will address the skid row population.

Dr. Sherin stated the county considered skid row for the pilot but chose Hollywood, which has the second greatest area of need. He stated, because the county wanted the pilot program to have a profound impact in an area of massive need, a difficult area was chosen but not the area that is almost impossible. He stated the hope that, through

changes in regulatory constraint, investment, greater flexibility, housing, urgent cares, and engagement of the private sector, there will be a bigger influence in skid row. Locating the project in nearby downtown will raise the bar and the awareness that it will take heroic efforts and courage of politicians to address that issue.

Commissioner Mitchell agreed the skid row will not be healed with one program but suggested future projects that will impact skid row. She used the analogy that an elephant is eaten one bite at a time but, if that bite is not taken, the elephant will never be eaten. She requested that all future proposals include a nibble at skid row.

Commissioner Boyd stated Commissioners are part of a family of Commissioners. Part of the legacy is in those who served before. He asked Richard Van Horn, former Chair and Commissioner of the MHSOAC, to share his thoughts.

Commissioner Emeritus Van Horn stated stakeholder outreach began in the summer of 1980. He stated he was sitting next to Mark Karmatz, who was a member of the first Project Return Club in 1980. That was the first hint that individuals with mental illness could have a life and local support in the community. He stated it morphed from there.

Commissioner Emeritus Van Horn stated the next piece of that was, around the time that The Village was started, he hired Dr. Pilon for the specific purpose of drafting The Village proposal. He stated the importance of that is that he was already thinking about Trieste. He stated he did not go to Trieste, Italy, but to Japan, where he attended a seminar with two individuals in recovery who ran the hotel in Trieste. He stated this was the first time he had heard of individuals in recovery running a business.

Commissioner Emeritus Van Horn stated Project Return then became the Project Return Peer Support Network, which is an independent agency and has its own life.

Commissioner Emeritus Van Horn stated The Village was established January 1, 1990, as a wellbeing model but this term was not yet established. Recovery was just beginning to be discussed; wellbeing as a model had never been considered – 29 years later, the proposed project does. He stated cultural change is incredibly important but the key here is that, in the initial pilot period with The Village 29 years ago, the program was paid quarterly in advance on an annual case rate. In Los Angeles County in that year, 50 percent of all dollars were going into 24-hour care. In the first year of The Village, 4 percent of the dollars went into 24-hour care. The ratio was entirely reversed from 50 percent to 4 percent and where the big money was going was in what was then called “case management,” but what it really was was community support. That is where the proposed project is headed – toward total transformation.

Vice Chair Ashbeck stated she continued to struggle with the fact that there was no slide on the budget and it felt like the proposed project was expected to be approved by the Commission. She asked Commissioner Emeritus Van Horn what counsel he would give to the county about the money.

Commissioner Emeritus Van Horn stated the need to remember that the percentage of the funding going to planning and evaluation is approximately 4 to 5 percent total and 90-plus percent is going into services. The next piece of that is that there are many different services as a part of this first planning year that are wrapped into that bundle.

Almost all of the funding is going into direct services to the people in a defined geographic area. He stated he would not be afraid of not having a detailed budget at this point. There cannot be a detailed budget at this time because there is too much work to be done to get to that level of detail that provides a spreadsheet that shows all of the dollars.

Commissioner Mitchell asked the county to provide biannual reports to the Commission on the milestones.

Commissioner Berrick stated showing the comparison between current expenditures in clinic structure and the expected differences would be helpful.

Chair Tamplen asked how transformative the proposed project will be and about the reimbursement system and documentation for Medi-Cal billing. She asked how individuals will be assessing their level of care and how the power will be given back to the consumer who is there for support.

Dr. Pilon stated, as part of the year-long planning process, the county will ask clients how they would like the project to assess if they are getting what they need in their lives to help the project proponents better understand what clients would like evaluated.

Chair Tamplen asked if the county is open and willing to change questions that clients say do not fit and where they want something different.

Dr. Pilon stated it is.

Dr. Sherin stated he is expecting stakeholder feedback to change things. That is the idea of intensive planning and that is why the county would like to take the time to do that.

Public Comment

Alicia Rhoden, Social Worker and consumer, stated concern that the proposed project will meet the total needs of the client. Home health is a good thing but it must be a peer that can relate to the client and can talk to them like they have sense and not tell them what to do.

Pamela Inaba, Recreation Therapist and ACCESS Ambassador, encouraged hiring peers and family members at all levels of the project.

Mark Karmatz spoke in support of the proposed project.

Rudy Salinas, Chair, Hollywood 4WRD, spoke in support of the proposed project.

Devin Blake, Resources Coordinator, The Center, spoke in support of the proposed project.

Amy Perkins, Director, Interim Housing Strategies, Mayor's Office, spoke in support of the proposed project.

Sarah Dusseault, advocate and family member, Homeless Services Authority, spoke in support of the proposed project.

Yanzie Chow, Asian Americans Advancing Justice-Los Angeles, questioned if this project has been adapted to serve a diverse population, especially Asian/Pacific Island communities.

Patricia Russell, National Alliance on Mental Illness (NAMI), spoke in support of the proposed project.

Jeff Briggs, resident and business owner, Hollywood, spoke in support of the proposed project.

Kris Larson, Hollywood Business Improvement District, spoke in support of the proposed project.

Brian Folb, Hollywood Property Owners Alliance, spoke in support of the proposed project.

Stacie Hiramoto thanked Yanzie Chow for outlining some of the concerns and Commissioners Ashbeck and Mitchell for holding the county accountable. The speaker stated there is no mention in the meeting materials of reducing disparities or hiring staff that speak multiple languages.

Bill Callahan, Peer Action for Change (PACS), spoke in support of the proposed project.

Steve Leoni spoke in support of the proposed project.

Lily Weiner, Hollywood Chamber of Commerce, spoke in support of the proposed project.

Elan Shultz, Los Angeles County, Board of Supervisors, Sheila Kuehl, spoke in support of the proposed project.

Marvin Thompson, consumer, spoke in support of the proposed project.

Carolyn Neal, Hollywood 4WRD, spoke in support of the proposed project.

Caroline Kelly, Former Chair, Mental Health Commission, spoke in support of the proposed project.

Frank Robbins, businessman and family member, spoke in support of the proposed project.

Reba Stevens spoke in support of the proposed project.

Keris Myrick spoke in support of the proposed project.

Lashelle Allison spoke in opposition to the proposed project. The speaker shared experiences of their son trying to navigate the system.

Commissioner Discussion

Vice Chair Ashbeck asked about scale and if the proposed project is transformative if it is not repeatable.

Dr. Sherin predicted that money will be saved along with lives, family, and community. The Department of Mental Health for Los Angeles County has a budget that approaches $3 billion. The county reverse-engineered the budget based on the costs of the area

and looked to take this model forward based on the fact that the current budget covers a certain set of services in communities around Los Angeles County. He stated the county is using the budget based on what it is spending and believes that money will be saved with this model because resources can be used more flexibly to achieve better outcomes. This is a feasible approach to transforming mental health in Los Angeles County.

Commissioner Brown asked about the current budget being spent for the Hollywood area.

Dr. Pilon stated the current budget is approximately $18 million. This project adds in crisis residential services for approximately another $8 million to bring the total to $26 million.

Action: Chair Boyd made a motion, seconded by Commissioner Wooton, that:

The Commission approves Los Angeles County's Innovation Project with the requirement to include a progress report to the Commission in six months, as follows:

Name: Trieste

Amount: Up to $116,750,000

Project Length: Five (5) Years

Motion carried 8 yes, 1 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Berrick, Boyd, Brown, Danovitch, Madrigal-Weiss, Mitchell, and Wooton, and Chair Tamplen.

The following Commissioner voted "No": Vice Chair Ashbeck.

ACTION

5: <u>Streamline Commission Approval of Innovation Plans</u>

Presenter:

- Brian Sala, Ph.D., Deputy Director; MHSOAC

Chair Tamplen stated the Commission will consider options for streamlining procedures for approval of County Innovation Project work plans. She asked staff to present this agenda item.

Brian Sala, Ph.D., Deputy Director, MHSOAC, provided an overview, with a slide presentation, of the Commission agenda time and options for consideration for streamlined Commission approval of innovation plans.

<u>Staff Recommendations</u>:

- Enhance the Role of the Innovation Subcommittee
  - Direct the Subcommittee to oversee implementation of the Innovation Incubator

  - Clarify that plans consistent with Subcommittee recommendations are eligible for Consent Agenda or delegated approval

- Utilize a Consent Agenda
  - Limit to plans for which staff analysis has identified no significant concerns, including from public comment
  - Require approval of the Chair
  - Allow any Commissioner to remove a plan from the Consent Calendar prior to a vote
- Expand delegated authority to Staff
  - Authorize the Executive Director, with the consent of the Chair, to approve county plans that meet any of the following conditions:
    - The county INN budget is $500,000 or less
    - The county plan proposes to join an existing project and would contribute to statewide learning
    - The plan has been developed in partnership with the Commission, such as through the Innovation Incubator

Commissioner Questions

Commissioner Berrick stated, in his experience, consent agendas are used less often than any other type of agenda and are inefficient. The idea of strictly a chair review as opposed to a Subcommittee review does not meet the intent of the oversight role of the Commission. He recommended using the Subcommittee process. The purpose of the Subcommittee is to take the burden off the Commission. He suggested referring new proposals with staff recommendations to a Subcommittee consent agenda. The renewals, particularly items under $500,000, do not need to come back to the Commission. The Subcommittee would then forward the items that should be on a consent agenda and pull items that should be considered by the Commission so there will be a full oversight function at every level.

Commissioner Danovitch stated he would raise the challenge of using the Subcommittee on a regular basis. There a substantial burden that could potentially be put on the members of the Subcommittee if the Subcommittee was required to meet on a monthly basis in order to formulate a consent calendar or agenda for every meeting. If it were done on a less frequent period basis, that might meet the needs of those Commissioners.

Chair Boyd asked if Commissioner Berrick's suggestion was that the Subcommittee would not necessarily go through all of the depth of each proposal but would trust staff recommendations and, in that process, make some decision around what needs to come to the Commission versus a consent agenda.

Commissioner Berrick agreed it would create something of a burden, but having an expanded consent agenda with staff recommendations holding the weight that it can

and should hold does not create an enormous burden on the Subcommittee. The Subcommittee would have effectively two different consent agendas:

- A straightforward approval of staff recommendations for renewals, etc.
- New proposals, which would be divided into two categories:
    - A second consent agenda of staff recommendations to approve where the Subcommittee could pull items off at their discretion.
    - An agenda where staff is less certain or recommends against a proposal where the Subcommittee would have a fuller discussion and would forward those to the Commission.

This would create an expedited process, both for the Subcommittee and for the Commission.

Commissioner Brown asked for greater clarification on what the Subcommittee will do.

Commissioner Berrick stated the first consent agenda that the Subcommittee will look at will contain renewal items, where the executive director has recommended approval, to determine if they agree with staff recommendations or if they want to pull them for the Subcommittee's consideration. Those are for the areas considered to be for staff discretion so they would include a secondary portion of oversight. This first consent agenda will be voted up or down or items will be pulled for further Subcommittee discussion.

Commissioner Berrick stated the second consent agenda that the Subcommittee will look at will contain new proposals with clear staff recommendation in favor to determine if they agree with staff recommendations or if they recommend broader Commission consideration. Items in favor of staff recommendations will go onto a consent agenda for the Commission. Items with less than clear staff recommendations in support will be pulled for the Subcommittee's consideration. The vast majority of those would come to the Commission for consideration.

Commissioner Danovitch stated his understanding that Commissioner Berrick is proposing to use the Subcommittee as the filter rather than the Chair.

Commissioner Berrick agreed.

Commissioner Brown stated this would create more work rather than less work. Any attempt to have the Subcommittee be involved in the process puts an undue burden on the Subcommittee and will make recruitment for the Subcommittee difficult. He stated the Commission will still maintain oversight while delegating authority to staff because items will come back to the Commission on a consent agenda as recommendations. The Commission will still receive and review the materials in a packet, including a one-page summary of the plans, prior to voting on them.

Commissioner Berrick stated the items that would come to the Subcommittee on a consent agenda would be heard as a single item and would not be presented by staff unless they were pulled in some way. The consent items are considered as a whole.

Commissioner Brown stated the items would have to be reviewed in order to get on a consent agenda for approval by the Commission.

Commissioner Berrick stated items would require only staff approval to get to the Subcommittee consent agenda.

Commissioner Brown asked about the value of having the Subcommittee be that interim step. He suggested that staff make the recommendations that come to the Commission consent agenda.

Commissioner Berrick stated the items in the first consent agenda would never come to the Commission.

Executive Director Ewing stated the proposal prepared by staff does not require the Subcommittee to meet to validate the staff recommendations. Staff recommendations would be validated by the Chair. The consent agenda would need to be adopted by the Commission in a public hearing. He stated his understanding that Commissioner Berrick is proposing hearing consent calendar items at the Subcommittee and Commission levels.

Commissioner Berrick stated he was suggesting that items that are renewals for $500,000 or less go on a consent agenda that never comes to the Commission.

Executive Director Ewing stated the Commission has delegated authority to staff to approve extensions of existing plans under the condition that they are less than $500,000 or 15 percent of the original proposal. Those items are done administratively and are not reviewed by the Commission.

Executive Director Ewing stated staff is proposing that, if there is a county proposal that has not raised substantive objections through the staff analysis or in public comment, it would be written up as a proposed consent item. The Chair sets the agenda for the Commission and, with the Chair's consent, the item would be put on a consent calendar.

Executive Director Ewing stated, as with the current process, the full analysis would be sent to Commissioners. Any Commissioner at any time could pull a plan. There would be a full Commission review through the voting process. The concept of creating a package of consent items is modeled after the Legislature's Committee process.

Commissioner Brown stated he was fine with the staff recommendations. The only clarification is, if staff recommended not approving a project, that there would be an appeal process for that county to take before the Commission.

Deputy Director Sala stated the intent is to work through the Chair on both of those processes. He stated, if the Chair either disagreed with the staff recommendation of rejection or felt it was appropriate to bring it to the Commission for full review or consent review, then that would be the alternative. This would be the process to ensure that counties had the opportunity for review.

Commissioner Wooton stated statute specifies that innovation plans are to come to the Commission for approval. She asked if laws would need to be amended if the process is changed.

Commissioner Wooton asked how streamlining the Commission approval process will impact the stakeholder process.

Deputy Director Sala stated the current process is to provide notice to stakeholders through the email LISTSERV when a county submits a draft plan for 30-day public comment or when a final county plan is received. Public comment is then incorporated into the staff analysis. This mechanism is already in place; the intent is to continue the staff analysis process including capturing public comment as a mechanism to ensure that the public can particulate. Items brought before the Commission on consent are subject to Bagley-Keene Open Meeting Act requirements – there will be an opportunity for public comment on items on the consent calendar prior to a vote on the consent calendar with the Commission.

Commissioner Wooton stated this is not always effective. Sometimes one letter is received, if any, during 30-day public comment periods in her county.

Commissioner Danovitch agreed. He stated he is strongly in support of making the current innovation plan approval process more efficient because, as important as innovation plans are, there are many other things the Commission needs to be doing that it is unable to because of the time required approving innovation plans.

Commissioner Danovitch stated he liked staff's idea of a blended approach of delegating authority, using a consent agenda, and enhancing the role of the Subcommittee. He suggested enhancing the role of the Subcommittee by using the Subcommittee to manage the Innovation Incubator. The mechanism of the incubator could improve proposals and address concerns without encumbering a Subcommittee with becoming a new administrative bottleneck.

Commissioner Danovitch suggested extending the delegated authority by increasing the cap to $2 million. As long as Commissioners would have the ability to pull from the consent calendar, it would address the concern that Commissioner Berrick raised about the oversight responsibility.

Commissioner Wooton stated, when innovation plans are reviewed at Commission meetings, it raises an awareness about mental health.

Commissioner Danovitch suggested taking the opportunity to use something that has been successfully done with prevention and early intervention funds and scaling that across different counties. He used the example of We Rise and suggested that it could be a traveling exhibition that has local artists. There are ideas and ways that the Commission can pursue its mission when not solely focusing on innovation plan approval. The idea would be to broaden the focus to other ways to pursue agendas.

Commissioner Brown agreed and stated, arguably, the Commission could get more focused on some of what is successful and happening in counties when not solely focused on innovation plan approval. Instead of focusing on innovative programs that have not yet been tried, the Commission could focus more on what is working and how to replicate that in other areas.

Vice Chair Ashbeck stated the question is the criteria for consent calendar items. The Commission has discussed over the years how to arrange projects in tiers. Some

projects require a two-hour discussion while others can go on a consent calendar. She suggested an ongoing agenda item where a county comes back and reports to the Commission on approved innovation plan successes, failures, and lessons learned. She stated that loop needs to begin to close so there are not 58 iterations of the same thing across California. She stated it is about how projects are ranked and how consent calendar items are determined. She agreed with extending the delegated authority by increasing the cap to $2 million. She stated the need to get to what has been learned from what has been done; otherwise, nothing will be transformed.

Commissioner Mitchell stated she loved the idea of an ongoing agenda item dedicated to lessons learned because Commissioners do not see the results of the programs they have approved.

Commissioner Madrigal-Weiss agreed with an ongoing agenda item dedicated to lessons learned but stated she did not only want to hear whether programs worked or not. She stated course-correction is important. It is important to learn how the county identified what was working, what was not working, and what they did to change the course. It is not all or nothing but about being thoughtful about making the necessary modifications for success. This way, success is always strived toward.

Executive Director Ewing suggested including representatives from entities such as the DHCS, the Center for Medicaid and Medi-Care Services, and from other states to do a deeper dive into not only what the lessons learned were in a county but about the lessons learned for the broader system because the intent is for the innovations to shape the system to drive change. There has never been an ability to do this before because ambitious projects have never been attempted before. It is important for the Commission to hear from the decision-makers at the state and federal levels on their receptiveness to shifting some of the state rules to allow innovations to flourish. This is difficult to do when most of the Commission's time is taken on approving plans. Alternatives would be to move to two-day meetings, bimonthly meetings, or shift the burden of this process to a Subcommittee. He stated, for the Commission to engage the innovation component so that it is impacting statewide transformational change, it needs to be involved differently and more deeply into the projects, particularly how they influence state practices.

Commissioner Berrick stated he was happy to defer to Commissioners Brown and Danovitch and Vice Chair Ashbeck. He stated his goal is to not have a consent agenda where a bunch of items are pulled off. He stated the need to ensure there is enough due diligence for each project and agreed that there could be a more thoughtful use of the Commission's time.

Public Comment

Poshi Walker stated, although they love the staff, staff cannot be subject matter experts on all marginalized populations. There have been so many projects that have come before the Commission that passed through staff that were then questioned or even voted down. The speaker has found as an advocate that the LGBTQ issues are almost always overlooked and those populations often were not engaged well in the community planning process. Having a voice at the statewide level is important.

Poshi Walker stated concern about what happens to a county if something is pulled off the consent calendar. The speaker stated appreciation that items can be pulled off the consent calendar for further review but stated the need for some sort of process. The speaker suggested that the Commission use its subject matter experts from their stakeholder contracts.

Poshi Walker stated they are on the LISTSERV and receive emails from the Commission but it is an onerous process to read through whole innovation proposals without being able to ask questions. The speaker stated stakeholders may not understand what they are reading without the ability to ask questions. Also, this is not part of the deliverables. The speaker recommended that reviewing innovation projects and providing feedback be made a deliverable for the stakeholder contractors to provide the time and resources to do it as part of the advice to staff, the Commission, and the counties about concerns seen in these projects.

Poshi Walker recommended that counties have a webinar for the public comment process to allow individuals to ask questions. There are not many stakeholders, especially consumers, who can read a large report and figure out what is going on. Having a webinar with a PowerPoint and the ability to ask questions through chat or voice would facilitate a better stakeholder process and would allow that vetting prior to innovation projects coming to the Commission and on consent.

Poshi Walker asked if there will be a process for members of the county to request a public vote in the case that the county may not have done their job.

Stacie Hiramoto stated the details for this agenda item were not available until today. More comments and letters could have been given if individuals knew about the recommended options. Stating that this item will be discussed on the agenda is not enough detail for consumers, family members, and individuals in the community to write a letter when they did not know the options that would be presented.

Stacie Hiramoto stated reviewing these plans is important. The speaker stated, if the Subcommittee were in charge, Commissioners could be a part of it on a rotating basis such as for three-month terms. The public’s ability to comment is at the legislative Committee level, not when bills go to the floor.

Stacie Hiramoto agreed that counties should provide progress reports to the Commission but asked to what end and how that information will spread. The speaker stated the counties should be doing this already. The speaker stated the biggest thing that REMHDCO will object to is more authority to staff without the ability for robust public comment.

Ahmad Bahrami. Fresno County Department of Behavioral Health, asked that the Commission consider the new proposal to authorize the Commission or staff to provide approval or convene a special meeting for Commissioners to formally approve counties joining one or more of the identified multicounty MHSOAC-sponsored innovation projects. The speaker stated Fresno County is one of ten counties that are seeking to join a statewide MHSOAC-sponsored project using reversion funds that will sunset in five weeks. This would not be possible with the current process.

Kiran Sahota stated to bring an innovation concept from start to finish is a difficult process and counties are not allowed to present their innovation ideas to the Commission until this difficult process has been completed. Counties also race against the clock against reversion. The speaker stated Ventura County had two innovation projects ready last year that, because of waiting in the queue to be heard at a Commission meeting, did not start until the following fiscal year. These projects were both under $500,000 each and may have been approved months earlier through a consent calendar process.

Kiran Sahota stated Ventura County would love to report on the progress of their approved innovation projects but does not want to take other counties' time to get their innovation projects approved. The speaker implored the Commission to find an alternative option to counties coming and presenting before the Commission. Travel for small counties is difficult.

Anne Kim stated they would love to see innovations translate into programs in mental health that is responsive to where individuals are and where they need it.

Commissioner Discussion

Commissioner Brown moved the staff recommendations with the modification to the enhanced delegated authority to increase the authority for any plan that was $1 million or less rather than $500,000.

Commissioner Danovitch seconded. He stated the criteria for the extend delegated authority option would be the price of the proposal or that it went through the incubator.

Commissioner Berrick asked what the process would have been if the proposal brought forward in Agenda Item 4 had gone through the incubator.

Commissioner Danovitch stated there would be communication between the Executive Director and the Chair as to whether that particular project should be agendized for full consideration or approved through the delegated authority.

Commissioner Berrick stated his understanding that, hypothetically, Agenda Item 4 could have been approved through the delegated authority.

Commissioner Danovitch stated it could have been approved through the delegated authority under that condition.

Executive Director Ewing added it could have been approved through the delegated authority only on the condition that it had gone through the Innovation Incubator. Part of that package of proposals is that it would have been vetted by the Innovation Subcommittee. If the Subcommittee had elected to invest in that project, it would have shaped it, there would have been public meetings of the Subcommittee, and, only with the Chair's consent, then it would have gone through the streamlined delegated authority.

Commissioner Danovitch stated that pathway does not currently exist but must be developed.

Commissioner Brown stated it would have been unlikely that Agenda Item 4 would have gone through on a consent agenda because of the language “had not raised substantive issues or concerns, including public comments received by the Commission.”

Vice Chair Ashbeck stated she was uncomfortable having the Innovation Subcommittee option in the motion when the process is unclear. She stated attending meetings takes a three-day commitment due to travel time.

Commissioner Brown stated he would be happy to amend his motion to not include the Innovation Subcommittee. He asked staff to present the clarified process at a future meeting for Commission consideration. He stated his amended motion includes only the establishment of the consent calendar and the delegation of authority to staff and the Executive Director with the amount to be raised to $1 million.

Executive Director Ewing stated the mental health system is running at approximately $8.5 billion; innovation funds are approximately 1 percent of the funding. The Commission has not had the opportunity to ask questions about the other 99 percent of the funding. The Commission’s ability to engage on the entire mental health system is constrained by time and staff.

Action: Commissioner Brown made a motion, seconded by Commissioner Danovitch, that:

The MHSOAC adopts the staff recommendations to utilize a consent agenda and expend delegated authority to staff with the modification of increasing the authority for any plan that is $1 million or less, and directs staff to present a clarified process to enhance the role of the Innovation Subcommittee at a future meeting for Commission consideration.

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

The following Commissioners voted “Yes”: Commissioners Berrick, Boyd, Brown, Bunch, Danovitch, Madrigal-Weiss, and Mitchell, Vice Chair Ashbeck, and Chair Tamplen.

The following Commissioner abstained: Commissioner Wooton.

GENERAL PUBLIC COMMENT

Lashelle Allison shared her experiences in trying to work through the system for her son, who is in a full-service partnership program in Los Angeles County. The speaker asked about alternatives for families who have filed grievances with the patient rights offices that have not been acted upon.

Executive Director Ewing stated, under state law, there is a process called the issue resolution process. The first step is to try to engage the county and, if dissatisfied, to then appeal to the DHCS. The DHCS will follow up to work with the family to try to resolve grievances. He stated staff will be happy to walk Lashelle Allison through that process. He provided his email address to Lashelle Allison.

Lashelle Allison stated they are tired of emailing everyone. The speaker has been counseled to file a lawsuit because nothing will be done.

Commissioner Mitchell stated everyone has a connection to mental illness. She stated she has a child with severe mental illness who is in and out of systems. She stated she understands Lashelle Allison's pain and frustration. She stated, to be the most effective advocate for her child, there is a way to approach the system because the system is needed. She offered to mentor, advocate for, and be whatever Lashelle Allison needs in order to get them the help that either they or their son needs. Commissioner Mitchell cautioned that there is a time and a place; there is a way to be loud and be heard. She stated she is willing to teach Lashelle Allison how to do that in the most effective manner to get what they need, if they are willing to listen and learn. She stated she will give Lashelle Allison her contact information.

Poshi Walker stated a hard copy of the State of LBGTQ Communities Report is now available. The statewide convening will be May 28th with a reception that evening. The speaker invited Commissioners and staff to a special pre-conference gathering. The speaker also distributed this year's brochure.

Mark Karmatz stated the system's leadership meetings are no longer being held. The monthly meetings need to be reconvened so more input can be given at local meetings.

Ruth Tiscareno, parent and advocate, stated the phrase "peers and family members" does not include parents and caregivers. If the word parents is not used in the conversation, the speaker does not feel included.

Mimi Martinez, Deputy Director, Los Angeles County Department of Mental Health, thanked the Commission for convening this meeting at We Rise and for approving the innovation project this afternoon. The speaker stated a lot of what the county is doing, including the Trieste project, is about connectiveness and purpose.

Ricardo Kim, Service Area Advisory Committee, Los Angeles County Department of Mental Health, agreed with Commissioner Mitchell's comments on revisiting skid row. The speaker asked the Commission to consider what can be done for skid row when hearing the reports from the Trieste project.

Commissioner Wooton stated ACCESS California's annual conference is to be held on August 23rd at the California Endowment in Los Angeles.

Celeste Walley thanked the Commission for including her at the table to help make decisions today and thanked the public for the comments made. This experience has shined light on both barriers and benefits each project presented, which has helped her determine how to implement those types of changes in programs to come.

ADJOURN

There being no further business, the meeting was adjourned at 4:42 p.m.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Teleconference Meeting
June 10, 2019

MHSOAC
Darrell Steinberg Conference Room
1325 J Street, Suite 1700
Sacramento, CA 95814

Additional Public Locations

811 Wilshire Blvd, Suite 1000
Los Angeles, CA 90017

2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

9300 Valley Childrens Place
Madera, CA 93636

State Capitol, Room 2082
Sacramento, CA 95814

13650 Mindanao Way
Marina Del Rey, CA 90292

7919 Folsom Blvd, Suite 180
Sacramento, CA 95826

6925 Chabot Road
Oakland, CA 94618

1144 Camino Del Rio
Santa Barbara, CA 93110

866-817-6550; Code 3190377

Members Participating:

Khatera Tamplen, Chair (via teleconference)
Lynne Ashbeck, Vice Chair (via teleconference)
Mayra Alvarez (via teleconference)
Reneeta Anthony (via teleconference)
Senator Jim Beall (via teleconference)
Ken Berrick (via teleconference)
Keyondria Bunch, Ph.D. (via teleconference)
Gladys Mitchell
Tina Wooton (via teleconference)

Members Absent:

John Boyd, Psy.D.
Sheriff Bill Brown
Assembly Member Wendy Carrillo
Itai Danovitch, M.D.
David Gordon
Mara Madrigal-Weis

Staff Present:

Toby Ewing, Ph.D., Executive Director
Norma Pate, Deputy Director, Program, Legislation, and Technology
Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations
Tom Orrock, Chief, Commission Operations and Grants

CONVENE AND WELCOME

Chair Khatera Tamplen called the teleconference meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:04 a.m. and welcomed everyone. Norma Pate, Deputy Director, Program, Legislation, and Technology, called the roll and announced a quorum was not yet present. A quorum was achieved after Commissioner Anthony arrived.

Chair Tamplen reviewed the meeting protocols.

ACTION

1: Transition Age Youth Request for Proposal Outline

Presenter:

- Tom Orrock, Chief of Commission Operations and Grants, MHSOAC

Chair Tamplen stated the Commission will consider approval of an outline for the Request for Proposal for Transition Age Youth (TAY) mental health advocacy. She asked staff to present this agenda item.

Commissioner Berrick recused himself from the discussion and decision-making with regards to this agenda item pursuant to Commission policy.

Tom Orrock, Chief of Commission Operations and Grants, MHSOAC, provided an overview, with a slide presentation, of the background, community engagement, contract structure, scope of work, and minimum qualifications for state- and local-level contractors.

Commissioner Questions

Commissioner Alvarez asked if the new hybrid approach also includes additional technical assistance (TA) for the statewide contractor to administer since it is a new responsibility being placed on them.

Mr. Orrock stated a lot of the TA takes place in the stakeholder collaboration component. A cohort of state-level advocates meets regularly to share important information with each other. Whether the statewide contractor will require additional TA will require further thought.

Public Comment

Sally Zinman, Executive Director, California Association of Mental Health Peer-Run Organizations, stated these advocacy contracts are important. Youth and all constituency groups should operate their own services; they are directly impacted and know what they need. The speaker referred to number 4 on page 2, “at least 51 percent of the program staff, board members, or advisory board members are TAY.” The speaker suggested including the word “and” so it would read, “at least 51 percent of the program staff and board members or advisory board members are TAY.”

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), did not disagree with the previous speaker but asked for clarification on the word “or” regarding the 51 percent. It needs to be clarified when the RFP goes out. The speaker suggested clarifying that the applicant must specify how they will reach racial, ethnic, LGBTQ, and other underserved communities, including English learners. The speaker suggested including a place to list local organizations planning to apply that are willing to partner and the communities, youth, or areas that they serve, to allow statewide organizations who wanted to partner to contact them.

Ruth Tiscareno, parent and advocate, was happy that the term “parents and caregivers” was included. The speaker suggested the involvement or participation of a parent or caregiver of 16- through 18-year-old youth. There are different views and laws for youth who are over 18 years of age. The 16- through 18-year-old TAY voice tends not to be heard because of their age.

Monique Hart-Washington (phonetic), Chair, Children, Teens, and Young Adults Committee, Contra Costa County, asked about the plan once the TAY staff age out since TAY will comprise 50 percent of the staff. It would be good to address long-term employment in the plan.

Commissioner Discussion

Commissioner Wooton suggested amending number 4 on page 2 to read “and 51 percent of the program staff, board members, and advisory board members are TAY.”

Commissioner Mitchell asked if all organizations can meet the requirement to include 50 percent TAY in all three areas.

Mr. Orrock stated staff would be concerned about that criteria based on history and lessons learned - there were only two applicants for the last TAY RFP. This additional restriction may create a barrier for many organizations. The thinking behind the word “or” versus “and” was to allow more organizations to meet the minimum qualifications to apply for the RFP.

Commissioner Wooton stated she understood that but, as was stated in public comment, it is the voice of the individuals who are receiving the services that should be planning their services and activities. The applicants should try to meet this.

Mr. Orrock stated the way to do this is to ensure that there is a wide gate so organizations can apply, and then to ensure that the activities and events are created, crafted, and led by TAY at the local and state levels in order for them to be effective.

Commissioner Mitchell suggested putting Mr. Orrock's language in. Changing the "or" to "and" will eliminate potential programs that would like to at least try to meet the requirements. It is better to write in that the activities are led by TAY.

Mr. Orrock stated staff would ensure that TAY-led activities and events are part of the main concept.

Commissioner Mitchell made a motion to approve.

Commissioner Wooton seconded with the friendly amendment to amend number 4 on page 2 to read "and 51 percent of the program staff, board members, and advisory board members are TAY." She stated, if the Commission cannot agree with this, she offered the friendly amendment that number 4 on page 2 include the phrase "TAY-led activities."

Commissioner Mitchell suggested going forward with the language as presented and asking staff to work "TAY-led activities" language into the RFP.

Action: Commissioner Mitchell made a motion, seconded by Commissioner Wooton, that:

- *The Commission approves the proposed outline of the scope of work for the TAY RFP and asks staff to work "TAY-led activities" language into the RFP.*
- *The Commission authorizes the Executive Director to initiate a competitive bid process.*

Motion carried 6 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Beall, Mitchell, and Wooton, and Chair Tamplen.

ACTION

2: <u>Contract Authority</u>

Presenter:

- Dawnté Early, Chief of Research and Evaluation, MHSOAC

Chair Tamplen stated the Commission will consider authorizing the Executive Director to enter into two or more contracts not to exceed $1,300,000 to support research and evaluation efforts, and two or more contracts not to exceed $214,000 to support communication efforts and IT services. She asked staff to present this agenda item.

Dawnté Early, Ph.D., Chief of Research and Evaluation, MHSOAC, provided an overview, with a slide presentation, of the goals and proposed funding for four contracts.

Public Comment

Steve Leoni commented about consumer and family participation. The first three of the four contracts are mostly technical, although, even there, the first contract talks about training individuals for policy research. Sometimes there are sources within consumer and family communities. The speaker stated the need to ensure that that was included in the curriculum.

Steve Leoni stated the need for robust stakeholder participation in the fourth contract with individuals, including consumers and family members, from the various communities the anti-stigma is focusing on.

Stacie Hiramoto stated REMHDCO sent a letter with its concerns to staff. REMHDCO wants to support the Commission's work but information on these contracts was not made available until Friday morning and the information was limited, making it difficult to determine whether it should be supported. There are questions about what the first grant is to be used for. This process is not in the spirit of the MHSA. An Evaluations Committee meeting would have been an ideal way for stakeholders to ask questions such as where this money comes from, how long it will go on, what the qualifications are, and what the U.C. is being asked to do. The speaker requested Committee meetings where million-dollar contracts could be discussed and stakeholders could ask questions.

Tiffany Carter, Assistant Statewide Advocate, ACCESS California, Mental Health America of Northern California (NorCal MHA), echoed Stacie Hiramoto's comments. The speaker questioned the use of the evaluation goals and measurement tools that will be implemented throughout the state. The speaker also questioned the tracking mechanism for the collection and tracking of mental health data. The speaker asked about the tracking tools for meaningful recovery outcomes deliverable from U.C. San Diego. It is premature to enter into additional contracts without a standardized tracking mechanism in place.

Executive Director Ewing stated the reason for this agenda item is because the amount of the contracts is above the delegated authority provided by the Commission. He stated this is a personnel issue. This work normally would be done by state employees, but, as the Commission has gotten into higher-level data analytics, the data tools are more complex. This proposal allows the Commission to contract for staff from the University of California to do the higher-level technical data work and to provide training for staff.

Action: Commissioner Berrick made a motion, seconded by Commissioner Beall, that:

The Commission authorizes the Executive Director to enter into four contracts as follows:

- *Regents of UC, San Francisco, for research and evaluation support*
  - *Not to exceed $1,161,008*
- *Crusade, Inc., for website support*
  - *Not to exceed $103,990*

- *Tableau Software for data visualization software*
  - *Not to exceed $130,079*
- *Crossings TV for multicultural and multilingual commercials and segments*
  - *Not to exceed $109,880*

Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Beall, Berrick, Mitchell, and Wooton, and Chair Tamplen.

GENERAL PUBLIC COMMENT

Ruth Tiscareno stated language is important, especially with the TAY population. The term "resiliency" is more appropriate for this population than terms such as "the recovery model." Recovery makes TAY feel that they need to get fixed.

Andrea Crook, Advocacy Director, ACCESS California, NorCal MHA, suggested posting a report and the tool that was created through the work the Commission did through UC San Diego.

Mark Karmatz asked why Senate Bill 10 was pulled off the menu for tomorrow. The speaker also requested a list of the names of the statewide organizations for the RFP so local organizations can have the opportunity to network with them.

Steve Leoni stated the word "recovery" was adopted in the client community many years ago and it means something closer to resilient. It is about getting lives back and getting back on track. There are false assumptions, such as in the clinical community, that recovery means being cured, better, well, and it is done, but that is not how the client community has been using it. It is now in danger of being lost. The difference between the word "resilience" and "recovery" is not great. It is important that the TAY population understand how this word is being used.

ADJOURN

There being no further business, the meeting was adjourned at 10:22 a.m.

AGENDA ITEM 2

Information

July 25, 2019 Commission Meeting

Criminal Justice Data Linkage Project Update

Summary: The Commission will be presented with an update and relevant findings in the Commission's ongoing Criminal Justice data linkage efforts.

The Mental Health Services Act (MHSA) specifically identifies reducing criminal justice involvement as one of the key goals of the MHSA. Individuals with serious mental illnesses are estimated to be incarcerated at about twice the rate of the general population. The Commission has recently invested in a variety of activities to better understand the drivers of criminal justice involvement for and better meet the needs of people with mental health challenges, from a major policy research project completed in 2017 to several new, Commission co-sponsored or incubated, multi-county projects.

In support of those efforts, Commission staff have investigated statewide data on the arrest histories of Full Service Partnership (FSP) partners by linking California Department of Justice arrest data to FSP client data. Data for this study included more than 64,000 FSP clients ages 18 years and older at enrollment between July 1, 2007 and June 30, 2016.

Preliminary findings show that arrest rates for FSP clients decline by nearly 50 percent during their partnership as compared to the 12 months prior to enrollment and by nearly 30 percent during the 12 months after exiting a program as compared to the 12 months before enrollment. Strikingly, arrest rates for "high-utilizers," clients who were arrested 3 or more times in the 12 months before enrollment, demonstrated the highest rates of decline during FSP program participation compared to "low-" (1-2 arrests) utilizers.

Findings from this study highlight the positive potential impact that FSP programs can have on criminal justice involvement and the need to better understand which features of FSP programs that have the greatest impact on reducing arrests and improving partner welfare.

Presenter:

- Dawnté Early, Ph.D., MA, Chief of Research and Evaluation

Enclosures: None.

Handouts: A PowerPoint presentation will be provided.

AGENDA ITEM 3

Action

July 25, 2019 Commission Meeting

Legislative and Budgetary Priorities

Summary: The Commission will receive an update on legislative activities, consider support for additional legislation and discuss potential future budget priorities.

Background: The Legislature is on Summer Recess from July 12 to August 12 and Interim Recess begins September 13, leaving one month to finalize legislative priorities for the 2019 calendar year. The Governor and Legislature are finalizing decisions for the 2019-20 Fiscal Year and the State's budget process for the 2020-21 fiscal year begins in September.

The Commission has been asked by the authors to consider supporting the following bills: Assembly Bill 480 (Salas): Mental Health Older Adults and Senate Bill 665 (Umberg): Mental Health Services Fund: County Jails. Additionally, the Commission is sponsoring SB 582 (Beall), relating to the Commission's administration of the Triage Grant Program. Recent passage of the Mental Health Student Services Act, as part of the 2019-20 state budget, may impact the bill and the opportunity it creates.

Consider the following:

Assembly Bill 480 (Salas): Would establish, within the State Department of Health Care Services, an Older Adult Mental Health Services Administrator to oversee mental health services for older adults. AB 480 would require that position to be funded with administrative funds from the Mental Health Services Fund. The Administrator's responsibilities would include: developing outcome and related indicators for older adults to assess the status of mental health services for older adults, monitoring the quality of programs for those adults, and guiding decision making on how to improve those services. The Administrator also would work in close coordination and collaboration with the Commission, the California Department of Aging, county behavioral health departments, and other relevant entities and stakeholders.

Presenter: Norma Pate, Deputy Director, MHSOAC

Senate Bill 665 (Umberg): Would authorizes a county to use Mental Health Services Act (MHSA) funds to provide mental health services to persons incarcerated in a county jail for a conviction other than a felony and to persons subject to mandatory supervision. Under current law, MHSA funding cannot be used for persons in state prison, on state parole or persons in a county jail, with the exception of services for persons in a jail that are supportive of release planning. SB 665 would authorize County Supervisors, subject to the community planning provisions of the MHSA, to allow MHSA funds to be used to support services for persons in a county jail. However, MHSA funds could not be used for persons in jail with a felony conviction.

Presenter: Toby Ewing, Executive Director, MHSOAC

Senate Bill 582 (Beall): Would require the Commission, when making Triage grant funds available on or after July 1, 2021, to dedicate at least half of those funds to support projects developed through a partnership that includes a local educational agency and a county mental health department or other mental health provider. The bill is in response to the Commission's work to ensure Triage funding is available to support school mental health needs.

Presenter: Senator Jim Beall

The Senator will provide an update on the status of SB 582, which the Commission is sponsoring and discuss how the bill may relate to the newly enacted Mental Health Student Service Act, which provides $50 million for school-county mental health partnerships. Of those funds, $40 million are one-time and $10 are on-going.

Enclosures (9):

- **Assembly Bill 480 (Salas)** Bill Text, Fact Sheet, Senate Health Committee Analysis.
- **Senate Bill 582 (Beall)** Bill Text, Fact Sheet, Assembly Education Committee Analysis.
- **Senate Bill 665 (Umberg)** Bill Text, Fact Sheet, Senate Health Committee Analysis.

Handout: None

AMENDED IN SENATE JUNE 25, 2019

AMENDED IN ASSEMBLY APRIL 22, 2019

AMENDED IN ASSEMBLY APRIL 11, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 480

Introduced by Assembly Member Salas

February 12, 2019

An act to add Article 5 (commencing with Section 5816) to Part 3 of Division 5 of the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

AB 480, as amended, Salas. Mental health: older adults.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs, including the Adult and Older Adult Mental Health System of Care Act. Existing law authorizes the MHSA to be amended by a 2/3 vote of the Legislature if the amendments are consistent with, and further the purposes of, the MHSA, and also permits the Legislature to clarify procedures and terms of the MHSA by a majority vote.

This bill would establish within the ~~California Department of Aging~~ *State Department of Health Care Services* an Older Adult Mental Health Services Administrator to oversee mental health services for older adults. The bill would require that position to be funded with administrative funds from the Mental Health Services Fund. The bill would prescribe the functions of the administrator and its

responsibilities, including, but not limited to, developing outcome and related indicators for older adults for the purpose of assessing the status of mental health services for older adults, monitoring the quality of programs for those adults, and guiding decisionmaking on how to improve those services. The bill would require the administrator to receive data from other state agencies and departments to implement these provisions, subject to existing state or federal confidentiality requirements. The bill would require the administrator to report to the entities that administer the MHSA on those outcome and related indicators by July 1, 2022, and would authorize the administrator to make the report available to the Legislature, upon request. The bill would also require the administrator to develop a strategy and standardized training for all county mental health personnel in order for the counties to assist the administrator in obtaining the data necessary to develop the outcome and related indicators.

This bill would declare that it clarifies procedures and terms of the Mental Health Services Act.

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

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

SECTION 1. Article 5 (commencing with Section 5816) is added to Part 3 of Division 5 of the Welfare and Institutions Code, to read:

Article 5. The Older Adult Mental Health Services Administrator

5816. (a) There is within the ~~California Department of Aging~~ *State Department of Health Care Services* an Older Adult Mental Health Services Administrator who shall oversee mental health services for older adults. The administrator position shall be funded with administrative funds pursuant to, and shall act in accordance with the purposes described in, subdivision (d) of Section 5892.

(b) The Older Adult Mental Health Services Administrator shall work in close coordination and collaboration with stakeholders, including, but not limited to, the following:

(1) The Mental Health Services Oversight and Accountability Commission.

(2) The Director of ~~Health Care Services.~~ *the California Department of Aging.*

(3) County behavioral health services departments.

(4) Any other relevant stakeholders to ensure that older adults have access to necessary behavioral health services and supports.

(c) In order to fulfill duties to consumers and family members as well as the requirements for research and evaluation of mental health services and outcomes as described in subdivision (d) of Section 5892, the Older Adult Mental Health Services Administrator's responsibilities shall include, but shall not be limited to, the following:

(1) Service integration for mental health services for older adults.

(2) Determining which outcome and related indicators counties are currently collecting, and which current services are being offered.

(3) Developing outcome and related indicators for older adults, using existing data, for the purpose of assessing the status of mental health services for older adults, for monitoring the quality of programs intended to serve those older adults, and to guide decisionmaking on how to improve those services.

(4) Ensuring that indicators shall reflect the following issues, including, but not limited to, screenings and assessments of affective disorders, suicide risk and suicide rates, medication review, cognitive review and assessment, alcohol use and substance misuse, housing and independent living assessment, social connections and social isolation, consumer and family satisfaction with care, access to care overall and for diverse populations, continuity and integration of care, health services utilization such as psychiatric hospitalizations and emergency room use for mental and behavioral health care, the number of eligible older adults with a mental health service need compared with the number of eligible older adults who received services in the measurement year, and services provided on a regional basis to determine regional areas with the greatest need for services.

(5) To the extent that data does not exist to sufficiently determine the outcome and related indicators identified in paragraph (4), working with all relevant stakeholders to develop a strategy to identify high-level indicators, including, but not limited to, for those indicators from paragraph (4) that cannot be sufficiently defined using existing and available data.

(6) Utilization of the new outcome and related indicators to prepare and disseminate, on an annual basis, reports to the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, and counties that would also include, but are not limited to, numbers of older adults served by age, differences in age categorization of older adult groups served, and effectiveness of services.

(7) In close coordination and consultation with experts in the field, establishing a standardized geriatrics training module for mental health professionals that would include a plan to account for cultural, linguistic, ethnic, geographic, and socioeconomic diversity among the older adult population, and that address barriers and stigma experienced by older adult populations. The standardized training module shall be made available to mental health professionals and other providers.

(d) The Older Adult Mental Health Services Administrator shall receive any data, the access to which is not restricted by any state or federal law, that is necessary to develop outcome-related indicators as specified in paragraph (4) of subdivision (c), including, but not limited to, data held by other state agencies or departments.

(e) The Older Adult Mental Health Services Administrator shall maintain the confidentiality of information received pursuant to this section in a manner that is equal to the manner in which other state agencies or departments maintain the confidentiality of data.

(f) The Older Adult Mental Health Services Administrator may establish one or more advisory bodies to guide and inform the selection of outcome and related indicators and the strategy for developing and reporting those indicators. An existing state entity that involves diverse representation of older adults, including, but not limited to, the California Commission on Aging, may act as an advisory body for purposes of this section.

(g) The Older Adult Mental Health Services Administrator shall report to the entities listed in subdivision (d) of Section 5892, on or before July 1, 2022, all of the outcome and related indicators developed by the administrator pursuant to paragraph (4) of subdivision (c). The report shall also include recommendations on ways to establish a system for monitoring those indicators on a continual basis, including additional staffing or technology that might be necessary, and any regulatory or fiscal barriers that may

hinder future progress on the development of a monitoring system. The report may be made available to the Legislature, upon request by the Legislature.

(h) The Older Adult Mental Health Services Administrator shall also develop a strategy and standardized training for all county mental health personnel, including clinicians, involved in delivering Mental Health Services Act mental health care and prevention services to older adults in order for counties to assist the administrator in obtaining the data necessary to develop the outcome and related indicators specified in paragraph (4) of subdivision (c).

SEC. 2. The Legislature finds and declares that this act clarifies procedures and terms of the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.

O

Assemblymember Rudy Salas, 32nd District

ASSEMBLY BILL 480 – MENTAL HEALTH SERVICES FOR OLDER ADULTS

FACT SHEET

BACKGROUND

According to the Centers for Disease Control and Prevention, it is estimated that 20 percent of people age 55 years or older experience some type of mental health concern.

Mental health issues that older adults face – which range from anxiety and depression to serious mental illness – can be complicated by other ailments and chronic diseases that are more common among older adults, such as dementia, heart disease, diabetes, arthritis, or cancer. Moreover, older adults diagnosed with a mental illness are more likely to develop chronic conditions and dementia as they age.

Mental health issues are often implicated as a factor in cases of suicide and, unfortunately, older adults also have the highest suicide rate in the country. Furthermore, the percentage increase in suicides from 1996 to 2016 in California has risen dramatically, notably among older adults. From 1991 to 2017, California saw a 58 percent increase in the number of suicides for those aged 65-84 and 50 percent for those 85 and older (compared with a 14.8 average increase statewide across all age groups). Suicide rates are particularly high in rural parts of California where access to mental health care is severely lacking.

In California, the older adult population will increase 64 percent by 2035 to 12 million adults age 60 and above. By that same time, the U.S. Census Bureau projects senior citizens will outnumber youth for the first time in our nation's history.

Mental health and well-being are as important for older adults as for any other age group. Therefore, it is critical that our state take steps to address this growing need.

ISSUE

Far too often older adults do not seek or receive the help they need, despite that fact that one in five older adults experience mental health concerns. By the age of 75, close to half of all Americans will have experienced a diagnosable mental disorder. The World Health Organization estimates that worldwide, 15 percent of adults age 60 and over live with mental illness.

However, according to a study conducted by the UCLA Center for Health Policy Research, less than one-third of all older adults in the United States who need mental health care receive it.

Undiagnosed and untreated mental health issues have a serious impact for older adults and their loved ones. The study conducted by the UCLA Center for Health Policy Research found a number of deficiencies in the current structure as it relates to mental health services for older adults. Among the deficiencies highlighted in the study, it found that: a) implementation of older adult mental health services is uneven; b) MHSA outcome reporting is inadequate for measuring the reach and effectiveness of services among older adults; c) there are significant and persistent deficits in the geriatrics workforce; d) there are numerous barriers to mental health services for older adults.

Given the rapidly growing segment of the state's population that is made up of older adults, and the significant and unique challenges that older adults face as it relates to mental health, it is critical that the state appoint a leader and adopt a plan to increase, improve and integrate mental health services for older adults.

EXISTING LAW

Under existing law, the Mental Health Services Act (MHSA), an initiative measure approved by voters as Proposition 63 in 2004, establishes the continuously appropriated Mental Health Services Fund to fund various mental health programs, including the Adult and Older Mental Health System of Care Act.

Since the passage of Prop. 63 until 2014, over $13 billion in the state's tax revenue has been allocated for public mental health services, yet a distinct administrative structure and specific funding older adult services are not mandated in MHSA, as they are for children under the age of 18.

Previously, there was a position within the California Department of Aging – the Geriatric Mental Health Specialist – that was funded by MHSA funds who was responsible for overseeing mental health services for older adults since 2007. However, this position no longer exists after state budget cuts in 2011 eliminated funding for the geriatric mental health specialist.

THIS BILL

This bill would establish an Older Adult Mental Health Services Administrator (Administrator) within the Department of Health Care Services to oversee mental health services for older adults, to be funded with administrative funds from the Mental Health Services Fund.

Specifically, the administrator would be responsible for increasing service integration, developing and identify outcome and related indicators, and establishing a standardized geriatrics training module for mental health professionals that would include a plan to account for cultural, linguistic, ethnic, geographic, and socioeconomic diversity.

SUPPORT

California Alliance for Retired Americans
California Assisted Living Association
California Association for Health Services at Home
California Behavioral Health Planning Council
California Commission on Aging
California Council of Community Behavioral Health Agencies
Contd. next page

Support contd:

California Hospital Association
California State Retirees
LeadingAge California
Steinberg Institute

FOR MORE INFORMATION

Erik Turner
P: (916) 319-2032
F: (916) 319-2132
Erik.Turner@asm.ca.gov

SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO:	AB 480
AUTHOR:	Salas
VERSION:	June 25, 2019
HEARING DATE:	July 3, 2019
CONSULTANT:	Reyes Diaz

SUBJECT: Mental health: older adults

SUMMARY: Creates an Older Adult Mental Health (MH) Services Administrator (Administrator) within the Department of Health Care Services who is required to oversee MH services for older adults. Sets forth various responsibilities for the Administrator, including working in close coordination and collaboration with various state and local entities, as specified.

Existing law:

1) Establishes the Bronzan-McCorquodale Act to organize and finance community MH services for those with MH disorders in every county through locally administered and controlled programs. [WIC §5600, et seq.]

2) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which qualified low-income individuals receive health care services. [WIC §14001.1]

3) Requires DHCS to require counties to use available state and matching funds for specified client target populations, which includes adults and older adults who have a serious mental disorder, and to develop a comprehensive array of services, as specified. Requires DHCS to require counties that receive funding to develop interagency collaboration with shared responsibilities, including provision of interagency case management services to coordinate resources to target population members who are using the services of more than one agency [WIC §5805, 5807]

4) Requires DHCS, pursuant to the MHSA and in coordination with counties, to establish a program designed to prevent mental illnesses from becoming severe and disabling, and requires the program to emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

    a) Suicide;
    b) Incarcerations;
    c) School failure or dropout;
    d) Unemployment;
    e) Prolonged suffering;
    f) Homelessness; and,
    g) Removal of children from their homes. [WIC §5840]

5) Establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC) to oversee the implementation of the Mental Health Services Act (MHSA), enacted by voters in 2004 as Proposition 63 to provide funds to counties to expand services, develop innovative programs, and integrate service plans for mentally ill children, adults, and

seniors through a 1% income tax on personal income above $1 million. Requires the MHSOAC to consist of 16 voting members, including a family member of an adult or senior with a severe mental illness. [WIC §5845]

6) Establishes the Mello-Granlund Older Californians Act, which establishes the Department of Aging (CDA), and sets forth its duties and powers, including, among other things, entering into a contract for the development of information and materials to educate Californians on the concept of aging in place. [WIC §9100, et seq.]

This bill:

1) Creates an Administrator within DHCS who is required to oversee MH services for older adults. Requires the Administrator's position to be funded by MHSA administrative funds, as specified.

2) Requires the Administrator to work in close coordination and collaboration with stakeholders, including, but not limited to, MHSOAC, CDA, county behavioral health services departments, and other relevant stakeholders, as specified.

3) Requires the Administrator's responsibilities to include, but not be limited to, the following:

    a) Service integration for MH services for older adults;
    b) Determining which outcome and related indicators counties collect, and services offered;
    c) Developing outcome and related indicators for older adults, as specified;
    d) Ensuring that indicators reflect such things as screenings and assessments of affective disorders, suicide risk and suicide rates, medication review, substance use and misuse, housing and independent living assessment, and social connections and isolation;
    e) Working with all relevant stakeholders to develop a strategy to identify high-level indicators, when information is not readily available, as specified;
    f) Utilization review of the new outcome and related indicators to prepare and disseminate annually to DHCS, the MHSOAC, and counties, as specified; and,
    g) Establishing a standardized geriatrics training module for MH professionals, in close coordination and consultation with experts, as specified, to be made available to MH professionals and other providers.

4) Requires the Administrator to receive any data, as permitted by state or federal law, necessary to develop outcome-related indicators, as specified, including data held by other state agencies or departments. Requires the Administrator to maintain the confidentiality of information received, as specified.

5) Permits the Administrator to establish one or more advisory bodies to guide and inform the selection of outcome and related indicators, and the strategy for developing and reporting those indicators. Permits an existing state entity, such as the California Commission on Aging, to act as an advisory body.

6) Requires the Administrator to report to DHCS, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, the MHSOAC, the Department of Public Health, and any other state agency that receives MHSA administrative

funds on or before July 1, 2022, of all the outcome and related indicators developed by the Administrator, and to include recommendations on ways to establish a system for monitoring those indicators, as specified. Permits the report to be made available to the Legislature, upon request.

7) Requires the Administrator to develop a strategy and standardized training for all county MH personnel, including clinicians, involved in delivering MHSA-funded MH care and prevention services to older adults in order for counties to assist the Administrator in obtaining the data necessary to develop the outcome and related indicators, as specified.

FISCAL EFFECT: According to the Assembly Appropriations Committee, as this bill was amended on April 22, 2019, with the Administrator within CDA:

1) Estimated one-time costs of up to $1million (General Fund [GF]) for CDA to develop the database that would collect specified MH-related data from a variety of sources. Additional annual costs in the range of $50,000 to $150,000 GF for ongoing maintenance of the database.

2) Estimated one-time costs in the range of $75,000 to $500,000 (Mental Health Services Fund [MHSF]), depending on the scope of work, for a consultant contract to provide expert guidance to the development of the geriatric training module and data collection and reporting training.

3) Estimated ongoing annual costs of approximately $686,000 MHSF to CDA for three positions to oversee and carry out the duties of the bill.

PRIOR VOTES:

Assembly Floor:	78 - 0
Assembly Appropriations Committee:	18 - 0
Assembly Health Committee	15 - 0
Assembly Aging and Long Term Care Committee:	7 - 0

COMMENTS:

1) *Author's statement.* According to the author, the Centers for Disease Control and Prevention estimates that 20% of people aged 55 years or older experience some type MH concern, but less than one-third of all older adults in the U.S. who need MH care receive it. In California, the older adult population will increase 64% by 2035 to 12 million adults aged 60 and above. By that same time, the U.S. Census Bureau projects seniors will outnumber youth for the first time in our nation's history. Given the rapidly growing segment of the state's population that is made up of older adults, and the significant and unique challenges that older adults face as it relates to MH, it is critical that the state appoint a leader and adopt a plan to increase, improve, and integrate MH services for older adults.

2) *MHSA.* The MHSA requires each county MH program to prepare and submit a three-year plan to DHCS that must be updated each year and approved by DHCS after review and comment by the MHSOAC. DHCS is required to provide guidelines to counties related to each component of the MHSA. In the three-year plans, counties are required to include a list of all programs for which MHSA funding is being requested and that identifies how the

funds will be spent and which populations will be served. The MHSA provides funding for programs within five components:

a) *Community Services and Supports (CSS)*: Provides direct MH services to the severely and seriously mentally ill, such as MH treatment, cost of health care treatment, and housing supports. Regulations require counties to direct the majority of its CSS funds to Full‑Service Partnerships (FSPs). FSPs are county coordinated plans, in collaboration with the client and the family, to provide the full spectrum of community services. These services consist of MH services and supports, such as peer support and crisis intervention services; and non-MH services and supports, such as food, clothing, housing, and the cost of medical treatment. Outside of FSPs, counties do not use CSS funds to assist with housing;
b) *Prevention and Early Intervention (PEI)*: Provides services to MH clients in order to help prevent mental illness from becoming severe and disabling;
c) *Innovation*: Provides services and approaches that are creative in an effort to address MH clients' persistent issues, such as improving services for underserved or unserved populations within the community;
d) *Capital Facilities and Technological Needs*: Creates additional county infrastructure such as additional clinics and facilities and/or development of a technological infrastructure for the MH system, such as electronic health records for MH services; and,
e) *Workforce Education and Training*: Provides training for existing county MH employees, outreach and recruitment to increase employment in the MH system, and financial incentives to recruit or retain employees within the public MH system.

SB 1004 (Wiener and Moorlach, Chapter 843, Statutes of 2018) requires, among other things, the MHSOAC, on or before January 1, 2020, to establish priorities for the use of PEI funds and to develop a statewide strategy for monitoring implementation of PEI services, including enhancing public understanding of PEI and creating metrics for assessing the effectiveness of how PEI funds are used and the outcomes that are achieved. SB 1004 also requires PEI funds in a county's three-year plan to focus on priorities established by the MHSOAC that include the following, at a minimum:

a) Childhood trauma prevention and early intervention to deal with the early origins of MH needs;
b) Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan;
c) Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college MH programs;
d) Culturally competent and linguistically appropriate prevention and intervention;
e) Strategies targeting the MH needs of older adults; and,
f) Other programs the MHSOAC identifies, with stakeholder participation, that are proven effective in achieving, and are reflective of, the goals of the MHSA.

3) *MH of older adults.* According to the World Health Organization, older adults (those aged 60 or above) make important contributions to society as family members, volunteers, and as active participants in the workforce. While most have good MH, many older adults are at risk of developing mental disorders, neurological disorders, or substance use problems, as well as

other health conditions, such as diabetes, hearing loss, and osteoarthritis. Furthermore, as people age, they are more likely to experience several conditions at the same time. Between 2015 and 2050, the proportion of the world's older adults is estimated to almost double from about 12% to 22%, an expected increase from 900 million to two billion people over the age of 60. Older people face special physical and MH challenges. Over 20% of adults aged 60 and over suffer from a mental or neurological disorder (excluding headache disorders), and 6.6% of all disability among people over 60 years is attributed to mental and neurological disorders. The most common mental and neurological disorders in this age group are dementia and depression, which affect approximately 5% and 7% of the world's older population, respectively. Anxiety disorders affect 3.8% of the older population, substance use problems affect almost 1%, and around a quarter of deaths from self-harm are among people aged 60 or above. Substance abuse problems among older people are often overlooked or misdiagnosed. MH problems are under-identified by health care professionals and older people themselves, and the stigma surrounding these conditions makes people reluctant to seek help.

4) *UCLA Center for Health Policy Research.* A study conducted by the UCLA Center for Health Policy Research, "California's Public Mental Health Services: How are Older Adults Being Served," found a number of deficiencies in the current structure as it relates to MH services for older adults, including that the availability of a complete system of services for older adults with mental illness is a work in progress and there is a need for programs to engage in targeted outreach specifically tailored to older adults. The study found that implementation of older adult MH services is uneven; MHSA outcome reporting is inadequate for measuring the reach and effectiveness of services among older adults; there are significant and persistent deficits in the geriatrics workforce; and, there are numerous barriers to MH services for older adults. The study concluded that California counties with a formal, designated older adult system of care offered more programming and services tailored to older adult needs than those without. The report recommended that such a dedicated system should be implemented in all counties.

5) *Governor's Master Plan for Aging.* On June 10, 2019, Governor Newsom signed Executive Order (EO) N-14-19 calling for the creation of a Master Plan for Aging to be developed by October 1, 2020, to serve as a blueprint that can be used by state government, local communities, private organizations, and philanthropy to build environments that promote healthy aging. The EO directs the Secretary of the California Health and Human Services Agency (CHHSA) to convene a cabinet-level Workgroup for Aging to advise the Secretary in developing and issuing the Master Plan. CHHSA, along with other state partners, will also convene a Master Plan for Aging Stakeholder Advisory Committee, which will include a Research Subcommittee and a Long-Term Care Subcommittee, with an interest in building an age-friendly California. These subcommittees are expected to include older Californians, adults with disabilities, local government representatives, health care providers, health plans, employers, community-based organizations, foundations, academic researchers, and organized labor. The Long-Term Care Subcommittee is tasked with issuing a report to the Governor by March 2020 on stabilizing state long-term care programs and infrastructure, including In-Home Supportive Services, with the full Master Plan completed by October 2020. The Workgroup's focus will go beyond the health and human services area to include transportation and housing issues and their impact on an individual's health outcomes and well-being, as well as focus outside of public programs as many older Californians do not utilize or have access to public programs and services the state administers.

6) *Double referral.* This bill was heard in the Senate Human Services Committee on June 10, 2019, and passed out by a vote of 5-0.

7) *Related legislation.* AB 1287 (Nazarian) requires CDA, in partnership with other specified departments and in consultation with stakeholders, to develop a plan and strategy for a phased statewide implementation of the No Wrong Door system, as specified. Requires CHHSA, in consultation with specified departments, to develop a universal tool and process to assess individual need and determine initial eligibility for programs and services available in the long-term services and supports delivery network. *AB 1287 is set to be heard in the Senate Human Services Committee on July 8, 2019.*

   AB 1382 (Aguiar-Curry) requires the state to develop a Master Plan for Aging, emphasizing workforce priorities, as provided in this section. Requires the Master Plan for Aging to prioritize the following issues related to preparing and supporting California's paid paraprofessionals, professionals, and unpaid family caregiver. *AB 1382 is set to be heard in the Senate Human Services Committee on July 8, 2019.*

   SB 228 (Jackson) requires the Governor to appoint a Master Plan Director (MPD) and establishes an Aging Task Force, as specified. Requires the MPD and the task force, to work with representatives from impacted state departments, stakeholders, and other agencies to identify the policies and priorities that need to be implemented in California to prepare for the aging of its population. *SB 228 was heard in the Assembly Aging and Long-Term Care Committee and passed by a vote of 7-0 on June 25, 2019.*

   SB 611 (Caballero) establishes the Master Plan for Aging Housing Task Force to, among other things, make recommendations to the Legislature for legislation that will help increase the supply of affordable housing for older adults and reduce barriers to providing health care and social services to older adults in affordable housing. *SB 611 is set to be heard in the Assembly Aging and Long-Term Care Committee on July 9, 2019.*

8) *Prior legislation.* SB 1004 (Wiener and Moorlach, Chapter 843, Statutes of 2018) among other things, requires the MHSOAC to establish priorities for the use of PEI funds to include, but are not limited to, early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan, and strategies targeting the MH needs of older adults.

9) *Support.* Supporters of this bill, largely MH and senior advocates, state that there currently is no behavioral health structure for older adults, and while one-in-five experience mental illness, less than one-third who need MH care receive it. Supporters argue that often mental wellness in older adults is overlooked in order to treat existing physical health needs, despite that mental and physical well-being are connected. Supporters also argue that as the aging population is expected to increase dramatically, coupled with a sharp increase in suicide rates among this population, it is critical to establish and prioritize geriatrics training for MH professionals.

10) *Policy comment*. While there is a stated need for attention to the aging population and their health care needs in general, it appears that there are existing methods for addressing the MH needs of the older adult population, particularly through the MHSOAC, the state's

Commission on Aging, DHCS's existing responsibilities, the Governor's proposed Master Plan for Aging taskforce, and the recently enacted SB 1004, which prioritizes PEI funds to focus on various populations, including older adults. It is unclear why an Administrator focusing only on older adults and not all populations suffering mental illness is needed to perform tasks that may be accomplished through increased coordination by existing entities focusing on MH issues and the aging population.

SUPPORT AND OPPOSITION:

Support: California Alliance for Retired Americans
California Assisted Living Association
California Association for Health Services at Home
California Behavioral Health Planning Council
California Commission on Aging
California Council of Community Behavioral Health Agencies
California Hospital Association
California State Retirees
LeadingAge California
Steinberg Institute

Oppose: None received

-- END --

AMENDED IN SENATE MAY 17, 2019

AMENDED IN SENATE APRIL 2, 2019

SENATE BILL No. 582

Introduced by Senator Beall
(Coauthor: Senator Rubio)

February 22, 2019

An act to amend Section 5848.5 of the Welfare and Institutions Code, relating to youth mental ~~health, and making an appropriation therefor.~~ *health.*

LEGISLATIVE COUNSEL'S DIGEST

SB 582, as amended, Beall. Youth mental health and substance use disorder services.

Existing law establishes the Investment in Mental Health Wellness Act of 2013. Existing law provides that funds appropriated by the Legislature to the California Health Facilities Financing Authority and the Mental Health Services Oversight and Accountability Commission for the purposes of the act be made available through a grant program to selected counties or counties acting jointly, except as otherwise provided, and be used to provide, among other things, a complete continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state.

This bill would require the commission, when making grant funds available on and after July 1, 2021, to allocate at least ½ of those funds to local educational agency and mental health partnerships, as ~~specified.~~ *specified, if moneys are appropriated for this purpose.* The bill would require this funding to be made available to support prevention, early intervention, and direct services, as determined by the commission. The bill would require the commission, in consultation with the

Superintendent of Public Instruction, to consider specified criteria when determining grant recipients. The bill would authorize the commission to allocate the funds towards other purposes if there is an inadequate number of qualified applicants, as specified. The bill would require the commission to provide a status report to the fiscal and policy committees of the Legislature, as specified, no later than March 1, 2022. ~~The bill would additionally annually appropriate $15,000,000 each fiscal year to the commission for the purpose of grants by the commission pursuant to these provisions.~~

Vote: ~~2/3~~ *majority*. Appropriation: ~~yes~~ *no*. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) Schools are the best place for early identification and alleviation of behavioral health challenges that are likely to lead to serious mental illness or substance use disorders if not addressed early in their onset.

(b) School-based health care programs substantially increase children's access to care, even for children covered by Medicaid or private health insurance. Prior research studies have linked school-based health care and mental health services to better child behavior in school, reduced emergency department usage by children, higher rates of educational success, and lower rates of teen births. While it is unclear which specific school-based health programs are most cost effective, the benefits of having at least some type of health care at every public school are typically far greater than the costs.

(c) California ranks at or near the bottom of all states in terms of the percentage of K–12 public students with access to various types of health care or mental health care inside their schools. California ranks 39th for school nurses per student, and 50th for school counselors per student. California ranks 43rd for Medicaid spending per student on school-based health and mental health services. Yet California's youth do not have low needs; for example, California ranks 28th among states in terms of the estimated percent of children with a serious emotional disturbance.

(d) Less than one-half of California's public school students have regular access to physical health care in their schools, less than one-half of California's elementary school students have access to mental health care in their schools, and more than 5 percent of California's high school seniors do not have access to a school counselor.

(e) Gaps in school-based health coverage are present throughout the state. Only 16 percent of school districts provide mental health coverage for all elementary school students. More than one quarter of school districts have at least one high school not offering any counselors. School-based health care coverage for the general student population is especially low in rural areas and in schools with high rates of special education classifications.

(f) Nonprofit organizations and other government agencies, such as local health districts, county departments of health, and local police departments, help to increase student access to school-based health care and especially mental health care, but these efforts are sporadic.

(g) Multitiered models to improve school climate and culture and to ensure prompt referral for support for students showing any level of challenge, and comprehensive integrated services for those with serious emotional disturbances or substance use disorders have been demonstrated to have the best outcomes in improving student health and academic performance.

(h) These integrated models, when able to leverage public or private health insurance funds, demonstrate that early investments pay for themselves in reduced special education costs and improved academic success while reducing school dropout rates and related problems.

(i) Initially, approximately 85 percent of triage grant funds are allocated to adult mental health services, leaving youth underserved. According to the Mental Health Services Oversight and Accountability Commission, in the first round of triage grants, only 6 of 50 applications for program funds received were specific to youth, and only three of those met or exceeded the minimum threshold for funding.

(j) Grantees with youth-centric programs received just over 15 percent of the total available triage funds. In order for California's schoolage population to be adequately served, parity in the distribution of triage grant funds is necessary.

(k) By allocating funds for the purpose of establishing partnerships between schools and local mental health plans, the entities involved would be able to leverage school and community resources in order to provide comprehensive multitiered interventions on a sustainable basis, which can yield greater mental health outcomes for California's youth.

SEC. 2. Section 5848.5 of the Welfare and Institutions Code is amended to read:

5848.5. (a) The Legislature finds and declares all of the following:

(1) California has realigned public community mental health services to counties and it is imperative that sufficient community-based resources be available to meet the mental health needs of eligible individuals.

(2) Increasing access to effective outpatient and crisis stabilization services provides an opportunity to reduce costs associated with expensive inpatient and emergency room care and to better meet the needs of individuals with mental health disorders in the least restrictive manner possible.

(3) Almost one-fifth of people with mental health disorders visit a hospital emergency room at least once per year. If an adequate array of crisis services is not available, it leaves an individual with little choice but to access an emergency room for assistance and, potentially, an unnecessary inpatient hospitalization.

(4) Recent reports have called attention to a continuing problem of inappropriate and unnecessary utilization of hospital emergency rooms in California due to limited community-based services for individuals in psychological distress and acute psychiatric crisis. Hospitals report that 70 percent of people taken to emergency rooms for psychiatric evaluation can be stabilized and transferred to a less intensive level of crisis care. Law enforcement personnel report that their personnel need to stay with people in the emergency room waiting area until a placement is found, and that less intensive levels of care tend not to be available.

(5) Comprehensive public and private partnerships at both local and regional levels, including across physical health services, mental health, substance use disorder, law enforcement, social services, and related supports, are necessary to develop and maintain high quality, patient-centered, and cost-effective care for

individuals with mental health disorders that facilitates their recovery and leads towards wellness.

(6) The recovery of individuals with mental health disorders is important for all levels of government, business, and the local community.

(b) This section shall be known, and may be cited, as the Investment in Mental Health Wellness Act of 2013. The objectives of this section are to do all of the following:

(1) Expand access to early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.

(2) Expand the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness, resiliency, and recovery oriented.

(3) Add at least 25 mobile crisis support teams and at least 2,000 crisis stabilization and crisis residential treatment beds to bolster capacity at the local level to improve access to mental health crisis services and address unmet mental health care needs.

(4) Add at least 600 triage personnel to provide intensive case management and linkage to services for individuals with mental health care disorders at various points of access, such as at designated community-based service points, homeless shelters, and clinics.

(5) Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services and improving access to timely assistance.

(6) Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.

(7) Provide local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for individuals with mental health disorders.

(8) Provide a complete continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state. The funds included in the Budget Act of 2016 for the purpose of developing the continuum of mental health crisis services for children and youth 21 years of age and under shall be for the following objectives:

(A) Provide a continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state.

(B) Provide for early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.

(C) Expand the continuum of community-based services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness-, resiliency-, and recovery-oriented.

(D) Add at least 200 mobile crisis support teams.

(E) Add at least 120 crisis stabilization services and beds and crisis residential treatment beds to increase capacity at the local level to improve access to mental health crisis services and address unmet mental health care needs.

(F) Add triage personnel to provide intensive case management and linkage to services for individuals with mental health care disorders at various points of access, such as at designated community-based service points, homeless shelters, schools, and clinics.

(G) Expand family respite care to help families and sustain caregiver health and well-being.

(H) Expand family supportive training and related services designed to help families participate in the planning process, access services, and navigate programs.

(I) Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services.

(J) Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.

(K) Provide local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for children and youth 21 years of age and under with mental health disorders.

(c) Through appropriations provided in the annual Budget Act for this purpose, it is the intent of the Legislature to authorize the California Health Facilities Financing Authority, hereafter referred to as the authority, and the Mental Health Services Oversight and Accountability Commission, hereafter referred to as the commission, to administer competitive selection processes as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, and specified personnel resources.

(d) Funds appropriated by the Legislature to the authority for purposes of this section shall be made available to selected counties, or counties acting jointly. The authority may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively supports this designation and collaboration in lieu of a county government directly receiving grant funds.

(1) Grant awards made by the authority shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase capacity for client assistance and services in the following areas:

(A) Crisis intervention, as authorized by Sections 14021.4, 14680, and 14684.

(B) Crisis stabilization, as authorized by Sections 14021.4, 14680, and 14684.

(C) Crisis residential treatment, as authorized by Sections 14021.4, 14680, and 14684 and as provided at a children's crisis residential program, as defined in Section 1502 of the Health and Safety Code.

(D) Rehabilitative mental health services, as authorized by Sections 14021.4, 14680, and 14684.

(E) Mobile crisis support teams, including personnel and equipment, such as the purchase of vehicles.

(2) The authority shall develop selection criteria to expand local resources, including those described in paragraph (1), and processes for awarding grants after consulting with representatives and interested stakeholders from the mental health community, including, but not limited to, the County Behavioral Health Directors Association of California, service providers, consumer organizations, and other appropriate interests, such as health care providers and law enforcement, as determined by the authority. The authority shall ensure that grants result in cost-effective expansion of the number of community-based crisis resources in regions and communities selected for funding. The authority shall also take into account at least the following criteria and factors when selecting recipients of grants and determining the amount of grant awards:

(A) Description of need, including, at a minimum, a comprehensive description of the project, community need,

population to be served, linkage with other public systems of health and mental health care, linkage with local law enforcement, social services, and related assistance, as applicable, and a description of the request for funding.

(B) Ability to serve the target population, which includes individuals eligible for Medi-Cal and individuals eligible for county health and mental health services.

(C) Geographic areas or regions of the state to be eligible for grant awards, which may include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(D) Level of community engagement and commitment to project completion.

(E) Financial support that, in addition to a grant that may be awarded by the authority, will be sufficient to complete and operate the project for which the grant from the authority is awarded.

(F) Ability to provide additional funding support to the project, including public or private funding, federal tax credits and grants, foundation support, and other collaborative efforts.

(G) Memorandum of understanding among project partners, if applicable.

(H) Information regarding the legal status of the collaborating partners, if applicable.

(I) Ability to measure key outcomes, including improved access to services, health and mental health outcomes, and cost benefit of the project.

(3) The authority shall determine maximum grants awards, which shall take into consideration the number of projects awarded to the grantee, as described in paragraph (1), and shall reflect reasonable costs for the project and geographic region. The authority may allocate a grant in increments contingent upon the phases of a project.

(4) Funds awarded by the authority pursuant to this section may be used to supplement, but not to supplant, existing financial and resource commitments of the grantee or any other member of a collaborative effort that has been awarded a grant.

(5) All projects that are awarded grants by the authority shall be completed within a reasonable period of time, to be determined by the authority. Funds shall not be released by the authority until the applicant demonstrates project readiness to the authority's

satisfaction. If the authority determines that a grant recipient has failed to complete the project under the terms specified in awarding the grant, the authority may require remedies, including the return of all or a portion of the grant.

(6) A grantee that receives a grant from the authority under this section shall commit to using that capital capacity and program expansion project, such as the mobile crisis team, crisis stabilization unit, or crisis residential treatment program, for the duration of the expected life of the project.

(7) The authority may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, for purposes of implementing this section.

(8) The authority may adopt emergency regulations relating to the grants for the capital capacity and program expansion projects described in this section, including emergency regulations that define eligible costs and determine minimum and maximum grant amounts.

(9) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before May 1, 2014, and on or before May 1, 2015, on the progress of implementation that include, but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(10) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

(e) Of the funds specified in paragraph (8) of subdivision (b), it is the intent of the Legislature to authorize the authority and the commission to administer competitive selection processes as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, family respite care, family supportive training and related services, and triage personnel resources for children and youth 21 years of age and under.

(f) Funds appropriated by the Legislature to the authority to address crisis services for children and youth 21 years of age and under for the purposes of this section shall be made available to selected counties or counties acting jointly. The authority may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively support this designation and collaboration in lieu of a county government directly receiving grant funds.

(1) Grant awards made by the authority shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase capacity for client assistance and crisis services for children and youth 21 years of age and under in the following areas:

(A) Crisis intervention, as authorized by Sections 14021.4, 14680, and 14684.

(B) Crisis stabilization, as authorized by Sections 14021.4, 14680, and 14684.

(C) Crisis residential treatment, as authorized by Sections 14021.4, 14680, and 14684 and as provided at a children's crisis residential program, as defined in Section 1502 of the Health and Safety Code.

(D) Mobile crisis support teams, including the purchase of equipment and vehicles.

(E) Family respite care.

(2) The authority shall develop selection criteria to expand local resources, including those described in paragraph (1), and processes for awarding grants after consulting with representatives and interested stakeholders from the mental health community, including, but not limited to, county mental health directors, service providers, consumer organizations, and other appropriate interests, such as health care providers and law enforcement, as determined by the authority. The authority shall ensure that grants result in cost-effective expansion of the number of community-based crisis resources in regions and communities selected for funding. The authority shall also take into account at least the following criteria and factors when selecting recipients of grants and determining the amount of grant awards:

(A) Description of need, including, at a minimum, a comprehensive description of the project, community need,

population to be served, linkage with other public systems of health and mental health care, linkage with local law enforcement, social services, and related assistance, as applicable, and a description of the request for funding.

(B) Ability to serve the target population, which includes individuals eligible for Medi-Cal and individuals eligible for county health and mental health services.

(C) Geographic areas or regions of the state to be eligible for grant awards, which may include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(D) Level of community engagement and commitment to project completion.

(E) Financial support that, in addition to a grant that may be awarded by the authority, will be sufficient to complete and operate the project for which the grant from the authority is awarded.

(F) Ability to provide additional funding support to the project, including public or private funding, federal tax credits and grants, foundation support, and other collaborative efforts.

(G) Memorandum of understanding among project partners, if applicable.

(H) Information regarding the legal status of the collaborating partners, if applicable.

(I) Ability to measure key outcomes, including utilization of services, health and mental health outcomes, and cost benefit of the project.

(3) The authority shall determine maximum grant awards, which shall take into consideration the number of projects awarded to the grantee, as described in paragraph (1), and shall reflect reasonable costs for the project, geographic region, and target ages. The authority may allocate a grant in increments contingent upon the phases of a project.

(4) Funds awarded by the authority pursuant to this section may be used to supplement, but not to supplant, existing financial and resource commitments of the grantee or any other member of a collaborative effort that has been awarded a grant.

(5) All projects that are awarded grants by the authority shall be completed within a reasonable period of time, to be determined by the authority. Funds shall not be released by the authority until the applicant demonstrates project readiness to the authority's

satisfaction. If the authority determines that a grant recipient has failed to complete the project under the terms specified in awarding the grant, the authority may require remedies, including the return of all, or a portion, of the grant.

(6) A grantee that receives a grant from the authority under this section shall commit to using that capital capacity and program expansion project, such as the mobile crisis team, crisis stabilization unit, family respite care, or crisis residential treatment program, for the duration of the expected life of the project.

(7) The authority may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, for the purposes of implementing this section.

(8) The authority may adopt emergency regulations relating to the grants for the capital capacity and program expansion projects described in this section, including emergency regulations that define eligible costs and determine minimum and maximum grant amounts.

(9) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before January 10, 2018, and annually thereafter, on the progress of implementation that include, but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(10) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

(g) Funds appropriated by the Legislature to the commission for purposes of this section shall be allocated for triage personnel to provide intensive case management and linkage to services for individuals with mental health disorders at various points of access. These funds shall be made available to selected counties, counties acting jointly, or city mental health departments, as determined by the commission through a selection process. It is the intent of the Legislature for these funds to be allocated in an efficient manner to encourage early intervention and receipt of needed services for individuals with mental health disorders, and to assist in navigating

the local service sector to improve efficiencies and the delivery of services.

(1) Triage personnel may provide targeted case management services face to face, by telephone, or by telehealth with the individual in need of assistance or the individual's significant support person, and may be provided anywhere in the community. These service activities may include, but are not limited to, the following:

(A) Communication, coordination, and referral.

(B) Monitoring service delivery to ensure the individual accesses and receives services.

(C) Monitoring the individual's progress.

(D) Providing placement service assistance and service plan development.

(2) The commission shall take into account at least the following criteria and factors when selecting recipients and determining the amount of grant awards for triage personnel as follows:

(A) Description of need, including potential gaps in local service connections.

(B) Description of funding request, including personnel and use of peer support.

(C) Description of how triage personnel will be used to facilitate linkage and access to services, including objectives and anticipated outcomes.

(D) Ability to obtain federal Medicaid reimbursement, when applicable.

(E) Ability to administer an effective service program and the degree to which local agencies and service providers will support and collaborate with the triage personnel effort.

(F) Geographic areas or regions of the state to be eligible for grant awards, which shall include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(3) The commission shall determine maximum grant awards, and shall take into consideration the level of need, population to be served, and related criteria, as described in paragraph (2), and shall reflect reasonable costs.

(4) Funds awarded by the commission for purposes of this section may be used to supplement, but not supplant, existing

financial and resource commitments of the county, counties acting jointly, or city mental health department that received the grant.

(5) Notwithstanding any other law, a county, counties acting jointly, or city mental health department that receives an award of funds for the purpose of supporting triage personnel pursuant to this subdivision is not required to provide a matching contribution of local funds.

(6) Notwithstanding any other law, the commission, without taking any further regulatory action, may implement, interpret, or make specific this section by means of informational letters, bulletins, or similar instructions.

(7) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation no later than March 1, 2014.

(h) Funds appropriated by the Legislature to the commission as described in paragraph (8) of subdivision (b) for the purposes of addressing children's crisis services shall be allocated to support triage personnel and family supportive training and related services. These funds shall be made available to selected counties, counties acting jointly, or city mental health departments, as determined by the commission through a selection process. The commission may, at its discretion, also give consideration to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively supports this designation and collaboration in lieu of a county government directly receiving grant funds.

(1) These funds may provide for a range of crisis-related services for a child in need of assistance, or the child's parent, guardian, or caregiver. These service activities may include, but are not limited to, the following:

(A) Intensive coordination of care and services.

(B) Communication, coordination, and referral.

(C) Monitoring service delivery to the child or youth.

(D) Monitoring the child's progress.

(E) Providing placement service assistance and service plan development.

(F) Crisis or safety planning.

(2) The commission shall take into account at least the following criteria and factors when selecting recipients and determining the amount of grant awards for these funds, as follows:

(A) Description of need, including potential gaps in local service connections.

(B) Description of funding request, including personnel.

(C) Description of how personnel and other services will be used to facilitate linkage and access to services, including objectives and anticipated outcomes.

(D) Ability to obtain federal Medicaid reimbursement, when applicable.

(E) Ability to provide a matching contribution of local funds.

(F) Ability to administer an effective service program and the degree to which local agencies and service providers will support and collaborate with the triage personnel effort.

(G) Geographic areas or regions of the state to be eligible for grant awards, which shall include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(3) The commission shall determine maximum grant awards, and shall take into consideration the level of need, population to be served, and related criteria, as described in paragraph (2), and shall reflect reasonable costs.

(4) Funds awarded by the commission for purposes of this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, counties acting jointly, or a city mental health department that received the grant.

(5) Notwithstanding any other law, a county, counties acting jointly, or a city mental health department that receives an award of funds for the purpose of this section is not required to provide a matching contribution of local funds.

(6) Notwithstanding any other law, the commission, without taking any further regulatory action, may implement, interpret, or make specific this section by means of informational letters, bulletins, or similar instructions.

(7) The commission may waive requirements in this section for counties with a population of 100,000 or less, if the commission determines it is in the best interest of the state and meets the intent of the law.

(8) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation no later than January 10, 2018, and annually thereafter.

(i) (1) (A) Except as specified in subparagraph (B), on and after July 1, 2021, when making grant funds appropriated by the Legislature available pursuant to this section, the commission shall allocate at least one-half of the funds to local educational agency and mental health partnerships, as described in paragraph (2), through a competitive process.

(B) The commission may allocate less than one-half of the funds to local educational agency and mental health partnerships if there is an inadequate number of qualified applicants to receive the funds. The commission may redirect any funds left unallocated pursuant to this paragraph toward youth services that are consistent with subdivision (b) and with the priorities of the commission.

(C) On and after July 1, 2026, if the commission determines that funds are not being allocated pursuant to this subdivision due to a lack of qualified applicants, the commission may redirect any funds left unallocated pursuant to this paragraph for purposes that are consistent with subdivision (b) and with the priorities of the commission.

(2) The commission, in consultation with the Superintendent of Public Instruction, shall establish criteria for the allocation of funds pursuant to this subdivision. In order to be eligible to receive funding, a partnership shall include one or more local educational agencies and one or more mental health partners. A mental health partner shall be either a county, including a county mental health plan, or a qualified mental health provider operating as part of the county mental health plan network.

(3) Funding allocated pursuant to this subdivision shall be available to support prevention, early intervention, and direct services, including, but not limited to, support for personnel, training, and other strategies that respond to the mental health needs of children and youth, as determined by the commission.

(4) These strategies may include, but are not limited to, the following:

(A) Communication, coordination, and referral.

(B) Monitoring service delivery to ensure the individual accesses and receives services.

(C) Monitoring the individual’s progress.

(D) Providing placement service assistance and service plan development.

(5) Funding allocated pursuant to this subdivision shall be made available to meet the mental health needs of children and youth, including those with an individual education plan, pursuant to the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.), or a plan adopted pursuant to Section 504 of the federal Rehabilitation Act of 1973 (29 U.S.C. Sec. 794), as well as other children and youth in need of mental health services.

(6) In determining grant recipients, the commission, in consultation with the Superintendent of Public Instruction, shall give positive consideration to each of the following:

(A) Description of need for mental health services for children and youth, including campus-based mental health services, as well as potential gaps in local service connections.

(B) Description of the funding request, including personnel and use of peer support.

(C) Description of how the funds will be used to facilitate linkage and access to services, including objectives and anticipated outcomes.

(D) Ability to obtain federal Medicaid or other reimbursement, including Early and Periodic Screening, Diagnosis, and Treatment funds, when applicable, or to leverage other funds, when feasible.

(E) Ability of the LEA to collect information on the health insurance carrier for each child or youth, with the permission of the parent, to allow the partnership to seek reimbursement for mental health services provided to children and youth, where applicable.

(F) Ability to engage a health care service plan or a health insurer in the LEA and mental health partnership, when applicable, and to the extent mutually agreed to by the LEA and the plan or insurer.

(G) Ability to administer an effective service program and the degree to which mental health providers and local educational agencies will support and collaborate to support the goals of the effort.

(H) Geographic areas or regions of the state to be eligible for funding, which shall include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(7) The commission, in consultation with the Superintendent of Public Instruction, shall determine maximum funding awards,

and shall take into consideration the level of need, population to be served, and related criteria, as described in paragraph (6).

(8) Funds awarded by the commission for purposes of this subdivision may be used to supplement, but not supplant, existing financial and resource commitments of the county, counties acting jointly, city mental health departments, qualified mental health agencies, or local education agencies that receive funding.

(9) For the purposes of this subdivision, "local educational agency" or "LEA" means a school district, a county office of education, a nonprofit charter school participating as a member of a special education local plan area, or a special education local plan area.

(10) Notwithstanding any other law, the commission, without taking any further regulatory action, may implement, interpret, or make specific this subdivision by means of informational letters, bulletins, or similar instructions.

(11) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation no later than March 1, 2022.

(12) Nothing in this subdivision shall require the use of funds included in the minimum funding obligation under Section 8 of Article XVI of the California Constitution for the partnerships established by this part.

~~(j) Notwithstanding Section 13340 of the Government Code, the sum of 15 million dollars ($15,000,000) is hereby appropriated annually each fiscal year from the General Fund to the Mental Health Services Oversight and Accountability Commission for the purpose of allocation pursuant to this section.~~

(13) Implementation of this subdivision shall be subject to an appropriation in the annual Budget Act or any other statute for that purpose.

O

SENATOR JIM BEALL

SB 582: School-Based Mental Health Partnerships

Coauthor: Senator Susan Rubio

SUMMARY

SB 582 increases access to school-based mental health services. It allocates at least half of SB 82 triage grant funding for services targeted to youth and encourages partnerships between schools and local mental health services. The funds will support prevention, early intervention, and direct services to address health needs of youth.

BACKGROUND

Children are more likely to experience or express a mental health crisis in a school setting and thus school-based programs can effectively respond and support the shared goals of promoting mental health and achieving desired educational outcomes for youth with mental health needs.

According to the Centers for Disease Control and Prevention, up to 20 percent of Americans under the age of 18 suffer from mental, behavioral, or emotional disorders.[1] This translates to approximately 15 million children across the country, according to the latest U.S. Census figures. Children with mental health problems are vastly more likely to develop substance abuse problems, become involved in criminal activity, and drop out of school. Among Americans ages 10 to 24, suicide is the third-leading cause of death.[2]

Partnerships between schools and community mental/behavioral health professionals offer students and families an extended network of mental health programs and services that are easily accessible. When programs are able to identify and address student mental and behavioral challenges early, students are more likely to gain resiliency skills and be successful in school and life while the threat of later harm is reduced.[3] Although youth mental health outreach has demonstrable benefits to children, only a handful of California schools have partnered with county mental health agencies and existing Triage funds are primarily utilized for adult mental health services.

EXISTING LAW

Existing law established the Investment in Mental Health Wellness Act of 2013 (SB 82) and provided that funds appropriated by the Legislature to Commission be used to provide a complete continuum of crisis services for children and youth.

Following the enactment of SB 82 in 2014, the Legislature followed up with the passage of SB 833 and modified the statute to clarify that Triage funds can and should be used to support crisis services for children and youth. SB 833 also directed the Commission to develop a program specific to meeting the needs of children, and provided $1.5 million for the purpose. The Legislation provided an additional $1.5 million to expand family supportive training and related services designed to help families participate in the planning process, access services, and navigate programs (W&C 5848.5(h)).

In response to the legislation, as well as the likelihood that counties would again seek to dedicate the vast majority of Triage funds to programs serving adults, the Commission elected to require half of Triage funds to be dedicated to programs targeting children and youth. Within that dedication, the Commission also directed $30 million of those funds to be set aside specifically for crisis Triage programs that can be developed through an integrated county mental health – school partnership.

SUPPORT

Alameda Unified School District
Amador County Unified School District
Association of California School Administrators
California Alliance of Child and Family Services
California Association of Local Behavioral Health Boards and Commissions (CALBHBC)
California Behavioral Health Planning Council
Courage Campaign
David and Margaret Youth and Family Services
Disability Rights California
Hathaway-Sycamores

[1] Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, Vol. 62, No.2, May 17, 2013

[2] NAMI, Mental Health Facts Children and Teens Infographic

[3] Psychiatric Services 66:9, September 2015

Hillsides
La Mesa-Spring Valley School District
Lassen County Office of Education
Los Angeles Trust for Children's Health
Los Angeles Unified School District
MHSOAC
Murrieta Valley Unified School District
National Center for Youth Law
Oakland Unified School District
San Jose Unified School District
Seneca Family of Agencies
Sutter County Superintendent of Schools
Teachers for Healthy Kids

FOR MORE INFORMATION

Carrie Holmes
Office of Senator Jim Beall
(916) 651-4015
Carrie.Holmes@sen.ca.gov

Date of Hearing: July 10, 2019

ASSEMBLY COMMITTEE ON EDUCATION
Patrick O'Donnell, Chair
SB 582 (Beall) – As Amended May 17, 2019

[Note: This bill was double referred to the Assembly Health Committee and was heard by that Committee as it relates to issues under its jurisdiction.]

SENATE VOTE: 38-0

SUBJECT: Youth mental health and substance use disorder services

SUMMARY: Requires the Mental Health Services Oversight and Accountability Commission (MHSOAC) to allocate at least one-half of the Investment in Mental Health Wellness Act (IMHWA) of 2013 triage grant program funds to local educational agency (LEA) and mental health partnerships, to support prevention, early intervention, and direct services to children and youth. Specifically, **this bill**:

1) Requires the MHSOAC, after July 1, 2021, when making triage grants under IMHWA, to allocate at least one-half of the funds to LEA and mental health partnerships, as specified, through a competitive process.

2) Provides that after July 1, 2026, the MHSOAC may, if it determines that funds are not being allocated due to a lack of qualified applicants, redirect any funds left unallocated for purposes that are consistent with the priorities of the MHSOAC, as specified.

3) Requires the MHSOAC, in consultation with the Superintendent of Public Instruction (SPI), to establish criteria for the allocation of funds. Requires, in order to be eligible to receive funding, a partnership to include one or more LEAs and one or more mental health partners. Requires a mental health partner to be either a county, including a county mental health plan or a qualified mental health provider operating as part of the county mental health plan network.

4) Requires funding allocated to be available to support prevention, early intervention, and direct services, including but not limited to, support for personnel, training, and other strategies that respond to the mental health needs of children and youth, as determined by the MHSOAC.

5) Provides that the strategies in 5) above may include, but are not limited to, the following:

    a) Communication, coordination, and referral;

    b) Monitoring service delivery to ensure the individual accesses and receives services;

    c) Monitoring the individual’s progress; and,

    d) Providing placement service assistance and service plan development.

6) Requires funding allocated to be made available to meet the mental health needs of children and youth, including those with an individual education plan (IEP) under the federal Individuals with Disabilities Education Act (IDEA) or a plan adopted under the federal Rehabilitation Act of 1973, as well as other children and youth in need of mental health services.

7) Requires the MHSOAC, in consultation with the SPI, to give positive consideration to each of the following factors in determining grant recipients:

   a) Need for mental health services for children and youth, including campus-based mental health services, as well as potential gaps in local service connections;

   b) Description of the funding request, including personnel and use of peer support;

   c) Description of how the funds will be used to facilitate linkage and access to services;

   d) Ability of the LEA to obtain federal Medicaid or other reimbursement, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) funds;

   e) Ability of the LEA to collect information on the health insurance carrier for each child or youth in order to seek reimbursement, as specified;

   f) Ability to engage a health care service plan or health insurer in the LEA and mental health partnership, as specified;

   g) Ability to administer an effective service program and the degree to which mental health providers and LEAs will support and collaborate; and,

   h) Geographic areas or regions of the state, including rural, suburban, and urban areas, as specified.

8) Requires the MHSOAC, in consultation with the SPI, to determine maximum funding awards, and to take into consideration the level of need, population to be served, and related criteria in 8) above.

9) Allows the MHSOAC to allocate less than one-half of the funds to LEA and mental health partnerships if there is an inadequate number of qualified applicants to receive the funds. Allows the MHSOAC to redirect any funds left unallocated toward youth services that are consistent with the priorities of the MHSOAC, as specified.

10) Permits funds awarded by the MHSOAC to be used to supplement, but not supplant, existing financial and resource commitments of the county, counties acting jointly, city mental health departments, qualified mental health agencies, or LEAs that receive funding.

11) Defines an LEA as a school district, a county office of education, a nonprofit charter school participating as a member of a special education local plan area, or a special education local plan area.

12) Permits the MHSOAC, without taking any further regulatory action, to implement, interpret, or make specific this bill by means of informational letters, bulletins, or similar instructions.

13) Requires the MHSOAC to provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation no later than March 1, 2022.

14) Requires that implementation of this bill be subject to an appropriation in the annual Budget Act or any other statute for that purpose.

EXISTING LAW:

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

2) Establishes the Investment in Mental Health Wellness Act of 2013 (IMHWA), which requires triage funds appropriated by the Legislature to be made available to specified entities to be used, among other things, for a complete continuum of crisis services for children and youth 21 years of age and under. (Welfare and Institutions Code 5848.5)

3) Requires the California Department of Health Care Services (DHCS), pursuant to the MHSA and in coordination with counties, to establish a program designed to prevent mental illnesses from becoming severe and disabling and requires the program to emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

    a) Suicide;

    b) Incarcerations;

    c) School failure or dropout;

    d) Unemployment;

    e) Prolonged suffering;

    f) Homelessness; and

    g) Removal of children from their homes.

4) Requires California counties to be responsible for both Medi-Cal specialty mental health services for seriously mental illness and for safety-net (non-Medi-Cal) community mental health services.

5) Expresses the intent of the Legislature that the governing board of each school district and each county superintendent of schools maintain fundamental school health services at a level that is adequate to accomplish all of the following: preserve pupils' ability to learn, fulfill existing state requirements and policies regarding pupils' health, and contain health care costs through preventive programs and education (Education Code 49427).

FISCAL EFFECT: According to the Senate Appropriations Committee:

1) Costs of $15 million (General Fund (GF)), ongoing, in local assistance to allocate IMHWA grants.

2) According to the MHSOAC, 2.0 Health Program Specialist II positions ($239,856) and 1.0 Research Program Specialist II ($119,928) to address the broader scope of applicant available uses, additional funding, additional preparation with California Department of Education (CDE) collaboration on level of need, as well as designing and evaluating the program outcomes to determine the effectiveness of the program. The MHSOAC would need research staff to develop metrics to evaluate the outcome of the triage grants on a statewide level.

3) The DHCS notes to the extent this bill facilitates linkages and access to services and leverages Medicaid funding, this may increase utilization of Medi-Cal Specialty Mental Health Services, and could result in additional claiming in the LEA Billing Option Program or the School-Based Medi-Cal Administrative Activities Program. According to the DHCS, this amount is indeterminate.

4) Staff notes potential one-time costs, likely between $50,000 and $100,000, for the DHCS to develop guidelines for county mental health departments to participate in the partnerships by the (GF).

5) According to the CDE, the 1.0 full-time, ongoing Education Program Consultant position to develop guidelines for local agencies to participate in the partnerships authorized in the bill, and to develop guidelines for the competitive grant program. Staff notes up to $140,000 (GF).

COMMENTS:

Need for the bill. According to the author, "Partnerships between schools and community mental/behavioral health professionals offer students and families an extended network of mental health programs and services that are easily accessible. When programs are able to identify and address student mental and behavioral challenges early, students are more likely to gain resiliency skills and be successful in school and life while the threat of later harm is reduced. Although youth mental health outreach has demonstrable benefits to children, only a handful of California schools have partnered with county mental health agencies and existing triage funds are primarily utilized for adult mental health services. A percentage of future triage grant funds should be dedicated to mental health crisis intervention services geared toward youth. SB 582 is of critical importance in providing equity in triage grant funds for youth mental health services. By directing 50% of the funds to school-based mental health strategies, SB 582 will incentivize partnerships and provide more robust mental health services in California schools."

Incidence of mental health and behavioral health issues for children and youth. A 2014 UCLA Policy Brief notes that nearly half of all Americans will need mental health treatment some time during their lifetimes, with initial symptoms frequently occurring in childhood or adolescence. According to a report by the American Institutes for Research (AIR), *Mental*

Health Needs of Children and Youth, up to 20 percent of children in the United States experience a mental, emotional, or behavioral health disorder every year.

Mental health needs of children and youth. According to a 2018 audit by the California State Auditor, between 97-98% of California children are enrolled in health coverage, with 5.5 million enrolled in Medi-Cal. The audit found that millions of children do not receive the preventive services to which they are entitled to under Medi-Cal. An annual average of 2.4 million children who were enrolled in Medi-Cal over the past five years had not received all of the preventive health services they were entitled to. California ranks 40th for all states in providing preventive health services to children.

According to a research brief, *Investments in Students' Physical and Mental Health in California's Public Schools*, published in 2018 as a part of the Getting Down to Facts II Study, "Child mental health is an increasingly important concern throughout the state due to rising rates of school shootings, teen hospitalizations for self-inflicted harm, and teen suicides. More than seven percent of children in California suffer from a serious emotional disturbance, and more than one in five female high school students report experiencing suicidal thoughts. Public schools can be a relatively desirable location for efficient and widespread distribution of mental health services to children. However, California provides fewer physical and mental health services in schools than almost any other state."

School-based and school-linked mental health services for pupils. Across the country, school systems are increasingly joining forces with community health, mental health, and social service agencies to promote student well-being and to prevent and treat mental health disorders. Because children spend more time in school than in community mental health centers, schools are well positioned to link students with mental health services.

Mental health services that are provided in schools may include counseling, brief interventions to address behavior problems, assessments and referrals to other systems. Providing mental health services in a school-based setting helps address barriers to learning and provides supports so that all students can achieve in school and ultimately in life. Schools are also places where prevention and early intervention activities can occur in a non-stigmatizing environment.

Research suggests that comprehensive school mental health programs offer three tiers of support:

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

Schools offering such programs may rely on partnerships with community systems, such as community mental health centers, hospitals, and universities. Schools, working with their community partners, can collect prevalence data to build a foundation to plan, develop, and implement comprehensive mental health programs and services through strong school-community partnerships.

Barriers to seeking treatment for mental and behavioral health disorders. Studies cite a lack of insurance coverage as one of the barriers to children and youth receiving mental health services. However, as mental health and substance abuse services were deemed to be an essential health benefit under the Affordable Care Act, this may be somewhat mitigated. Additional barriers to accessing mental health services include parents with limited English proficiency – 88% of children whose parents had limited English proficiency did not receive any mental health treatment compared to 66% of children with English proficient parents. Other barriers include the complexity of the care system, the inadequate linguistic capacity of existing professional services and resources, as well as the stigmas and cultural barriers to recognizing and seeking treatment for mental health problems.

Public mental health delivery system. A report from the California Health Care Foundation published in March of 2018 entitled "Mental Health in California: For Too Many, Care Not There," stated that California's mental health delivery system is a complex one. California counties are responsible for both Medi-Cal specialty mental health services for the seriously mentally ill and for safety-net (non Medi-Cal) community mental health services.

While counties have the same mandate and same funding streams, each county approaches the delivery of care in its own way. Oftentimes a county may be unaware of programs or activities being conducted in other counties – programs that may work well in their own community. Many counties lack resources and may be unable to develop the level of expertise required to develop or implement new ideas or concepts.

Proposition 63: The Mental Health Services Act (MHSA). Proposition 63 was passed by voters in November, 2004. The MHSA imposes a one percent income tax on personal income in excess of $1 million and creates the 16 member MHSOAC, charged with overseeing the implementation of MHSA. The MHSA addresses a broad continuum of prevention, early intervention and service needs as well as providing funding for infrastructure, technology and training needs for the community mental health system.

The MHSA requires each county behavioral health department to prepare and submit a three-year plan to DHCS that must be updated each year and approved by DHCS after review and comment by the Commission. In their three-year plans, counties are required to include a list of all programs for which MHSA funding is being requested and that identifies how the funds will be spent and which populations will be served. Counties must submit their plans for approval to the Commission before the counties may spend certain categories of funding, including the following:

1) **Community Services and Supports**: Provides direct mental health services to the severely and seriously mentally ill, such as mental health treatment, cost of health care treatment, and housing supports.

2) **Prevention and Early Intervention**: Provides services to mental health clients in order to help prevent mental illness from becoming severe and to improve timely access for underserved populations. Prevention and early intervention programs emphasize strategies to reduce negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.

3) **Innovation**: Provides services and approaches that are creative in an effort to address mental health clients' persistent issues, such as improving services for underserved or unserved populations within the community.

Arguments in support. The MHSOAC states, "The Commission has found that children are more likely to experience or express a mental health crisis in a school setting and therefore school-based programs are best able to effectively respond and support the shared goals of promoting mental health and achieving desired educational outcomes for youth with mental health needs. When programs are able to identify and address student mental and behavioral challenges early, students are more likely to gain resiliency skills and be successful in school and life while the threat of later harm is reduced.

SB 582 allocates at least half of the triage grant funds for services targeted to youth and encourages partnerships between schools and local mental health services. Although youth mental health outreach has demonstrable benefits to children, only a handful of California schools have collaborated with county mental health agencies and existing Triage funds are mostly utilized for adult mental health services. The Commission strongly supports SB 582 and the work to increase partnerships between schools and community mental/behavioral health professionals so that California can offer students and families an extended network of mental health programs and services that are easily accessible."

Related legislation. AB 8 (Chu) of this Session would require public schools, including charter schools, to have one mental health professional who is accessible on campus during school hours for every 600 pupils by December 31, 2024, and requires counties to provide Mental Health Services Act funding to school districts, county offices of education, and charter schools for that purpose.

AB 1126 (O'Donnell) of this Session requires the MHSOAC to take specific measures to increase the transparency and accountability of mental health expenditures, and to support and share innovative practices in the delivery of mental health services, with a focus on youth mental health. This bill was held in the Assembly Appropriations Committee.

AB 1443 (Maienschein) of this Session would require the MHSOAC, subject to available funding to establish one or more technical assistance centers to support counties in addressing mental health issues as determined by the Commission, that are of statewide concern.

SB 604 (Bates) of this Session, would have required the MHSOAC, by January 1, 2021, to establish centers of excellence to provide the counties with technical assistance to implement best practices related to elements of the MHSA, would have required the centers of excellence to be funded with state administrative funds provided under MHSA. This bill was held in the Senate Appropriations Committee.

AB 875 (Wicks) of this Session would update the Healthy Start Support Services for Children Grant Program, previously administered by CDE, and identifies potential funding sources to provide health, mental health and other support services to pupils and their families.

SB 1019 (Beall) of the 2017-18 Session, was substantially similar to this bill. SB 1019 was vetoed by the Governor, with the following message:

> The bill as written would limit the Commission's authority to exercise its judgment in the distribution of these grants. I believe the better practice would be to leave this matter to the Commission.

SB 191 (Beall) of the 2017-18 Session, was substantially similar to this bill, and was held in the Senate Appropriations Committee.

SB 1113 (Beall) of the 2015-16 Session was substantially similar to this bill, and was vetoed by the Governor, with the following message:

> Despite significant funding increases for local educational agencies over the past few years, the Local Control Funding Formula remains only 96 percent funded. Given the precarious balance of the state budget, establishing new programs with the expectation of funding in the future is counterproductive to the Administration's efforts to sustain a balanced budget and to fully fund the Local Control Funding Formula. Additional spending to support new programs must be considered in the annual budget process.

SB 82 (Committee on Budget and Fiscal Review) Chapter 34, Statutes of 2013, establishes the Investment in Mental Health Wellness Act of 2013 and states the objectives of the Act regarding the need for renewed investment in community-based mental health treatment options.

REGISTERED SUPPORT / OPPOSITION:

Support

Alameda Unified School District
Amador County Unified School District
Aviva Family and Children's Services
Big Valley Joint Unified School District
California Behavioral Health Planning Council
California Academy of Child and Adolescent Psychiatry
California Alliance of Child and Family Services
Courage Campaign
David & Margaret Youth and Family Services
Disability Rights California
East Side Union High School District
Hathaway-Sycamores
Hillsides
Lake County Office of Education
Lassen County Office of Education
Los Angeles Unified School District
Mental Health Services Oversight And Accountability Commission
NAMI California
National Center For Youth Law
Oakland Unified School District
San Diego County Office of Education
San Diego; County of
San Francisco Unified School District

San Francisco Unified School District Community Advisory Committee For Special Education
Santa Clara County Office of Education
Seneca Family Of Agencies
Teachers For Healthy Kids
The California Association of Local Behavioral Health Boards and Commissions

Opposition

None on file

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

AMENDED IN SENATE APRIL 23, 2019

AMENDED IN SENATE APRIL 10, 2019

SENATE BILL No. 665

Introduced by Senator Umberg

February 22, 2019

An act to amend Section 5813.5 of the Welfare and Institutions Code, relating to mental health, ~~and~~ making an appropriation ~~therefor.~~ *therefor, and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

SB 665, as amended, Umberg. Mental Health Services Fund: county jails.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, funds a system of county mental health plans for the provision of mental health services. The MHSA establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. Existing law prohibits MHSA funds from being used to pay for persons incarcerated in state prison or parolees from state prisons. The MHSA authorizes its provisions to be amended by the Legislature by a ⅔ vote of the Legislature if the amendment is consistent with and furthers the intent of the act, and authorizes the Legislature to clarify procedures and terms of the act by majority vote.

Existing law, the 2011 Realignment Legislation addressing public safety and related statutes, requires that certain specified felonies be punished by a term of imprisonment in a county jail, rather than the state prison, and provides for mandatory supervision, a period of

suspended execution of a concluding portion of the sentence that is supervised by the county probation officer.

This bill would authorize a county to use MHSA funds, if that use is included in the county plan, to provide services to persons who are incarcerated in a county jail or subject to mandatory supervision, except persons who are incarcerated in a county ~~jail, or subject to mandatory supervision,~~ *jail* for a conviction of a ~~felony.~~ *felony, except for purposes of facilitating discharge.* By allocating moneys in the Mental Health Services Fund for a new purpose, this bill would make an appropriation. The bill would also declare that ~~it clarifies procedures and terms~~ *this change is consistent with and furthers the intent* of the MHSA.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ~~majority~~ *2/3*. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 5813.5 of the Welfare and Institutions Code is amended to read:

5813.5. Subject to the availability of funds from the Mental Health Services Fund, the state shall distribute funds for the provision of services under Sections 5801, 5802, and 5806 to county mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3. For purposes of this act, "seniors" means older adult persons identified in Part 3 (commencing with Section 5800) of this division.

(a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this part with the medically necessary mental health services, medications, and supportive services set forth in the applicable treatment plan.

(b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds, including other mental health funds, public and private insurance, and other local, state, and federal funds.

(c) Each county mental health program's plan shall provide for services in accordance with the system of care for adults and

seniors who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3.

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

(2) To promote consumer-operated services as a way to support recovery.

(3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.

(4) To plan for each consumer's individual needs.

(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5 (commencing with Section 5890) of this division, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.

(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Notwithstanding any other law and consistent with subdivision (a) of Section 5891, funds may be used, if that use is included in the county plan pursuant to Section 5847, to provide services to persons who are incarcerated in a county jail or subject to mandatory supervision, except as otherwise provided in this subdivision. Funds shall not be used to pay for persons who are incarcerated in a county ~~jail, or subject to mandatory supervision,~~ *jail* for a conviction of a ~~felony~~ *felony, except for purposes of facilitating discharge,* or for persons incarcerated in the state prison or on parole from the state prison. If included in county plans pursuant to Section 5847, funds may be used for the provision of mental health services under Sections 5347 and 5348 in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of Part 1).

(g) The department shall contract for services with county mental health programs pursuant to Section 5897. After November 2, 2004, the term "grants," as used in Sections 5814 and 5814.5 refers to those contracts.

~~SEC. 2. The Legislature finds and declares that this act clarifies procedures and terms of the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.~~

SEC. 2. The Legislature finds and declares that this act is consistent with and furthers the intent of the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.

SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to address the ongoing health issues inside of county jails and to further the alignment of state funding with new policies being proposed by county governments throughout California as soon as possible, it is necessary that this act take effect immediately.

O

TOM UMBERG

SENATOR, 34TH SENATE DISTRICT

SB 665: Mental Health Services Act: County Jails

SUMMARY

Senate Bill 665 will authorize a county to use certain Mental Health Services Act (MHSA) funds to provide mental health services to persons incarcerated in a county jail for a conviction other than a felony and to persons subject to mandatory supervision. SB 665 will also authorize the use of MHSA funds to provide re-entry mental health services to persons incarcerated in a county jail on a felony conviction.

BACKGROUND/EXISTING LAW

On November 2, 2004, California voters passed proposition 63, which enacted California's MHSA Although existing law expressly prohibits use of MHSA funds for provision of mental health services to persons incarcerated in state prison or parolees from state prison, it is silent on the use of these funds for provision of mental health services to persons incarcerated in county jails.

In Orange County, approximately 30% of the incarcerated population have a mental health issue. According to 2018 data from the Board of State and Community Corrections, approximately one fifth of county jail inmates throughout the state are taking psychotropic medications, a 25% increase since 2013.

With the number of those incarcerated who are suffering from a mental health issue and the limited funding sources for treatment services, it is critical to explore the flexibility of existing mental health funding sources. Therefore, funds should be provided to county jails, to help this population and to help reduce the recidivism rate among this vulnerable population.

SOLUTION

SB 665 will allow certain MHSA funds, such as the Community Support Services component, to be used to provide mental health services to people incarcerated in county jails. These mental health services can be provided to people who are incarcerated for a conviction other than a felony. Further, the person must meet the MHSA target population criteria specified in Welfare and Institutions Code Section 5006.3, subdivision (b). These MHSA funds will also be available to pay for re-entry mental health services to people incarcerated in a county jail on a felony conviction.

SUPPORT

Orange County Board of Supervisors (Sponsor)
Orange County Sheriff Don Barnes

FOR MORE INFORMATION

Zach Keller
Email: zach.keller@sen.ca.gov
Phone: (916) 651-4034

SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO: SB 665
AUTHOR: Umberg
VERSION: April 23, 2019
HEARING DATE: July 10, 2019
CONSULTANT: Reyes Diaz

SUBJECT: Mental Health Services Fund: county jails

SUMMARY: Permits Mental Health Services Act funds to be used to provide services to persons incarcerated in county jails or subject to mandatory supervision, except for those convicted of a felony, as specified. Contains an urgency clause that will make this bill effective upon enactment.

Existing law:

1) Establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC) to oversee the implementation of the Mental Health Services Act (MHSA), enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs, and integrate service plans for mentally ill children, adults, and seniors through a 1% income tax on personal income above $1 million. [WIC §5845]

2) Requires each county mental health program (CMHP) to prepare and submit a three-year program and expenditure plan, with annual updates, adopted by the county board of supervisors, to the MHSOAC and the Department of Health Care Services (DHCS) within 30 days after adoption. Requires the plan to include, among other things, programs for services to adults and seniors. [WIC §5847]

3) Requires DHCS, pursuant to the MHSA and in coordination with CMHPs, to establish a program designed to prevent mental illnesses from becoming severe and disabling, and requires the program to emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

    a) Suicide;
    b) Incarcerations;
    c) School failure or dropout;
    d) Unemployment;
    e) Prolonged suffering;
    f) Homelessness; and,
    g) Removal of children from their homes. [WIC §5840]

4) Prohibits MHSA funds from being used to pay for persons incarcerated in state prison or parolees from state prison. [WIC §5813.5]

5) Permits CMHPs to use MHSA funds from the Community Services and Supports (CSS) component for programs and services provided in juvenile hall and/or county jails only for the purpose of facilitating discharge. [9 CCR §3610(g)]

6) Requires a "health authority" in cooperation with the mental health (MH) director and facility administrator of a local detention facility/system, to establish policies and procedures to provide MH services, including identification and referral of inmates with MH needs,

treatment provided by qualified staff, crisis intervention services, and basic MH services as clinically indicated. Defines "health authority" to include a physician, an individual, or a health agency designated with responsibility for health care policy pursuant to a written agreement, contract, or job description. [15 CCR §1209, 1006]

This bill:

1) Permits MHSA funds, if included in a CMHP's plan, to be used to provide services to persons incarcerated in a county jail or subject to mandatory supervision, as specified.

2) Prohibits the use of funds to pay for persons who are incarcerated in a county jail for a conviction of a felony, except for purposes of facilitating discharge, or for persons incarcerated in state prison or on parole from state prison.

3) Contains an urgency clause for this bill to go into immediate effect in order to address the ongoing health issues inside of county jails.

4) Makes other technical, nonsubstantive changes.

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

COMMENTS:

1) *Author's statement.* According to the author, the MHSA partly funds counties' MH system of care for certain adults and older adults. Although existing law expressly prohibits use of MHSA funds for provision of MH services to persons incarcerated in state prison or parolees from state prison, it is silent on use of these funds for services to persons incarcerated in county jails. Therefore, this bill would authorize a county to use MHSA funds to provide MH services to persons incarcerated in a county jail for a conviction other than a felony and to persons subject to mandatory supervision. This bill would also authorize use of MHSA funds to provide community re-entry MH services to persons incarcerated in a county jail on a felony conviction.

2) *MHSA.* The MHSA requires each CMHP to prepare and submit a three-year plan to DHCS that must be updated each year and approved by DHCS after review and comment by the MHSOAC. DHCS is required to provide guidelines to CMHPs related to each component of the MHSA. In the three-year plans, CMHPs are required to include a list of all programs for which MHSA funding is being requested and that identifies how the funds will be spent and which populations will be served. CMHPs also must submit their plans for approval to the MHSOAC before they can spend innovation program funds. The MHSA provides funding for programs within five components:

    a) *CSS*: Provides direct MH services to the severely and seriously mentally ill, such as treatment, cost of health care treatment, and housing supports. Regulations require CMHPs to direct the majority of CSS funds to Full-Service Partnerships (FSPs). FSPs are county-coordinated plans, in collaboration with the client and the family, to provide the full spectrum of community services. These services consist of MH services and supports, such as peer support and crisis intervention services; and non-MH services and supports, such as food, clothing, housing, and the cost of medical treatment;
    b) *Prevention and Early Intervention*: Provides services to MH clients in order to help prevent mental illness from becoming severe and disabling;

c) *Innovation*: Provides services and approaches that are creative in an effort to address MH clients' persistent issues, such as improving services for underserved or unserved populations within the community;
d) *Capital Facilities and Technological Needs*: Creates additional county infrastructure, such as additional clinics and facilities, and/or development of a technological infrastructure for the MH system, such as electronic health records for MH services; and,
e) *Workforce Education and Training*: Provides training for existing county MH employees, outreach, and recruitment to increase employment in the public MH system, and financial incentives to recruit or retain employees within the public MH system.

The MHSA requires that funds be used to pay for programs for children, adults and older adults, innovative programs, prevention and early intervention programs, and the No Place Like Home Program. The MHSA requires funds to be used to expand MH services and for funds to supplement, rather than supplant, other funding sources for MH services. The provision in existing law that permits CMHPs to use MHSA funds for programs and services provided in juvenile hall and/or county jails only for facilitating discharge has been interpreted differently by counties and is not specific about what constitutes facilitating discharge. DHCS issued Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice 19-007 on February 26, 2019, which reiterates that those who are supervised by county probation departments are not considered parolees or inmates and thus are eligible for MHSA-funded services as long as requirements are met. The information notice also states that, when included in a county's three-year plan for the CSS component, counties may use MHSA funds to pay for MH services for those who are on county probation.

DHCS has indicated to Committee staff that, typically, facilitating discharge involves developing a plan to transition a person from an institutional setting to a community-based setting successfully. For example, CMHPs are required in their contracts to provide appropriate discharge planning for Medi-Cal beneficiaries receiving short-term and long-term hospital and institutional care in order to coordinate care between those institutional settings and community-based settings. Similarly, MHSA funding may be used to develop a discharge plan to ensure an individual incarcerated in a county jail is connected to appropriate community-based services that meet the individual's MH needs. DHCS states the discharge plan should be developed near the individual's anticipated release from the institution. Although there are not specific timeframe standards set to begin discharge planning in county jails using MHSA funds, discharge planning in similar situations typically begins around 30 days prior to the date of discharge. For example, Medi-Cal allows MH plans to be reimbursed for targeted case management services provided to someone in a hospital 30 days prior to the individual's discharge from the hospital. Understanding that a person's condition may change in that 30 days, requiring the individual to remain in the hospital longer than expected, MH plans may bill targeted case management for three nonconsecutive 30-day periods prior to discharge.

3) *MH and the incarcerated population.* According to the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) 2017 "Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison," jails and prisons house significantly greater proportions of individuals with mental, substance use, and co-occurring disorders than are found in the general public. While it is estimated that approximately 5% of people living in the community have a serious mental illness,

comparable figures in state prisons and jails are 16% and 17%, respectively. The prevalence of substance use disorders (SUDs) is notably more disparate, with estimates of 8.5% in the general public (aged 18 or older) but 53% in state prisons and 68% in jails. The co-occurrence of mental disorders and SUDs has been higher among people who are incarcerated in prisons or jails (33% to 60%) compared with people who are not incarcerated (14% to 25%). SAMHSA states that the high prevalence of mental disorders and SUDs in correctional settings produces poorer outcomes for both affected individuals and correctional agencies. Individuals with mental disorders and SUDs are less likely to make bail, and more likely to have longer jail stays, serve time in segregation during incarceration, and experience victimization or exploitation. Within jails and prisons, justice system personnel report that individuals with mental disorders or SUDs present with a range of physical, behavioral, and developmental conditions and exhibit greater difficulty coping with institutional rules. According to SAMHSA, upon release from jail or prison, many people with mental disorders or SUDs continue to lack access to services and too often become enmeshed in a cycle of costly justice system involvement. The days and weeks following community reentry are a time of heightened vulnerability.

4) *Related legislation.* SB 389 (Hertzberg) permits MHSA funds to be used to provide services to persons who are participating in a presentencing or postsentencing diversion program or who are on parole, probation, postrelease community supervision, or mandatory supervision. *SB 389 was heard in the Assembly Health Committee on June 25, 2019, and passed by a vote of 15-0.*

5) *Support.* The Orange County Board of Supervisors (OCBS) cites SAMHSA's guidelines for transitioning people with mental illness and SUDs from jail and prison to the community. OCBS cites many of the same statistics from SAMHSA related to the prevalence of those in jails and prison who experience mental illness and SUD, as well as the difficulty in accessing and receiving services once the individual is in the community. OCBS also states that expanding the eligible use of MHSA funds reduces net county cost expenditures for services provided to persons who are incarcerated or subject to mandatory supervision.

6) *Oppose unless amended.* The County Behavioral Health Directors Association of California (CBHDAC) states that, currently, the use of MHSA funding for individuals who are incarcerated is limited to discharge planning and related services. County behavioral health agencies work closely with justice partners to fund programs for the justice-involved population including, but not limited to: inmate discharge planning, mobile crisis response, forensic FSPs, MH court, and co-located staff with probation departments through a variety of funding streams. CBHDAC requests this bill be amended to test lifting the exclusion on services in county jail as a pilot program under MHSA Innovation funding, and requests the pilot be time-limited and rigorously evaluated to see if this new usage of MHSA funds reduces arrest rates and recidivism, and improves linkages to community treatment, housing attainment, and employment.

SUPPORT AND OPPOSITION:

Support: Orange County Board of Supervisors (sponsor)

Oppose: County Behavioral Health Directors Association of California (unless amended)

-- END --

AGENDA ITEM 4

Action

July 25, 2019 Commission Meeting

Budget Overview

Summary: The Commission will consider approval of its final Fiscal Year 2018-19 Operations Budget and its proposed Fiscal Year 2019-20 Operations Budget.

Background:

Fiscal Year 2018-19
The Commission will be presented with the final expenditures for its 2018-19 Budget. The total budget in 2018 was $36.5 million, which included a significant reduction for the Triage grant program in the amount of $12 million, an increase in the amount of $670,000 annually to support immigrants and refugees advocacy efforts and $2.5 million for the Innovation Incubator focusing on the Incompetent to Stand Trial population.

Fiscal Year 2019-20
The Commission's current budget for Fiscal Year 2019-20 is $121.8 million, which includes $105 million for local assistance (an increase of $85 million).

The local assistance budget includes:

- $20 million one-time funds for Early Psychosis Detection and Intervention;
- $15 million one-time funds to develop mental health drop-in centers for youth;
- $40 million one-time funds for partnerships between county mental or behavioral health departments and K-12 schools;
- $10 million ongoing funds to encourage collaboration between county mental health or behavioral health departments and K-12 schools; and
- $20 million ongoing funds for the Triage grant program.

The budget also includes $2.5 million for the Innovation Incubator and $5.4 million for stakeholder advocacy efforts.

Presenter: Norma Pate, Deputy Director

Enclosures: None.

Handouts (1): A PowerPoint will be provided at the meeting.

AGENDA ITEM 5

Action

July 25, 2019 Commission Meeting

MHSOAC New Funding and Programs

Summary: The Commission will hear an update on funding provided in the Budget Act to support school-mental health partnerships, Early Psychosis Programs, and Integrated Youth Drop-in Centers.

Background:

Mental Health School Services Act Funding

The Governor's 2019 Budget creates the Mental Health School Services Act Fund and includes $40 million one-time funds and $10 million on-going funds for the Commission to support crisis intervention services for children and youth. The funds will be awarded through a competitive grant program to facilitate access and linkages of on-going mental health services for children and youth.

This funding further supports the Commission's commitment to increase funding for children and youth mental health services. In 2017, the Commission dedicated 50 percent of its Triage grant program funds to children and youth, aged 21 years and under and directed $21.2 million to strengthen school-county partnerships to provide crisis intervention services for children in grades pre-kindergarten through twelve, with an emphasis on children in grades pre-kindergarten through third. While the funding for these programs is beneficial in increasing students' access to services, it was not enough funding to meet the increasing needs for intensive mental health services to support the mental health needs for children and youth. The Governor's 2019 Budget directs funds to help address the need for these additional services.

The Commission is currently supporting Senate Bill 582 (Beall) that would implement the provisions for the school-county partnerships, and would modify the Triage grant program to allow the funds to be made available for a broader range of local agencies, for the purposes other than staffing – such as program development or training- and for needs other than crisis services, such as prevention-oriented services.

Early Psychosis Research and Treatment

The Governor's 2019 Budget includes $20 million one-time funds for early psychosis research and treatment to expand the use of evidence-based treatment that can prevent mental health conditions from becoming severe or disabling. Currently, only 24 counties have specialty early psychosis programs. In January, the Governor's 2019 Proposed Budget set aside funding for the Department of Health Care Services to administer the grants for this program, however the Governor in the final budget shifted those funds to the Commission to support early psychosis programming already underway.

In 2017, the Commission supported Assembly Bill 1315 (Mullin) and its goals to establish a program to raise funds to support the enhancement of existing early psychosis programs and the expansion of the number of programs throughout California. Since the passage of AB 1315 the Commission has established the required Advisory Committee to assist the Commission in developing the program, the state has established the Special Fund to receive revenues, and the Commission has begun to work with state, local and national leaders on the issue of early psychosis treatment and interventions.

As part of that work, the Commission has facilitated a multi-county collaborative – using Commission operational funds and county Innovation funding – that has resulted in the commitment of $10 million in public and private funds to support improvements in existing early psychosis programs and the development of a technical assistance, research and evaluation strategy to support those programs. The Commission is partnering with UC Davis, UC San Francisco and UC San Diego in this work. The Commission is also supporting our university partners to connect these efforts with a federally funded strategy to build a national early psychosis data network that can support improved understanding of how best to respond to early psychosis and related mental health needs.

The Commission's goal is to work with California's local mental health leaders, our research and philanthropic partners and others to build a statewide initiative that results in every county in California having an early psychosis system in place that can respond to people in need. Research – and the personal experiences of Californians and their family members – demonstrate that the early and appropriate response to psychosis can make the difference in the quality of life that people experience throughout their lifetime, as well as the cost of responding to their needs.

To support and expand that work, the Commission also has explored models to support the private fundraising that is envisioned by AB 1315 and has consulted with experts in the fundraising field. The California Department of Public Health operates a similar program. One challenge the Commission has encountered is the difficulty of raising funds, without access to start-up funds to begin that process.

Senate Bill 79 signed into law by the Governor on June 27, 2019 will facilitate the implementation of the Early Psychosis Program established under AB 1315 by removing the original requirement that prohibited the use of public dollars to support the program. Recognizing the significance of the challenges facing Californians with mental health needs, the potential for this program to fundamentally improve how we respond to early psychosis and its potential to improve lives and reduce costs

The $20 million one-time funds provides the seed funding that the Commission needs to expand early psychosis programs statewide and launch a fundraising strategy and leverage other county funding for early psychosis research and treatment grant program for projects that demonstrate innovative approaches to deter and intervene when a young person has experienced a first episode of psychosis.

Youth Mental Health Drop-In Centers

This year's budget also includes $15 million one-time funds to develop mental health drop-in centers for youth, which will support a statewide strategy to improve health outcomes for youth and young adults. The Commission, in partnerships with county behavioral health leaders, researchers, and community providers, has initiated an approach to improve how youth and young adults are served through integrated approaches to health, mental health, substance use services, reproductive health and related needs, including education, social, employment and housing support.

As you may know, Australia, Canada and other countries have launched youth-driven approaches to delivering integrated care. Referred to as *Headspace* in Australia and the *Foundry* in Canada, these programs have demonstrated significant success. With support from the Commission, Stanford University and others, Santa Clara County has initiated a program called *allcove. Alllcove* was developed with youth, both as a brand and as a strategy, in order to respond to the unique and specific needs of youth and young adults. The model brings together a range of health, mental health and related services within an environment that is youth-designed and, thus, youth friendly. This model has proven successful in other countries. Australian officials report that 60 percent of young people served report improved mental health outcomes. Santa Clara is currently launching two sites for the allcove model, using a range of local resources, which include Innovation funds from their Mental Health Services Act revenues.

These funds will allow the Commission to extend the work underway and improve how our community health and mental health programs respond to the needs of this significant segment of our population.

Presenter: Norma Pate, Deputy Director, MHSOAC

Enclosures: None.

Handouts (1): A PowerPoint will be provided at the meeting.

AGENDA ITEM 6

Action

July 25, 2019 Commission Meeting

Children's Mental Health Funding Proposal

Summary: The Commission will receive a presentation from Alex Briscoe on the work of the California Children's Trust. The California Children's Trust is a statewide initiative that seeks to improve child wellbeing through policy and systems reform. The Trust is seeking financial support to expand its activities.

Presenter: Alex Briscoe, Principal, California Children's Trust

Enclosures (2): (1) The California Children's Trust Initiative: Financing New Approaches to Achieve Child Well-Being (July 2019); (2) Leveraging MHSA Funding to Coordinate Mental Health Care for Children (July 2018).

Handouts: None.

The California Children's Trust Initiative: Financing New Approaches to Achieve Child Well-Being

July 2019

California Children's Trust

Children Now®

The California Children's Trust Initiative: Financing New Approaches to Achieve Child Well-Being

There is striking evidence of a growing crisis in the health and well-being of California's children. As detailed in *The California Children's Trust Initiative: Reimagining Child Well-Being*[1], nearly all children and youth in California are vulnerable to, or already experiencing, social, emotional, mental, and developmental stressors and impairments. Yet paradoxically most children are not receiving any supports, including services covered by their health insurance. This is true for children in California at every developmental stage.

Children Under Age Six
For California's children under age six, 1 in 4 is at risk for developmental, behavioral or social delays[2]. Yet less than 1 in 3 receive timely screenings. This places California 43rd in the nation for infant and toddler developmental screenings.[3]

School-aged Children
For school-aged children, school readiness and achievement are critical drivers of child well-being and mobility. Yet, data from 2017 demonstrates that 40 percent of third graders are not reading at grade level, a critical indicator of future academic outcomes. More specifically, approximately 50 percent of California's Black and Latinx third graders are not reading at grade level, which exponentially increases their risk of dropping out of high school.[4]

California's Adolescents
For California's adolescents and transitional age youth, high rates of depression and substance abuse have contributed to increasing inpatient visits for suicide, suicidal ideation, and self-injury. This has contributed to a 50 percent increase in hospitalizations for mental health related concerns for kids in California from 2007-2015.[5] Despite this increase, 66 percent of adolescents who reported a major depressive episode in the past year did not receive any treatment.[6]

Whether measured by risk, symptoms, utilization, or cost, California is underserving its children and youth's social, emotional, mental and developmental health needs. This is despite the fact that almost all children in California have an insurance plan with a mental health benefit.

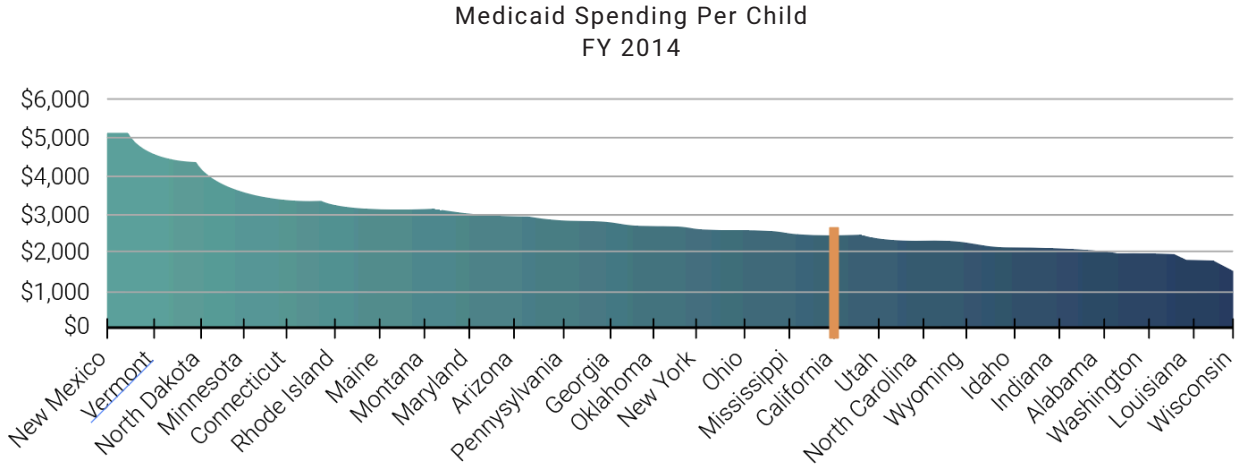
This brief outlines fiscal opportunities to initiate and invest in a fundamental re-imagining of how public child-serving systems approach and support children's social, emotional, mental, and developmental health in California.

While this brief focuses on the financial choices and opportunities for California, simply adding capacity and resources to the existing system is not an adequate solution. *California needs a holistic and prevention-oriented system of care that reaches children where they are, and provides the right services and supports, at the right time, across all child-serving systems. This will be the subject of an upcoming publication.*

Why is Medi-Cal the Foundation of Child-Serving Supports in California?

A majority of California children have Medicaid (called Medi-Cal in California). Approximately 6.1 million children, nearly 60 percent of all kids in California, are enrolled in Medi-Cal.[7] This reflects a large number of children who live in or near poverty in our state, but also signals a major opportunity to serve over half of California's children through one publicly-funded system.

Unfortunately, California does not have a history of strong and sustained behavioral health investments in children and their families. In 2014, health spending per full-benefit child enrollee in California was $2,500, ranked in the bottom third of all states.[8]



For children, the importance of Medi-Cal is magnified since the federal law governing the program includes specific benefit requirements for covering children and youth under the age of 21 through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. This federal mandate states that because children experience unique developmental and behavioral changes, states should have the ability to cover a wider range of supports and services for them, under a broad definition of "medical necessity."[9] However, until recently,[10] California state law included a confusing definition of medical necessity that resulted in more restrictive applications of the broad federal standard. As a result, many California children have not been deemed eligible to receive crucial services.

EPSDT is a federal entitlement. Every child covered under Medi-Cal has the opportunity to access services from multiple state and county agencies that are tasked with meeting the social, emotional, mental, and developmental needs of children and youth. Each state agency has different infrastructure and rules guiding what it can pay for, different definitions and measurements for child well-being, and difficulties sharing information—resulting in a lack of accountability to each other and to the children and families they serve. Further complicating the picture is that for children and families to receive services, multiple local departments across each of California's 58 counties must interpret, administer, and coordinate the funds and programs with all of these state agencies.This structure creates an unnecessarily confusing and burdensome process for families trying to navigate services and manage their

child's specific needs.

When Medi-Cal falls short of its promise, kids, families, and communities lose. To date, California has failed to ensure widespread access through the EPSDT entitlement despite its generous financing and eligibility rules. While EPSDT services are federally entitled to all 6 million children in California's Medicaid program, less than 5 percent[11] are receiving any specialty mental health services; many get the wrong service, obtain services late or get treatment in a restrictive, punitive, or high acuity setting; and most children receive no services at all. California has not taken full advantage of flexibility and funding opportunities in Medi-Cal and the EPSDT entitlement represents a critical opportunity to get it right for the state's children and families.

How Does Medicaid Financing Work?

Medicaid is a federal cost sharing program, dependent on state and county administration and funding to generate federal matching dollars. In California, much of the responsibility for seeking federal matching funds for mental health services devolves to counties. Current practices among counties are plagued by a difficult administrative burden and the uneven and fragmented sources of non-federal dollars counties receive.

Specifically, the federal government guarantees matching funds for certain Medi-Cal expenditures by providing at least $1 in federal funds for every $1 in state spending on the program. For some services or populations, the federal government provides a higher matching rate, such as for children in Medi-Cal who are eligible for the Children's Health Insurance Program (CHIP). Additionally, California has flexibility in determining the sources of state and local funding for the non-federal share of Medicaid spending. This open-ended financing structure allows federal funds to go to states based on costs and needs. If medical costs rise, more individuals enroll due to an economic downturn, or there is a natural disaster (like the recent Camp Fire[12]), Medicaid can respond and federal payments automatically adjust to reflect the additional costs of the program.

In the following section we have outlined some key federal and state opportunities that will allow California to approach care for children differently, while leveraging Medi-Cal to maximize revenue.

Federal Opportunities for Innovation and Programmatic Change

Historically, there has been a tradition of bi-partisan agreement on children's health coverage, and recent legislation and programs have continued to signal the federal government's commitment to children's health. Some of these efforts offer opportunities for innovation, integration, and new models of care and coordination to support children's social and emotional health. Opportunities that California should explore further or consider include:

1915(b) and 1115(a) Waiver Renewal Opportunities:[13] Traditionally, federal waivers have been used to include health care treatments that are usually not covered by Medi-Cal and to waive certain provisions of Medicaid law to give states greater flexibility. In recent years, some states have begun using federal waivers to expand the role of traditional health care by funding services that address social determinants of health. For example, CMS approved North Carolina's 1115 Waiver, authorizing the state to run a pilot program coordinating organizations to provide non-medical care like housing supports, legal assistance, meal delivery, and transportation assistance for victims of domestic and other violence.[14] Section 1115(a) of the Social Security Act gives states the ability to plan, negotiate, and implement experimental, pilot or demonstration projects that promote the objectives of Medicaid and CHIP. Section 1915(b) of the Social Security Act gives states the ability to restrict enrollee's freedom of choice. California uses its Section 1915(b) waiver to implement its specialty mental health services program through local mental health plans. In November 2018, CMS sent a letter to state Medicaid directors specifically encouraging states to pursue waivers that targeted children with serious emotional disturbance (SED)[15.] This type of Medicaid reimbursement mechanism is known as an Intergovernmental Transfer (IGT) model.

In California, both Section 1115(a) and 1915(b) waivers were approved for a five-year term in 2015 and are up for renewal in 2020. This impending negotiation provides an opportunity for the state to revisit and restructure the financing and delivery system of behavioral health services.

Enhanced Federal Matching Funds Available for Data Sharing:[16] In a recent letter, CMS reminded states of existing opportunities to better coordinate care, such as improving data-sharing capabilities between schools, hospitals, primary care providers, criminal justice, and specialized mental health providers. Not only can states draw down a higher match for improving their data sharing, CMS encourages it, noting that the ability to share data across agencies "can help improve access to treatment." California must improve data sharing in order to ease administrative burdens and improve services and outcomes.

The Social Impact Partnerships to Pay for Results Act (SIPPRA):[17] SIPPRA is a new federal program that funds "social impact partnerships." SIPPRA will provide federal dollars for health-related projects, including, but not limited to: improving birth outcomes and early childhood health and development among low-income families and individuals; reducing rates of asthma and diabetes; improving the health and well-being of those with mental, emotional, and behavioral health needs; and improving the educational outcomes of special-needs or low-income children. Although the deadline has passed for 2019 funding, SIPPRA could be an important model for California's efforts going forward.

Integrated Care for Kids (InCK) Model:[18] The Centers for Medicare and Medicaid Services (CMS) announced a funding opportunity to test interventions focused on fighting the opioid crisis. InCK is a child-centered model to be delivered through local service systems while using state payment models to fund services. The model will offer states and local providers support to address prevention and intervention supports through a framework of child-centered care integration across behavioral, physical, and other child providers. Although the deadline has passed for 2019 funding, InCK could be an important model for California's efforts going forward.

Opportunities to Better Leverage State and Federal Funds

Through the opportunities referenced above, federal policymakers have signaled their desire to redesign and restructure supports and services to support children's social and emotional health in Medicaid. Numerous opportunities exist with known revenues to reimagine California's support for children and to secure the resources necessary to dramatically expand the nature and scope of services.

California must examine every possible mechanism to simplify and improve claiming models and practices—something that California did when it transformed its physical health payment models from fee-for-service to managed care in the late 1990's. It is critical to recognize the essential role non-federal dollars play in the Medicaid program for children—particularly under the EPSDT entitlement. If the state and counties identify allowable non-federal dollars, and claim them appropriately, this could draw down significant new federal dollars.

How Can We Access More Federal Funds?

Counties can increase their ability to claim federal funds for specialty mental health services: Unlike the majority of physical health services provided under traditional managed care, county Mental Health Plans (MHPs) are not paid on a capitated basis.[19] Instead, MHPs must pay providers for care at the time of service using local or state dollars. After submitting required documentation to the state, counties then receive the federal match on an interim basis throughout the year.[20] This process requires county MHPs to have enough revenue available to incur the full cost of a service prior to receiving federal reimbursement. This Medicaid reimbursement mechanism is known as a Certified Public Expenditure (CPE) model.

Mechanisms for Claiming Medicaid Dollars[21]

Certified Public Expenditure (CPE): CPE is a statutorily recognized Medicaid financing approach by which a governmental entity, including a provider (e.g., county hospital, local education agency), incurs an expenditure eligible for federal match. The Department of Health Care Services (DHCS) certifies that the funds expended are public funds used to support the full cost of providing the Medicaid-covered service or the Medicaid program administrative activity. Based on this certification, the state then claims federal funds. In other words, counties must spend money first, and then be reimbursed by the federal matching funds.

Intergovernmental Transfer (IGT): An IGT is a transaction whereby local public dollars are pooled and used as the non-federal share of a matching program that pulls down federal financial participation. IGTs are commonly used by counties to contribute to the non-federal share for certain governmental providers (e.g., community mental health centers, hospitals) located in those counties. IGTs may also be contributed to directly by governmental providers themselves, such as hospitals operated by state or local government. IGTs can be used to contribute to CPEs that the state then certifies to claim federal funds.

2011 Realignment funding is a primary source of county revenue used for EPSDT federal match: As part of the 2011–12 budget plan and in response to the state budget crisis, Governor Brown and the Legislature enacted a major shift, or "realignment," of fiscal and programmatic responsibility for designated public safety and health and human services programs to counties, with key provisions codified in the state Constitution when voters passed Proposition 30 in 2012. Realigned programs are funded by a dedicated portion of vehicle license fees and state sales tax revenues, and allocated to counties based on a formula. Counties receive 2011 Realignment funds for EPSDT through the Behavioral Health Subaccount, as well as the Behavioral Health Services Growth Special Account.

The impact of 2011 Realignment on children's behavioral health services is obscured by the lack of publicly available data on how realignment funds are used, as well as several concurrent policy changes, such as the implementation of the Affordable Care Act (ACA). DHCS has clarified that EPSDT is a federal entitlement and that Subaccount allocations are not intended to result in caps to services. Given that service engagement rates for specialty mental health services have stagnated at just above 3 percent[22] over the past four fiscal years, despite more than $800 million in Growth Special Account Fund and Behavioral Health Subaccount allocations to counties between FY 12-13 and FY 17-18,[23] it is clear that more oversight is needed to understand how funds are used, and to hold counties accountable for providing and measuring the effectiveness of entitlement services.

There is a need to increase capacity to claim for administrative activities related to behavioral health: Due to the complexity of documentation and rules of the claiming process,[24] there is variability in counties' ability to receive federal matching funds for the administration of services. For example, in 2016-2017, MHPs claimed a total of $28 million of behavioral health administrative activities, also known as Behavioral Health MAA. Alameda County, which represents only 5 percent of the state's Medi-Cal managed care population,[25] claimed $17.3 million, while Los Angeles County, with almost 30 percent of the state's Medi-Cal managed care population, only claimed $2.7 million[26].

The state can better leverage expenditures to claim federal funds: There are a number of additional current Medi-Cal programs and activities for which California should gain federal matching funds. These include funding models through Managed Care Organizations, Local Education Agencies (LEAs), Federally Qualified Health Centers (FQHCs), and Local Government Agency (LGA) claiming programs.

For example, through the School-based Medi-Cal Administrative Activities (SMAA) program, school districts can be reimbursed for coordinating services from outside providers like translation services. Similarly, through the LEA Medi-Cal Billing Option Program, school districts can be reimbursed for health care services provided by either district employees or outside providers. The majority of the students receiving both SMAA and LEA services are eligible for Medi-Cal. The services provided are eligible for Medi-Cal federal matching funds, but California school districts have reported a hesitancy to bill for these services due to administrative burden and increased financial risk. California ranks 28th in the county for the estimated percent of children with a serious emotional disturbance, but ranks 43rd for Medicaid spending per student on school-based physical and mental health services, illustrating the state's inability to fully realize the benefit of Medicaid.[27]

Working with counties to standardize and improve their claiming practices can generate significant new revenue in the form or technical assistance and guidance from DHCS,

from regional collaborations, or from new models of reimbursement tied to enrollees, like capitation or case rate models.

How Can We Apply More State Funding to the Well-being of California's Children?

There are a number of potential sources of state funds that can serve as new, non-federal sources for an expansion of Medicaid funded services and supports.

Mental Health Services Act (MHSA) (Proposition 63) can be used to better coordinate care: MHSA continues to be a pillar of support for mental health services for children and youth. Statewide, MHSA generated more than $2 billion in FY 2017-18,[28] and these funds should be used as a source of non-federal share. Recently, DHCS and the Mental Health Services Oversight and Accountability Commission have been criticized because many counties have struggled to spend down their MHSA dollars. In 2018, it was reported that counties had built up approximately $230 million in unused funds.[29] There are many ways to utilize MHSA funds to redesign, improve and expand behavioral health supports for children. Recommendations about how to use those funds to benefit youth can also be found in Children Now's Leveraging MHSA Funding to Coordinate Care for Children.[30]

Proposition 64 is available to support youth: In 2016, voters approved Proposition 64, which legalized the use of cannabis for nonmedical purposes by adults age 21 and over. Proposition 64 taxed the purchase of cannabis and directed its revenues for various purposes. After allocating the dollars on specific revenues, Proposition 64 requires 60 percent of the remaining funds be dedicated to the Youth Education, Prevention, Early Intervention and Treatment Account. Funds will be allocated to DHCS to support youth programs, including the substance use disorder education, prevention, and treatment program.[31] Recent reports show that more than a year after implementation, funding to youth programs is not yet flowing.[32]

Mental Health Plan (MHP) financing reforms can be explored: California should explore alternative payment models for county mental health plans, targeting how plans receive dollars from the state and federal government and how they provide and procure services at the local level. By creating greater alignment between MHP service delivery and reimbursement with managed care organizations, the state can begin to explore different ways to ease the burden on plans and providers focusing on both aspects of payment reform—how plans get paid and what they pay for. New financing models could include capitated payments or the merging of county MHPs with traditional managed care plans, particularly in underserved regions struggling with the administrative burden and complexity of Medicaid administration and financing. Using waivers to implement creative financing models in California, known as Intergovernmental Transfers (see page 6), California could pilot new payment models between local jurisdictions and the state, or between providers and plans. Similar to what the state has pursued in Whole Person Care and in Health Homes, California can apply proven Medicaid financing strategies to the crisis of youth mental health in California.

Increased State General Funds are available: California's economic security has increased substantially over the last few years. The general fund boasts a strong discretionary reserve of $9.1 billion[33], a surplus the state has the ability to use to increase spending on key programs if it chooses.

The Opportunity to Fund a New Future

California has a unique opportunity to fund a more robust and responsive network of child-serving agencies and organizations to address the growing social, emotional, mental, and developmental health needs of our children. The urgency to meet these needs demands new resources that can make a new future possible. The federal government has signaled that it is willing to support substantive change to the way states provide for the well-being of children, and California has the wherewithal to restructure and increase funding across child-serving systems. California can create an equitable, holistic, coordinated system that meets the individual needs of children by leveraging Medi-Cal's ability to reduce poverty by providing health insurance, its unique promise to children through the EPSDT benefit, and its capacity to provide services across child-serving systems.

Credits & Acknowledgments

This brief was co-developed by Children Now and the California Children's Trust. Children Now authors include Lishaun Francis & Kelly Hardy, with support from Children Now staff Maya Kamath, Mike Odeh, Jessica Haspel, Ted Lempert and Nima Rahni. The California Children's Trust authors include Alex Briscoe, Nila Rosen, Rhea Boyd and Reed Connell.

We would like to thank the California Children's Trust Coalition and Design Team Partners for engaging in building the work of the CCT. Special acknowledgements go to the following additional reviewers and contributors to this brief:

Elizabeth Estes, Breaking Barriers
Diane Dooley, American Academy of Pediatrics
Ken Epstein, former Director San Francisco Children, Youth and Families Community Behavioral Health
Emily Higgs Allison, Seneca Family of Agencies
Jodie Langs, WestCoast Children's Clinic
Kim Lewis, National Health Law Program
Ron Powell, Special Education Consultant, Early Childhood Mental Health Advocate
Amy Price, Zellerbach Family Foundation

California Children's Trust

The California Children's Trust was established to transform the administration, delivery and financing of our child-serving systems to ensure that they are equity-driven and accountable for improved child health outcomes. We are a statewide initiative that seeks to improve child well-being through policy and systems reform.

Learn more at www.cachildrenstrust.org

Children Now®

Children Now is on a mission to build power for kids. The organization conducts non-partisan research, policy development, and advocacy reflecting a whole-child approach to improving the lives of kids, especially kids of color and kids living in poverty, from prenatal through age 26.

Learn more at www.childrennow.org

Endnotes

1 The California Children's Trust (2018). The California Children's Trust Initiative: Reimagining Child Well-Being. Retrieved from https://cachildrenstrust.org/wp-content/uploads/2018/11/PolicyBriefReimaginngChildWellBeing.pdf

2 The California Children's Trust (2018). The California Children's Trust Initiative: Reimagining Child Well-Being. Retrieved from https://cachildrenstrust.org/wp-content/uploads/2018/11/PolicyBriefReimaginngChildWellBeing.pdf Children Now (2018). California Children's Report Card. Retrieved from https://www.childrennow.org/files/9015/1975/3343/RC18_FINALonlineSPR.compressed.pdf

3 Infographic: The Importance of Development Screenings. Children Now. June 2018 Retrieved from https://www.dropbox.com/s/mn3zev57dokwaaq/Developmental%20Screenings.pdf?dl=1

4 2018-19 California Scorecard of Children's Well-Being. Children Now. Retrieved from https://www.childrennow.org/portfolio-posts/2018scorecard/

5 CA youth mental health hospitalizations up 50 percent since 2007. Kids Data. February 2017. Retrieved from https://www.kidsdata.org/blog/?p=7813

6 https://www.chcf.org/wp-content/uploads/2018/03/MentalHealthCalifornia2018.pdf

7 Department of Health Care Services. Performance Outcome Systems. Demographics Report: Unique Count of Children and Youth Receiving SMHS by Fiscal Year. February 2019. https://www.dhcs.ca.gov/services/MH/Documents/00-20190304-Statewide-SUP-Final.pdf

8 Mental Health in California: For Too Many, Care Not There. California Health Care Foundation Almanac. March 2018. Retrieved from https://www.chcf.org/publication/california-health-care-spending/

9 EPSDT requires that states provide youth under the age of 21 with all the medically necessary services to "correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services.

10 National Health Law Program (2018). California's Mandate to Treat Children on Medi-Cal is Now a Little Clearer. Retrieved from https://healthlaw.org/californias-mandate-to-treat-children-on-medi-cal-is-now-a-little-clearer/

11 Performance Outcome System. Department of Health Care Services. February 2019. Retrieved from https://www.dhcs.ca.gov/services/MH/Documents/00-20190304-Statewide-SUP-Final.pdf

12 National Public Radio (2019). In the Aftermath of the Camp Fire A Slow Simmering Crisis in Nearby Chico. Retrieved from https://www.npr.org/2019/01/14/685137701/in-the-aftermath-of-the-camp-fire-a-slow-simmering-crisis-in-nearby-chico

13 Center for Health Care Strategies (2018). Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations. Retrieved from https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf

14 Center for Medicare & Medicaid Services (2018). North Carolina Approval Letter for Section 1115 Demonstration Waiver. Retrieved from https://files.nc.gov/ncdhhs/CMS-1115-DemonstrationWaiver-Approval-Letter.pdf

15 Opportunities to Design Innovative Delivery Systems for Adults with a Serious Mental Illness or Children with Serious Emotional Disturbance. Center for Medicare and Medicaid Services. Department of Health and Human Services. Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

16 Center for Medicare & Medicaid Services (2018). Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance. Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

17 Urban Institute. Social Impact Partnership Pay Results Act. Retrieved from https://pfs.urban.org/get-started/issue-areas/content/social-impact-partnership-pay-results-act-sippra

Endnotes Continued

18 Center for Medicare & Medicaid Services (2018). Fact Sheet: Integrated Care Kids Model. Retrieved from https://www.cms.gov/newsroom/fact-sheets/integrated-care-kids-inck-model

19 Capitation is a payment arrangement for health care service providers such as physicians, physician assistants or nurse practitioners. It pays a physician or group of physicians a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

20 California Health Care Foundation (2013). A Complex Case: Public Mental Health Delivery and Financing in California. Retrieved from https://www.chcf.org/wp-content/uploads/2017/12/PDF-ComplexCaseMentalHealth.pdf

21 Medicaid and CHIP Payment and Access Commission. Federal Financing. Retrieved from https://www.macpac.gov/subtopic/non-federal-financing/

22 Department of Health Care Services. Performance Outcome Systems. January 2019. Retrieved from https://www.dhcs.ca.gov/services/MH/Documents/00-20190304-Statewide-SUP-Final.pdf

23 State Controller's Office. Behavioral Health Services Growth Special Account. Retrieved from https://www.sco.ca.gov/Files-ARD-Payments/beh_hlth_1718_ytdgrowth.pdf

24 Department of Health & Human Services: Office of Inspector General (2018). California Claimed Millions of Dollars in Unallowable Federal Medicaid Reimbursement for Specialty Mental Health Services. Retrieved from https://oig.hhs.gov/oas/reports/region9/91502040.pdf

25 Department of Health Care Services (2018). Medi-Cal Managed Care Enrollment Report. Retrieved from https://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-EligiblesRecentTrends.aspx

26 Department of Health Care Services. MHMAA Claims Paid Data. FY 16/17.

27 Reback, Randall. Getting Down to Facts II (2018). Investments in Student Health and Mental Health in California's Public Schools. Retrieved from https://www.gettingdowntofacts.com/sites/default/files/2018-09/GDTFII_Report_Reback_1.pdf

28 California Governor's Budget (2019-20). Department of Health Care Services. Retrieved from http://www.ebudget.ca.gov/2019-20/pdf/GovernorsBudget/4000/4260FCS.pdf

29 California State Auditor (2018). Mental Health Services Act The State Could Better Ensure the Effective Use of Mental Health Services Act Funding. Retrieved from http://www.auditor.ca.gov/pdfs/reports/2017-117.pdf

30 Children Now (2018). Leveraging MHSA Funding to Coordinate Mental Health Care for Children. Retrieved from https://www.dropbox.com/s/zennsje716azkz8/MHSA.pdf?dl=1

31 Legislative Analyst Office (2017). Proposition 64 Revenues. Retrieved from https://lao.ca.gov/handouts/crimjust/2017/Proposition-64-Revenues-021617.pdf

32 KCRA (2019). Youth Programs Left Wanting by California Marijuana Law. Retrieved from https://www.kcra.com/article/youth-programs-left-wanting-by-california-marijuana-law/26347652

33 Legislative Analyst Office (2019). 2019-20 Budget, California's Fiscal Outlook. Retrieved from https://lao.ca.gov/reports/2018/3896/fiscal-outlook-111418.pdf

Leveraging MHSA Funding to Coordinate Mental Health Care for Children

July 2018

CH1LDREN NOW

Table of Contents

Executive Summary

Too many California children are failing to get the well-coordinated mix of medical and mental health care services that they need to thrive. There is a clear need for expansion of the child-centered health home model to provide comprehensive health care management and coordination to improve the mental health outcomes of California children. While that model is not yet widespread in California, counties have an opportunity now to use Mental Health Services Act (MHSA) funding and other funds to provide better coordination between medical and mental health care for children and youth. While most counties have submitted their plans to spend any unused MHSA funds, there are still opportunities to revisit these plans to ensure children have the best possible mental wellness supports and services. In support of that goal, this brief highlights three counties that are leveraging MHSA funds to better coordinate care for children and youth by solidifying administrative practices, braiding funding, and implementing innovative programs.

The Current Mental Health System is Fragmented and Difficult to Navigate

Mental illness is the number one reason children in California are hospitalized, followed by asthma and pneumonia.[1] Moreover, an estimated 75 percent of children do not receive needed mental health services — even when covered by health insurance.[2] These statistics, in part, reflect the fact that the current system is fragmented causing parents and caregivers to be overwhelmed with traveling to separate appointments to see behavioral and medical providers, administering treatments and medicine, and managing their child's specific educational needs, all while making sense of insurance coverage. Without timely and easily accessible mental health care children are more likely to: have difficulties managing day-to-day life, be hospitalized, drop out of high-school, become involved with the juvenile justice system, or commit suicide.[3] As a result, children's advocates have long suggested child-centered health homes as an improvement over this fragmented delivery system. At UCLA's Mattel Children's Hospital, a Pediatric Medical Home Project that serves over 130 children found that once children were enrolled in a health home , emergency room visits went down dramatically. Still, only 45% of children in California get coordinated care through a health home or similar model. The data are worse for California's vulnerable children – only 36% of kids with special health care needs, 34% of Latino children, and 25% of children in poverty are served by a health home.

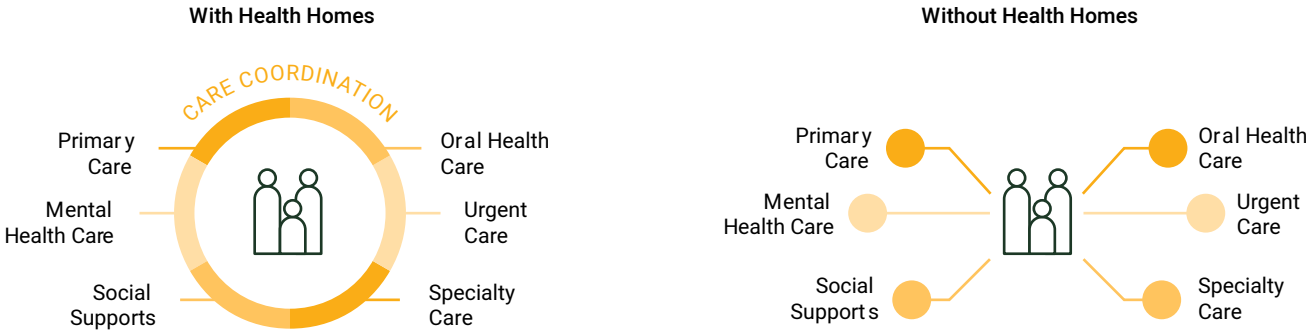
The Affordable Care Act (ACA) defines health homes as "…comprehensive and timely high-quality services… that are provided by a designated provider, a team of health care professionals operating with such a provider or a health team." Services included in the ACA's definition are: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support (including authorized representatives); referral to community and social support services; and use of health information technology to link services. A health home team can include anyone who provides coordinated services and support, such as hospitals and health plans; physicians, nurse practitioners, social workers, community health workers and other health professionals; clinical practices, group practices, community clinics, community health centers, and school-based health centers.

A "health home" is not a physical location, but an innovative model for coordinating critical health care and other services to support a child's physical, mental, and emotional well-being.

The federal government recently approved California to begin a health home program. California's program focuses on better ways to coordinate care and reduce costs for adults with co-occurring physical and mental health disorders. However, health homes must have a different intent for children. The majority of health care expenses for adults with co-occurring disorders are for physical health issues, like diabetes, while the majority of expenses for children with co-occurring disorders are in behavioral health.[4] This difference requires stakeholders to think critically about health homes and how they should be structured for children, which may operate differently than the strict definition of a health home.

A child-centered health home model should include "family friendly" components like enhanced and increased access to care providers open scheduling, expanded hours, additional communications options (e.g., email, text message), and other techniques. In addition, child-centered health homes include families as health team members – often making children and families the center of the team.

Family engagement, education, and empowerment give families greater opportunities to participate in key decisions about the health care of their children.[5]



Children and youth rarely receive mental health services until they need urgent help from their health, social service, or justice system — at which time their mental health problems have become more difficult and costly to treat. Accessible prevention and early intervention services can provide timely care so mental health concerns are managed and addressed earlier. Despite clear benefits, there has been little political will in California to broadly implement child-centered health homes.[6] However, some California counties have focused on how to best coordinate care for youth in spite of the slow expansion of health homes for children. Using a mix of federal, state, and local funding streams, California counties are finding creative ways to coordinate care for children. While the result may not look like a full-fledged health home, some counties are clearly making gains in providing more coordination of mental health care for children and youth.

Funds **are** available to improve mental health care for kids.

There are a number of funding streams for children's mental health; the largest is Medi-Cal. This brief focuses on the second largest funding stream for mental health, Proposition 63 or the Mental Health Services Act (MHSA), as it is the most flexible funding stream. Counties are continuing to determine how to best use MHSA dollars to their full potential to support kids.

Funding Source	Description
Medicaid Early and Periodic Screening, Diagnostic and Treatment	The goal of this benefit is to ensure that children under the age of 21 who are enrolled in Medicaid receive age-appropriate screening, preventive services, and treatment services that are medically necessary to correct or ameliorate any identified conditions.
Individuals with Disabilities Education Act (IDEA)	Federal law, under the Individuals with Disabilities Education Act (IDEA) was designed to help students with disabilities succeed academically. Enacted by Congress in 1975, IDEA gives states federal funding to provide instruction to children whose mental health needs limit one or more life activity, including the ability to learn. As of 2011, Local Education Agencies became solely responsible for ensuring that children and youth are identified and served as required by the IDEA.
Proposition 63, or the Mental Health Services Act (MHSA)	Passed as a ballot initiative in November 2004, Proposition 63 provides financial support to the state and ultimately counties to increase funding, personnel and other resources to support county mental health programs for children, transition age youth, adults, older adults and families.
Substance Abuse and Mental Health Services Administration (SAMSHA)	A federal program, SAMSHA provides technical assistance and grants to support programs that serve children with serious emotional disorders.
Local Government	When a youth is incarcerated in the Division of Juvenile Justice, local funds must cover the vast majority of their mental health services as Medi-Cal benefits are suspended for inmates of a public institution (with the exception of acute care provided off prison grounds for a period of 24 hours or more).

MHSA imposes a 1 percent income tax on annual personal income in excess of $1 million. MHSA funding is distributed to county mental health agencies upon approval of their plans for six components. The components are as follows:

Community Services & Supports (CSS)	focused on community collaboration, cultural competence, client- and family-driven services and systems. Housing is also a large part of the CSS component. CSS is the largest component of the MHSA.
Prevention & Early Intervention (PEI)	helps counties implement services that promote wellness. State regulations require that: "At least 51 percent of the Prevention and Early Intervention Fund shall be used to serve individuals who are 25 years old or younger."[7]
Innovative Programs funding	used to increase access to underserved groups, increase the quality of services, promote interagency collaboration and increase access to services.
Workforce Education & Training (WET)	develops a diverse workforce.
Capital Facilities and Technology (CFTN) funds	used to improve the infrastructure of California's mental health system towards the creation of a facility for the delivery of MHSA services to mental health clients and their families or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system.

MHSA Estimated Revenue by Component

Component	FY 2017-18 Dollars in Millions
Community Services and Supports	$1,363.7
Prevention and Early Intervention	$340.9
Innovation	$89.8
State Administration	$94.4
Total Estimated Revenue	$1,888.8

Note: Both WET and CFTN received funding in 2008-09 that needs to be expended by 2017-18[8]

Statewide, MHSA was projected to generate approximately $1.9 billion in FY 2017-18.[9] Recently, the state Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission (MHSAOAC) were criticized because many counties struggled to spend down their MHSA dollars. In total, counties have built up approximately $230 million in unused funds.[10]

In the 2017-18 budget year, California's budget bill revised state policy related to the reversion of unused local MHSA dollars. The original MHSA statute requires unused county MHSA funding to revert to the state after three years so it can be made available for use by other counties. However, to date, the state's MHSA reversion policy has not been enforced, resulting in counties building up large balances of MHSA funding potentially subject to reversion. The legislation made a number of changes, including: "(1) holding counties harmless for unused MHSA funds potentially subject to reversion for fiscal years prior to 2017-18; (2) requiring counties to submit a plan to spend down current balances of unused MHSA funds by July 1, 2020; (3) extending the reversion period from three years to five years for small counties; (4) requiring reverted funds to be reallocated to other counties for the same purposes for which they were originally allocated; and (5) resetting the reversion period start date for county innovation funding to the date that the state approves a county's innovation plan, rather than date in which the funds are allocated." [11]

Counties that are still seeking MHSA plan approval from their County Board of Supervisors[12] have an opportunity to revisit these plans to ensure children have the best possible mental wellness supports and services. In support of that goal, this brief highlights three counties that are leveraging MHSA funds in order to better coordinate care for children and youth.

Example 1: Santa Clara County Focuses on Youth-Led Prevention and Wellness

Santa Clara County focused a recent MHSA Innovation Fund proposal on prevention and early intervention for children and transition-age youth (TAY) ages 12-25. Specifically, in 2016, Santa Clara County's Behavioral Health Services department (BHSD) solicited ideas from the public on how to better support children and TAY. After an extensive stakeholder and application process, Santa Clara received approval from MHSAOAC to develop and implement *headspace*, an Australian program based on prioritizing early intervention for youth by providing youth-friendly centers where young people can receive early intervention and mental health treatment. In Australia, *headspace* centers are located across metropolitan, regional and rural areas. The centers are built and designed with input from young people in an effort to create a youth-friendly environment. The centers help children and youth access primary care physicians, psychologists, social workers, etc.[13]

Modeled after the Australian program, Santa Clara County's *headspace* is a four-year project presented in partnership with Stanford University's Center for Youth Mental Health and Wellbeing. The project will develop two youth centers with direct input from a youth advisory group whose recommendations will allow Santa Clara to meet the needs of the adolescents and young adults served in each center.[14]

With a focus on "marginalized youth" — defined as LGBTQ youth, youth in foster care, youth who are homeless, and youth whose primary language is not English — Santa Clara County aims for their model to "focus on collaboration with community agencies and service providers to promote continuity of care.'' [15] Santa Clara is hoping to have similar success to that of *headspace* Australia, which boasts that young people who first attended headspace with very high or high levels of psychological distress were the most likely to experience clinically significant improvements in their levels of distress after participating in the headspace program.[16]

Santa Clara aims to open the first headspace center in Summer 2018.

Example 2: Mendocino Employs Positive Parenting Program (Triple P)

Often, providing support to parents is not considered when discussing better mental health outcomes among youth. However, studies show that providing support to parents can have a direct impact on the mental health and overall outcomes of children. A program like the Positive Parenting Program (Triple P) is a prime example. Triple P is an evidence-based and internationally recognized program that provides support for parents in an effort to reduce parental stress, increase the emotional and behavioral wellbeing of children, and promote confidence in parenting skills. The program has been proven to reduce behavioral problems in children, reduce rates of substantiated child abuse and neglect, and minimize the need for foster care placements by improving the parenting skills of caregivers.[17] Despite its proven success, out of the nearly 40 counties who have trained facilitators in Triple P, only 20 counties have a substantial public roll-out of the program. This is due mainly to the cost of the trademarked program and its trainings.

In Mendocino, Triple P is focused on parents with certain risk factors including those who live below the poverty line, live in rural areas, have little access to resources, and are most vulnerable and susceptible to becoming involved in the child welfare system. Triple P is offered via county-wide Family Resource Centers (FRCs). FRCs are places that offer parent education, after school programs, information and referrals, health insurance application assistance, and other community support for families. Accredited Triple P parent educators offer on-site trainings to parents who access other FRC resources, and each Triple P facilitator is able to provide culturally and linguistically appropriate support for parents.

In spite of the high cost, Mendocino County has had a Triple P program for 10 years, and was the first county to bring Triple P into California. Through extensive discussion with the county MHSA division, FIRST 5 Mendocino was able to show that offering parenting support leads to better mental health outcomes for children. MHSA monies were approved to help fund Mendocino's Triple P under the Prevention and Early Intervention component. Once approved by the County Board of Supervisors, Mendocino County will begin to collect evaluation data and provide the information to the MHSA team in order to measure program effectiveness.

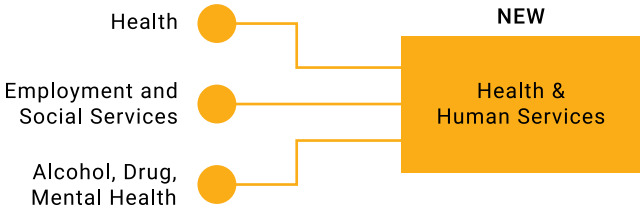
Mendocino has successfully received funding for its Triple P program from the county Health and Human Services department, FIRST 5 Mendocino, and the MHSA. This blended funding model has enabled Mendocino County to spread the financial burden for an expensive but effective program across agencies — ensuring the sustainable implementation of a longstanding program proven to provide better mental health outcomes for kids.

Example 3: Yolo County's Integration Leads to Co-location and Coordination

Mental health advocates often promote a "no wrong door" policy when it comes to treatment for mental illness. However, in practice this policy is often found to be very difficult to implement. This is true for children who may enter state services through either the child welfare, juvenile justice, physical health or mental health departments. These many points of contact have created a system where those who need behavioral health care are often rerouted after realizing a particular department (like primary care) cannot help, causing delays in treatment. While ensuring that services are coordinated within counties is within the purview of MHSA funding, implementing the administrative protocols is often daunting. Nevertheless, the first step to providing a "no wrong door" policy is to change the way systems are administered, as a coordinated system will help "braid" funding, limit multiple visits from families seeking care, and ultimately save county dollars. Yolo County's process of co-locating and coordinating health and human service departments ensured public monies (including MHSA dollars) were being used efficiently for children and youth.

In 2014, Yolo County's Board of Supervisors approved a plan to create a combined Health and Human Services Agency. The new Health and Human Services Agency would combine three distinct departments: Alcohol, Drug and Mental Health (ADMH), Health, and the Employment and Social Services. Prior to the mergers, each department had three separate leadership teams, organizational structures and policies and procedures. A feasibility study noted that the county's existing structure of individual departments created poor cross-departmental coordination and planning at the program and administrative levels, and little knowledge of policy, practices and services in other departments. Those with mental health issues and residents in rural areas lacked regular access to services, and there was a need for more culturally and linguistically competent services. Finally, there was a potential for contract duplication or overlap between ADMH and the other departments, unknowingly spending more money than needed. In light of this fragmentation and with the vision of a "no wrong door" approach to services, Yolo County determined there was inconsistency between customer demands and county resources. This misalignment of resources was not entirely due to the lack of resources, often, it reflected that resources were not being used effectively and efficiently.

Consolidating Departments



ADMH operated two areas of services, organized around substance abuse and mental health. Substance use disorder treatment programs were largely for adults, except for a small Prevention Services for Adolescents program. The mental health treatment programs focused on outpatient services, crisis intervention and residential treatment and support, psychiatric inpatient services for adults with serious mental illness and children/youth with emotional disturbance. Under the MHSA, the department also provided community services and supports to children/youth with emotional disturbance through full-service partnership programs and through prevention and early intervention services. Separately, the health department provided environmental health services, public health programs like tobacco prevention, child safety and lead poisoning prevention. The Department of Employment and Social Services administered a range of eligibility, employment and social services. Child Welfare Services included emergency response, case management for those in the foster care system and assistance for potential foster parents.[18]

By combining substance abuse, mental health, health, and social services under one leadership structure, the county was able to ensure that children's needs were being met with clarity and without duplication. This shift of administration required an overhaul of staff, staff duties, and leadership over a total of three years. The shift also required some county services/administration to exist in either the same building or office complex, co-locating services in an effort to have a "one-stop" for families. Yolo County officials now report that due to co-location of child welfare and mental health teams, workers are better able to treat entire family systems with special focus on the needs of each individual. For example, staff across sectors can ask questions of one another, reducing the need to refer families outside of the office to seek answers.

The county is still navigating how to access files and standardize administrative practices, allowing county employees to better serve families. From the family's perspective, it is an organized process where providers know what the child needs—in its entirety—not just what they need for their child welfare case or the child's behavioral health needs.

Conclusion

Given the complexities for families to navigate the mental health system, it is important that counties implement best practices and innovative programming to improve care coordination for children and youth. We hope this brief will be used by counties and stakeholders to gain insight on what is possible to ensure children have the best possible mental wellness programs and supports.

Endnotes

1 California Children's Report Card. Children Now. 2018. Retrieved from http://www.childrennow.org

2 D. Imelda Padilla-Frausto, David Grant, May Aydin, Sergio Aguilar-Gaxiola. (2014). Three Out of Four Children with Mental Health Needs in California Do Not Receive Treatment Despite Having Health Care Coverage. Los Angeles, CA. UCLA Center for Health and Policy Research. Retrieved from http://healthpolicy.ucla.edu/publications/Documents/PDF/2014/childmentalhealthbrief-july2014.pdf

3 Children Now. Retrieved from https://www.childrennow.org/issue-areas/health/mental-health/

4 Customizing Health Homes for Children with Serious Behavioral Health Challenges. Center for health care Strategies. Retrieved from http://www.chcs.org/media/Customizing_Health_Homes_for_Children_with_Serious_BH_Challenges_-_SPires.pdf

5 Child-Centered Health Homes in California: An Opportunity to Better Coordinate Care and Improve Outcomes for the State's Most Vulnerable Kids. Children Now (2014). Retrieved from https://www.childrennow.org/files/8314/2567/6762/CN-Health-Homes-Policy-Brief.pdf

6 Children Now. Retrieved from https://www.childrennow.org/issue-areas/health/health-homes/

7 Mental Health Services Oversight & Accountability Commission. Prevention and Early Intervention Regulations. http://mhsoac.ca.gov/document/2016-03/pei-regulations

8 MHSA Expenditure Report. January 2017. Retrieved from http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Mental%20Health/MHSAExpenditureReport_Jan2017.pdf

9 California Department of Health Care Services. Mental Health Services Act Expenditures Report. 2017. Retrieved from http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Mental%20Health/MHSAExpenditureReport_Jan2017.pdf

10 Mental Health Services Act: The State could Better Ensure the Effective Use of Mental Health Services Act Funding. Report 2017-17. Retrieved from http://www.auditor.ca.gov/pdfs/reports/2017-117.pdf

11 The 2017-18 Budget: California Spending Plan. Legislative Analyst's Office. Retrieved from http://www.lao.ca.gov/reports/2017/3694/spending-plan-2017.pdf

12 Mental Health Services Act Oversight and Accountability Commission. Retrieved from: http://www.mhsoac.ca.gov/3-year-plans

13 Headspace. Retrieved from https://headspace.org.au/about-us/who-we-are/

14 Santa Clara County Innovation Project Description. 2017. Retrieved from http://www.mhsoac.ca.gov/sites/default/files/documents/2017-11/OAC_Santa_Clara_County_INN_Plan_Description_Headspace_11162017.pdf

15 Santa Clara County Innovation Project Description. 2017http://www.mhsoac.ca.gov/sites/default/files/documents/2017-11/OAC_Santa_Clara_County_INN_Plan_Description_Headspace_11162017.pdf

16 Evaluation of Headspace Program. Headspace. Retrieved from: https://headspace.org.au/assets/Uploads/Evaluation-of-headspace-program.pdf

17 Ronald J. Prinz, Matthew R. Sanders, Cheri J. Shapiro, Daniel J. Whitaker, John R. Lutzker. Prevention Science. Population-Based Prevention of Child Maltreatment: The U.S. Triple P System Population Trial. March 2009. https://link.springer.com/article/10.1007%2Fs11121-009-0123-3

18 Yolo County Health & Human Services Consolidation Analysis. Resource Development Associates. 13 December 2013.

About Children Now

Children Now is dedicated to ensuring every California child, regardless of race or socioeconomic status, can reach his or her full potential. The organization conducts nonpartisan, whole-child research, policy development, and advocacy to improve children's health, education, and well-being in California.

Learn more at www.childrennow.org.

CH1LDREN NOW

Acknowledgments

Thank you to the The California Endowment for their support for this work.

Thank you to county staff who shared their expertise and insights about their programs.

Research and Writing By Lishaun Francis; Editing By Kelly Hardy and Adrienne Bell; Design by Nima Rahni.

AGENDA ITEM 7

Information

July 25, 2019 Commission Meeting

Executive Director Report Out

Summary: Executive Director Ewing will report out on projects underway, on county Innovation plans approved through delegated authority and on other matters relating to the ongoing work of the Commission.

Presenter:

- Toby Ewing, Ph.D., Executive Director, MHSOAC

Enclosures (8): (1) Motions Summary from the May 24, 2019 Meeting; (2) Motions Summary from the June 10, 2019 Teleconference Meeting; (3) Evaluation Dashboard; (4) Innovation Dashboard; (5) County Presentation Guidelines; (6) Calendar of Tentative Agenda Items; (7) Department of Health Care Services Revenue and Expenditure Reports Status Update; (8) Legislative Report to the Commission.

Handouts: None.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
May 23, 2019

Motion #: 1

Date: May 23, 2019 **Time:** 9:41AM

Motion:

The Commission approves the April 25, 2019 meeting minutes as amended on pages 11, 17, and 23.

Commissioner making motion: Vice-Chair Ashbeck
Commissioner seconding motion: Commissioner Danovitch

Motion carried 6 yes, 0 no, and 2 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☐	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☐	☐	☒
7. Commissioner Bunch	☒	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☐	☐	☒
13. Commissioner Wooton	☐	☐	☐
14. Vice-Chair Ashbeck	☒	☐	☐
15. Chair Tamplen	☒	☐	☐

Motion #: 2

Date: May 23, 2019 **Time:** 11:26AM

Motion: The Commission approves the following Orange County's Innovation Plan with a requirement that the County submit an annual report to the Commission:

Name: Behavioral Health System Transformation

Additional Amount: Up to $18,000,000 in MHSA Innovation funds

Project Length: 3 years

Commissioner making motion: Commissioner Danovitch
Commissioner seconding motion: Commissioner Bunch

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☐	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☒	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☒	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☐	☒	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☒	☐	☐
15. Chair Tamplen	☒	☐	☐

Motion #: 3

Date: May 23, 2019 **Time:** 12:03PM

Motion: The Commission approves Ventura County's Innovation Project, as follows:

Name: Conocimiento: Addressing ACEs through Core Competencies

Additional Amount: Up to $1,047,100 in MHSA Innovation funds

Project Length: 4 years

Commissioner making motion: Commissioner Madrigal-Weiss
Commissioner seconding motion: Commissioner Berrick

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☐	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☒	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☒	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☒	☐	☐
15. Chair Tamplen	☒	☐	☐

Motion #: 4

Date: May 23, 2019 **Time:** 3:08PM

Motion: The Commission approves the following Los Angeles County's Innovation Project with a requirement to provide an update to the Commission in six months:

Name: The TRIESTE Project: True Recovery Innovation Embraces Systems That Empower

Additional Amount: Up to $116,750,000 in MHSA Innovation funds

Project Length: 5 years

Commissioner making motion: Commissioner Boyd

Commissioner seconding motion: Commissioner Wooton

Motion carried 8 yes, 1 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☐	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☒	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☐	☒	☐
15. Chair Tamplen	☒	☐	☐

Motion #: 5
Date: May 23, 2019 **Time:** 4:22PM
Motion:
The MHSOAC adopts the following County Innovation plan approval process:

- Utilize a Consent Agenda:
  - A county Innovation plan for which staff analysis has identified no significant concerns or issues, including from public comments received by the Commission prior to the posting of the agenda, with the approval of the Commission Chair shall be placed on the Consent Agenda
  - Any Commissioner may without explanation remove a plan from the Consent Agenda prior to a vote
- The Commission authorizes the Executive Director, with the consent of the Commission Chair, to approve a county Innovation plan that meet any of the following conditions:
  - The county Innovation plan, plan extension or modification does not raise significant concerns or issues and includes total MHSA Innovation spending authority of $1,000,000 or less
  - The county Innovation plan is substantially similar to a county Innovation proposal that has been approved by the Commission within the past three years, if in the judgement of the Executive Director, differences in the county Innovation proposal and a previously approved plan are not material to concerns raised by the Commission in its previous review, are non-substantive, and the new project furthers the ability of the previously approved Innovation plan to support statewide transformational change.

  The Executive Director shall publicly report to the Commission, at the first available opportunity, any county Innovation plan approved by the Executive Director on behalf of the Commission.

Commissioner making motion: Commissioner Brown

Commissioner seconding motion: Commissioner Danovitch

Motion carried 7 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☐	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☒	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☐	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☐	☐	☒
14. Vice-Chair Ashbeck	☒	☐	☐
15. Chair Tamplen	☒	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
June 10, 2019

Motion #: 1

Date: June 10, 2019

Motion:

- The Commission approves the proposed outline of the scope of work for the Transition Age Youth RFP and asks staff to work "TAY-led activities" language into the RFP.
- The Commission authorizes the Executive Director to initiate a competitive bid process.

Commissioner making motion: Commissioner Mitchell

Commissioner seconding motion: Commissioner Wooton

Motion carried 6 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☒	☐	☐
4. Commissioner Berrick	☐	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☐	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☐	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☐	☐	☐
15. Chair Tamplen	☒	☐	☐

Motion #: 2

Date: June 10, 2019

Motion:
The Commission authorizes the Executive Director to enter into four contracts as follows:

- **Regents of UC, San Francisco for research and evaluation support**
  - Not to exceed $1,161,008
- **Crusade, Inc. for website support**
  - Not to exceed $103,990
- **Tableau Software for data visualization software**
  - Not to exceed $130,079
- **Crossings TV for multicultural and multilingual commercials and segments**
  - Not to exceed $109,880

Commissioner making motion: Commissioner Berrick

Commissioner seconding motion: Commissioner Beall

Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☒	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☐	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☐	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☐	☐	☐
15. Chair Tamplen	☒	☐	☐

Summary of Updates

Contracts

New Contract: 18MHSOAC040

Total Contracts: **5**

Funds Spent Since the May Commission Meeting

Contract Number	Amount
17MHSOAC024	$34,800
17MHSOAC081	$0
17MHSOAC085	$0
18MHSOAC020	$0
18MHSOAC040	$0
Total	**$34,800**

Contracts with Deliverable Changes

17MHSOAC24

17MHSOAC81

17MHSOAC85

The iFish Group: Hosting & Managed Services (17MHSOAC024)

MHSOAC Staff: Rachel Heffley

Active Dates: 12/28/17 - 9/30/19

Total Contract Amount: $423,923

Total Spent: $410,273

To provide hosting & managed services (HMS) such as Secure Data Management Platform (SDMP) & a Visualization Portal where software support will be provided for SAS Office Analytics, Microsoft SQL, Drupal CMS 7.0 Visualization Portal, & other software products. Support services & knowledge transfer will also be provided to assist MHSOAC staff in collection, exploration, & curation of data from external sources.

Deliverable	Status	Due Date	Change
Secure Data Management Platform	Complete	12/28/17	No
Visualization Portal	Complete	12/28/17	No
Data Management Support Services	In Progress	09/30/19	Yes

Regents of University of California, Los Angeles: Population Level Outcome Measures (17MHSOAC081)

MHSOAC Staff: Katherine Elliot

Active Dates: 7/1/2018-7/31/2020

Total Contract Amount: $1,200,000

Total Spent: $385,300

The purpose of this project is to develop, through an extensive public engagement effort and background research process, support for datasets of preferred (recommended) & feasible (delivered) measures relating to

1) negative outcomes of mental illness
2) prevalence rates of mental illness by major demographic categories suitable for supporting the evaluation of disparities in mental health service delivery & outcomes
3) the impact(s) of mental health & substance use disorder conditions (e.g., disease burden),
4) capacity of the service delivery system to provide treatment and support,
5) successful delivery of mental health services
6) population health measures for mental health program client populations.

Deliverable	Status	Due Date	Change
Work Plan	Complete	09/30/18	No
Survey Development Methodology/Survey	Complete	12/31/18	No
Survey Data Collection/Results/Analysis of Survey	In Progress	3/30/20	No
Summary Report (3 Public Engagements)	Complete	3/30/19	No

MHSOAC Evaluation Dashboard Month July 2019
(Updated July 10th, 2019)

Deliverable	Status	Due Date	Change
Summary Report (3 Public Engagements)	In Progress	6/30/19	Yes
Outcomes Reporting Draft Report —3 Sections	Not Started	9/31/19	No
Outcomes Reporting Draft Report – 4 Sections	Not Started	12/31/19	No
Outcomes Reporting Final Report	Not Started	06/01/20	No
Outcomes Reporting Data Library & Data Management Plan	Not Started	06/01/20	No
Data Fact Sheets and Data Briefs	Not Started	06/01/20	No

Mental Health Data Alliance: FSP Pilot Classification & Analysis Project (17MHSOAC085)

MHSOAC Staff: Rachel Heffley

Active Dates: 07/01/18 - 12/31/19

Total Contract Amount: $234,279

Total Spent: $100,405

The intention of this pilot program is to work with a four-county sample (Amador, Fresno, Orange, & Ventura) to collect FSP program profile data, link program profiles to the FSP clients they serve, & model a key outcome (early exit from an FSP) as a function of program characteristics, service characteristics, & client characteristics

Deliverable	Status	Due Date	Change
Final Online Survey	Complete	02/04/19	No
FSP Program Data Sets	Complete	05/06/19	Yes
FSP Formatted Data Sets	In Progress	09/07/19	Yes
FSP Draft Report	Not Started	10/07/19	No
FSP Final Report	Not Started	12/09/19	No

The iFish Group: Hosting & Managed Services (18MHSOAC020)

MHSOAC Staff: Rachel Heffley

Active Dates: 01/01/19 - 12/31/19

Total Contract Amount: $306,443

Total Spent: $261,443

To provide hosting & managed services (HMS) such as Secure Data Management Platform (SDMP) & a Visualization Portal where software support will be provided for SAS Office Analytics, Microsoft SQL, Drupal CMS 7.0 Visualization Portal, & other software products. Support services & knowledge transfer will also be provided to assist MHSOAC staff in collection, exploration, & curation of data from external sources.

Deliverable	Status	Due Date	Change
Secure Data Management Platform	Complete	01/01/19	No
Data Management Support Services	Not Started	12/31/19	No

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (18MHSOAC040)

MHSOAC Staff: Dawnte Early

Active Dates: 07/01/19 - 06/30/21

Total Contract Amount: $1,161,008

Total Spent: $0

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis activities.

Deliverable	Status	Due Date	Change
Quarterly Progress Report	Not Started	09/30/19	No
Quarterly Progress Report	Not Started	12/31/19	No
Quarterly Progress Report	Not Started	03/31/2020	No
Quarterly Progress Report	Not Started	06/30/2020	No
Quarterly Progress Report	Not Started	09/30/2020	No
Quarterly Progress Report	Not Started	12/31/2020	No
Quarterly Progress Report	Not Started	03/31/2021	No
Quarterly Progress Report	Not Started	06/30/2021	No

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD

JULY 2019

UNDER REVIEW	Delegated Authority	Consent Agenda	Full Commission	Draft Proposals	TOTALS
Number of Projects	2	2	0	7	**11**
Participating Counties*	2	2	0	5	**9**
Dollars Requested	$1,305,715	$11,400,287	$0	$4,281,001	**$16,987,003**

* **Delegated Authority:** Glenn (1), Siskiyou (1)
Consent Agenda: Alameda (1), Sutter-Yuba (1)
Full Commission: None
Drafts: Colusa (1), SLO (2), Napa (1), Madera (1), El Dorado (2)

PREVIOUS PROJECTS	Received	Approved	Total INN Dollars Approved	Participating Counties
2014-2015	N/A	26	$128,853,402	16 (27%)
2015-2016	N/A	23	$52,534,133	15 (25%)
2016-2017	33	30	$68,634,435	18 (31%)
2017-2018	34	31	$149,219,320	19 (32%)
2018-2019	51	51	$302,671,169	31 (53%)

TO DATE	Received	Approved	Total INN Dollars Approved	Participating Counties
2019-2020	UPCOMING	UPCOMING	UPCOMING	UPCOMING

Total number of counties that have presented an INN Project since 2013:
56 (95%)
Average Time from Final Proposal Submission to Commission Deliberation†:
52 days

Process Definitions

Delegated Authority: Authorizes the Executive Director, with the consent of the Chair, to approve county projects that meet any of the following conditions: Project budget of $1,000,000 or less, or county project proposes to join an existing project

Consent Agenda: For projects over $1,000,000 and limited to plans for which staff analysis has identified no significant concerns, including from public comment; requires approval of the chair; allows any Commissioner to remove the plan from the consent calendar prior to vote

Full Commission: For any project in which staff analysis or any Commissioner deems it necessary for the county to present before the Commission for live deliberation and vote

† This excludes extensions of previously approved projects, Tech Suite additions, and government holidays.

PROJECT DETAILS

FINAL PROPOSALS							
STATUS	COUNTY	PROJECT NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO MHSOAC	FINAL PROJECT SUBMITTED TO MHSOAC	COMMISSION MEETING MONTH
Delegated Authority	Glenn	CRCC-Crisis Response and Community Connections	$787,535	5 Years	3/26/2019	5/31/2019	N/A
Delegated Authority	Siskiyou	Integrated Care Project	$518,180	5 Years	2/14/2019	4/19/2019	N/A
Consent Agenda	Alameda	Supportive Housing Community Land Trust (CLT)	$6,171,599	5 Years	11/2/2018	2/8/2019	PENDING
Consent Agenda	Sutter-Yuba	iCARE	$5,228,688	5 Years	5/6/2019	6/17/2019	PENDING

DRAFT PROPOSALS							
STATUS	COUNTY	PROJECT NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO MHSOAC	FINAL PROJECT SUBMITTED TO MHSOAC	COMMISSION MEETING MONTH
In Review	Colusa	Social Determinants of Rural Mental Health Project	$161,200	3 Years	8/30/2018	PENDING	TBD
In Review	San Luis Obispo	SLOTAP (San Luis Obispo Threat Assessment Program	$559,811	4 Years	3/21/2019	PENDING	TBD
In Review	San Luis Obispo	Holistic Adolescent Health	$500,000	4 Years	3/21/2019	PENDING	TBD
In Review	Napa	Statewide Early Psychosis Learning Health Care Network	$251,286	5 Years	4/30/2019	PENDING	TBD
In Review	Madera	Living Well Madera	$200,000	5 Years	4/19/2019	PENDING	TBD
In Review	El Dorado	Partnership Between Senior Nutrition & Behavioral Health to Reach Home Bound Older Adults in Need of Mental Health Services	$450,000	2 Years	4/30/2019	PENDING	TBD
In Review	El Dorado	HUBS Project	$2,158,704	1 Year	4/30/2019	PENDING	TBD

Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING PRESENTATION GUIDELINES

These recommendations for innovation plan presentations have been developed to support the dialogue between the Commission and the counties. Please note that the recommendations below regarding length, the county brief, PowerPoint presentation and presenter information are to ensure that counties and the Commission have ample opportunity to engage in a dialogue to gain a better understanding of the needs in the county, how the innovation plan meets those needs, why it is innovative and how will it be evaluated to support shared learning.

1. **Length of Presentation**
    a. County presentations should be no more than 10-15 minutes in length
    b. The Commission will have received the Innovation Project Plan as well as the Staff Analysis prior to the meeting
    c. The remaining time on the agenda is reserved for dialogue with the Commission and for public comment

2. **County Brief**
    a. Recommend 2-4 pages total and should include the following three (3) items:
        i. Summary of Innovation Plan / Project
        ii. Budget
        iii. Address any areas indicated in the Staff summary

3. **PowerPoint Presentation**
    a. Recommend 5 slides and include the following five (5) items:
        i. Presenting Problem / Need
        ii. Proposed Innovation Project to address need
        iii. What is innovative about the proposed Innovation Project? How will the proposed solution be evaluated (learning questions and outcomes)?
        iv. Innovation Budget
        v. If successful, how will Innovation Project be sustained?

4. **Presenters and Biographies**
    a. We request no more than a few (2-4) presenters per Innovation Project
        i. If the county wishes to bring more presenters, support may be provided during the public comment period
    b. Recommend biography consisting of brief 1-2 sentences for individuals presenting in front of the Commission
        i. Include specific names, titles, and areas of expertise in relation to Innovation Plan / Project

Note: Due dates will be provided by Innovation Team upon Commission calendaring for the following items: Presenter Names, Biographies, County Brief, and PowerPoint presentation.

Calendar of Tentative Commission Meeting Agenda Items

Proposed 07/15/19

Agenda items and meeting locations are subject to change

August 22: Sacramento, CA

- **Awarding of the Transition Age Youth Stakeholder Contract**
  The Commission will consider awarding a stakeholder contract in the amount of $*1,840*,000 to the highest scoring applicant in response to the Transition Age Youth Stakeholder RFP.
- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.
- **MHSOAC Conflict of Interest Code**
  The Commission will consider approving proposed amendments to the MHSOAC's Conflict of Interest Code needed due to new staffing classifications.
- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.
- **Strategic Planning**
  The Commission will be presented with the draft of the Strategic Plan.
- **Executive Director Report Out**
  The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.

September 26: Sacramento, CA

- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.
- **Suicide Prevention Strategic Plan**
  The Commission will be presented with the draft of the statewide Suicide Prevention Strategic Plan.
- **Use of County Innovation Funds**
  The Commission staff will provide an overview of county uses of Innovation funds since implementation of Assembly Bill 1467 (Chapter 23, Statutes of 2012).
- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.
- **Rules of Procedure**
  The Commission will consider revisions to the Rules of Procedure.
- **Executive Director Report Out**
  The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.

October 24: San Diego, CA

- **Workplace Mental Health Project**
  Panel presentation on the Commission's SB 1113 project on voluntary standards for Mental Health in the Workplace.
- **School Mental Health Policy Project**
  The Commission will be presented with a draft of the School Mental Health Policy Project findings.
- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.
- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.
- **Executive Director Report Out**
  The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.

Calendar of Tentative Commission Meeting Agenda Items

Proposed 07/15/19

Agenda items and meeting locations are subject to change

November 21: TBD

- **SB 1004 Prevention and Early Intervention Project**
  The Commission will hear panel presentations on statewide PEI priorities, evaluation strategies, and technical assistance strategies. *[Tentative]*
- **Suicide Prevention Strategic Plan**
  The Commission will be presented with the Final Statewide Suicide Prevention Strategic Plan.
- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.
- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.
- **Executive Director Report Out**
  The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.

December: No Meeting Scheduled

Attached 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 July 9th, 2019.

This Status Report covers the FY 2014-15 through FY 2017-18 County RERs.

For each reporting period, the Status Report provides a date received by the Department of the County's RER and a date on which Department staff completed their "Final Review."

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. MHSOAC staff process data from County RERs for inclusion in the Fiscal Reporting Tool only after the Department determines that it has completed its Final Review.

The Department also publishes on its website a web page providing access to County RERs. This page includes links to individual County RERs for reporting years FY 2006-07 through FY 2015-16. This page 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 2017-18 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.

Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these reports through its Fiscal Reporting Tool at http://mhsoac.ca.gov/fiscal-reporting for Reporting Years FY 2012-13 through FY 2016-17 and a data reporting page at http://mhsoac.ca.gov/documents?field_county_value=All&date_filter%5Bvalue%5D%5Byear%5D=&field_component_tid=46.

On July 1, 2018 DHCS published a report detailing MHSA funds subject to reversion for allocation years FY 2005-06 through FY 2014-15 to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). The report details all funds deemed reverted and reallocated to the county of origin for the purpose the funds were originally allocated. The report can be accessed at the following webpage: http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/MHSA_Reversion_Funds_Report.pdf

DHCS MHSA Annual Revenue and Expenditure Report Status Update

	FY 14-15		FY 15-16		FY 16-17			FY 17-18		
County	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date
Alameda	9/14/2017	9/29/2017	9/29/2017	9/29/2017	1/2/2018		1/3/2018	3/25/2019	3/26/2019	4/9/2019
Alpine	6/26/2017	6/26/2017	11/22/2017	11/27/2017	7/23/2018		7/23/2018	5/10/2019	5/13/2019	5/15/2019
Amador	3/27/2017	3/27/2017	4/7/2017	4/10/2017	4/12/2018		4/13/2018	12/19/2018	12/19/2018	12/21/2018
Berkeley City	5/2/2016	7/26/2016	4/13/2017	4/13/2017	1/25/2018		2/1/2018	12/28/2018	1/2/2019	1/8/2019
Butte	4/4/2016	6/23/2016	4/17/2017	4/18/2017	5/4/2018		5/7/2018	6/26/2019		6/26/2019
Calaveras	1/4/2016	1/13/2016	4/18/2017	4/19/2017	6/1/2018	6/14/2018	7/20/2018	1/10/2019		1/11/2019
Colusa	1/8/2016	2/10/2016	5/17/2017	5/17/2017	5/8/2018		5/9/2018	3/28/2019	4/25/2019	4/30/2019
Contra Costa	3/8/2016	3/14/2016	4/17/2017	4/18/2017	12/29/2017	1/5/2018	1/24/2018	12/31/2018	1/7/2019	1/22/2019
Del Norte	5/13/2016	5/16/2016	4/17/2017	5/19/2017	2/23/2018		2/26/2018	12/31/2018		1/2/2019
El Dorado	2/9/2016	2/11/2016	4/17/2017	4/19/2017	12/29/2017	1/5/2018	1/24/2018	12/28/2018	1/3/2019	1/25/2019
Fresno	12/14/2015	12/18/2015	4/17/2017	4/18/2017	12/29/2017	1/8/2018	5/7/2018	12/28/2018	1/2/2019	1/2/2019
Glenn	3/17/2016	3/24/2016	7/20/2017	7/20/2017	2/22/2018		2/22/2018	12/31/2018	1/7/2019	2/11/2019
Humboldt	9/30/2016	10/3/2016	4/13/2017	4/18/2017	12/21/2017	1/3/2018	4/25/2018	12/20/2018	12/21/2018	1/2/2019
Imperial	12/31/2015	1/4/2016	4/27/2017	4/27/2017	12/28/2017		1/9/2018	12/26/2018		1/2/2019
Inyo	2/24/2016	2/24/2016	5/9/2017	5/9/2017	7/6/2018		7/9/2018	3/19/2019	3/20/2019	3/22/2019
Kern	10/31/2016	10/31/2016	5/30/2017	2/7/2018	1/30/2018		2/7/2018	1/4/2019		1/7/2019
Kings	4/7/2016	5/2/2017	5/2/2017	5/24/2017	1/29/2018		1/29/2018	1/31/2019	2/4/2019	2/11/2019
Lake	7/25/2018	7/26/2018	7/25/2018	7/26/2018	9/12/2018	9/12/2018	7/2/2019			
Lassen	9/21/2016	9/29/2016	5/18/2017	5/25/2017	5/14/2018	5/16/2018	7/23/2018	1/8/2019	1/14/2019	1/31/2019
Los Angeles	4/20/2017	4/21/2017	1/31/2018	2/1/2018	6/29/2018	7/2/2018	7/20/2018	12/31/2018	1/14/2019	1/29/2019
Madera	12/6/2016	12/7/2016	5/12/2017	6/13/2018	3/27/2018	6/14/2018	7/26/2018	12/31/2018	1/7/2019	2/4/2019
Marin	10/21/2016	10/21/2016	5/10/2017	5/11/2017	1/31/2018		2/1/2018	12/21/2018	12/21/2018	12/21/2018
Mariposa	9/23/2016	9/28/2016	5/18/2017	5/19/2017	3/14/2018		3/14/2018	12/20/2018	1/3/2019	1/31/2019
Mendocino	5/31/2017	5/31/2017	8/31/2017	8/31/2017	4/27/2018		4/30/2018	12/31/2018		1/3/2019
Merced	3/28/2017	3/29/2017	7/21/2017	7/21/2017	2/1/2018		2/1/2018	12/21/2018	12/21/2018	12/31/2018
Modoc	3/24/2016	3/25/2016	4/17/2017	4/19/2017	4/20/2018		4/23/2018	1/16/2019	1/16/2019	1/24/2019
Mono	3/30/2016	4/6/2016	4/25/2017	6/20/2017	5/18/2018	5/22/2018	6/13/2018	12/28/2018	1/3/2019	1/17/2019
Monterey	3/29/2018	4/23/2018	10/4/2018	10/4/2018	10/4/2018		10/4/2018	3/5/2019	3/6/2019	
Napa	8/18/2017	8/25/2017	11/9/2017	11/13/2017	5/15/2018		5/15/2018	12/28/2018	1/2/2019	1/4/2019
Nevada	6/21/2018	6/21/2018	7/20/2018	7/25/2018	8/13/2018		8/13/2018	12/21/2018		12/21/2018
Orange	12/30/2015	12/30/2015	12/27/2016	4/13/2017	12/29/2017	1/17/2018	1/25/2018	12/28/2018	1/2/2019	1/31/2019
Placer	11/15/2016	11/17/2016	4/14/2017	4/18/2017	12/22/2017		1/23/2018	1/18/2019		1/22/2019
Plumas	6/8/2017	6/23/2017	3/27/2018	3/28/2018	10/8/2018		10/15/2018			
Riverside	5/12/2017	5/15/2017	6/9/2017	6/12/2017	12/29/2017	1/24/2018	1/25/2018	12/31/2018		1/29/2019
Sacramento	5/8/2017	5/8/2017	6/19/2017	6/20/2017	12/29/2017	1/24/2018	1/25/2018	12/31/2018	1/2/2019	1/2/2019
San Benito	10/24/2016	3/8/2016	9/8/2017	9/12/2017	9/25/2018		9/27/2018	3/8/2019	3/8/2019	3/18/2019
San Bernardino	5/19/2016	5/19/2016	5/1/2017	5/1/2017	6/29/2018		7/2/2018	12/31/2018		1/2/2019
San Diego	12/18/2015	5/26/2017	5/26/2017	5/26/2017	5/11/2018		6/11/2018	12/26/2018		1/15/2019
San Francisco	3/4/2016	3/4/2016	7/5/2017	9/18/2017	3/21/2018		3/27/2018	12/31/2018	1/3/2019	1/30/2019
San Joaquin	6/8/2017	6/13/2017	10/3/2017	10/4/2017	12/29/2017	1/24/2018	1/25/2018	12/31/2018		1/7/2019
San Luis Obispo	1/15/2016	1/15/2016	5/12/2017	5/16/2017	2/15/2018		2/16/2018	12/14/2018	12/18/2018	12/28/2018
San Mateo	5/9/2017	5/9/2017	10/10/2017	10/18/2017	4/20/2018		4/30/2018	12/31/2018		1/2/2019
Santa Barbara	5/24/2017	6/20/2017	5/24/2017	6/20/2017	12/22/2017	1/22/2018	1/25/2018	12/21/2018	1/3/2019	1/14/2019
Santa Clara	5/5/2017	5/11/2017	12/18/2017	1/4/2018	4/20/2018		4/23/2018	12/27/2018		1/2/2019
Santa Cruz	4/5/2018	4/9/2018	7/19/2018	7/20/2018	8/15/2018		8/16/2018	12/31/2018	1/3/2019	1/7/2019
Shasta	10/7/2016	10/7/2016	4/14/2017	4/17/2017	3/29/2018		4/23/2018	12/13/2018	12/17/2018	1/2/2019
Sierra	10/17/2016	10/17/2016	8/16/2017	5/25/2018	6/28/2018	6/28/2018	7/23/2018	12/28/2018		1/2/2019
Siskiyou	6/30/2017	7/10/2017	6/30/2017	7/10/2017	7/27/2018		1/15/2019			
Solano	12/29/2015	12/30/2015	3/23/2017	4/4/2017	12/28/2017	1/23/2018	1/25/2018	12/31/2018	1/3/2019	2/21/2019
Sonoma	4/10/2017	4/10/2017	6/26/2017	6/27/2017	7/13/2018		7/23/2018	1/16/2019	1/29/2019	2/1/2019
Stanislaus	12/22/2015	12/22/2015	4/5/2017	4/5/2017	4/27/2018		4/30/2018	12/26/2018		1/3/2019
Sutter-Yuba	8/15/2018	8/17/2018	8/15/2018	8/17/2018	8/15/2018	5/1/2018	8/17/2018	1/7/2019	1/28/2019	1/31/2019
Tehama	4/29/2016	5/11/2017	5/8/2017	5/16/2017	7/25/2018		7/26/2018	6/20/2019		
Tri-City	12/30/2015	2/3/2016	4/6/2017	4/6/2017	12/29/2017	1/24/2018	2/15/2018	12/31/2018	1/3/2019	1/30/2019
Trinity	9/19/2016	9/23/2016	7/14/2017	7/14/2017	6/29/2018		7/2/2018	1/30/2019		2/7/2019
Tulare	3/17/2016	3/22/2016	4/12/2017	4/12/2017	12/26/2017	1/22/2018	1/25/2018	12/19/2018	12/21/2018	12/26/2018
Tuolumne	12/23/2015	12/28/2015	4/10/2017	5/18/2017	2/16/2018		3/1/2018	12/11/2018	12/12/2018	12/12/2018
Ventura	12/31/2015	1/4/2016	4/14/2017	4/27/2017	4/27/2018		5/25/2018	12/20/2018		12/21/2018
Yolo	6/21/2017	6/21/2017	3/9/2018	3/12/2018	3/23/2018		3/26/2018	1/30/2019	1/31/2019	1/31/2019
Total	59	59	59	59	59		59	56	37	54

* FY 2005-06 through FY 2013-14, all Counties are current

Current Through: 07/09/2019

2019 Legislative Report to the Commission
As of July 18, 2019

SPONSORED LEGISLATION

Senate Bill 10 (Beall)
Title: Mental health services: peer support specialist certification.

Summary: Would require the State Department of Health Care Services to establish, no later than July 1, 2020, a statewide peer certification program, as a part of the state's comprehensive mental health and substance use disorder delivery system and the Medi-Cal program.

Status/Location: 7/3/19 Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. (Ayes 15. Noes 0.) (July 2). Re-referred to Com. on APPR.

Co-Sponsors: Steinberg Institute

Senate Bill 11 (Beall)
Title: Health care coverage: mental health parity.

Summary: Would require the Department of Managed Health Care and the Department of Insurance annually to report to the Legislature the information obtained through activities taken to enforce state and federal mental health parity laws.

Status/Location: 5/17/19 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/13/2019) (May be acted upon Jan 2020).

Co-Sponsors: The Kennedy Forum; Steinberg Institute

Senate Bill 12 (Beall)
Title: Mental health services: youth.

Summary: This bill would require the commission, contingent on appropriation, to administer an Integrated Youth Mental Health Program for purposes of establishing local centers to provide integrated youth mental health services, as specified. The bill would authorize the commission to establish the core components of the program, subject to specified criteria, and would require the commission to develop the selection criteria and process for awarding funding to local entities for these purposes.

Status/Location: 6/26/19 June 26 set for first hearing. Placed on APPR. suspense file.

SPONSORED LEGISLATION

Assembly Bill 46 (Carrillo)

Title: Individuals with mental illness: change of term.

Summary: Current law refers to an insane or mentally defective person in provisions relating to, among other things, criminal proceedings, correctional facilities, and property tax exemptions. This bill would state the intent of the Legislature to enact legislation to replace derogatory terms, including, but not limited to, "insane" and "mentally defective," with more culturally sensitive terms when referring to individuals with mental illness.

Status/Location: 6/26/19 Approved by the Governor. Chaptered by Secretary of State - Chapter 9, Statutes of 2019.

Co-Sponsors: Disability Rights California

SUPPORTED LEGISLATION

Senate Bill 66 (Atkins)

Title: Medi-Cal: federally qualified health center and rural health clinic services.

Summary: This bill will facilitate the ability to transition patients from primary care to an onsite mental health specialist on the same day, to ensure that a patient receives needed care and follows through with treatment. This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit.

Status/Location: 7/3/19 Coauthors revised. From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 15. Noes 0.) (July 2). Re-referred to Com. on APPR.

Senate Bill 582 (Beall)

Title: Youth mental health and substance use disorder services.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, when making grant funds available on and after July 1, 2021, to allocate at least 1/2 of those funds to local educational agency and mental health partnerships, as specified. The bill would require this funding to be made available to support prevention, early intervention, and direct services, as determined by the commission. The bill would require the commission, in consultation with the Superintendent of Public Instruction, to consider specified criteria when determining grant recipients.

Status/Location: 7/11/19 From committee: Do pass and re-refer to Com. on APPR. with recommendation: To consent calendar. (Ayes 7. Noes 0.) (July 10). Re-referred to Com. on APPR. (Received at desk July 10 pursuant to JR 61(a)(10)).

SUPPORTED LEGISLATION

Senate Bill 604 (Bates)

Title: Mental Health Services Act: centers of excellence.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, by January 1, 2021, to establish one or more centers of excellence to provide counties with technical assistance to implement best practices related to elements of the act. The bill would require those centers of excellence to be funded with state administrative funds provided under the act. In implementing these provisions, the bill would require the commission to determine the areas of focus for the centers of excellence, including, but not limited to, the areas of service delivery that need improvement.

Status/Location: 5/16/19 May 16 hearing: Held in committee and under submission.

Assembly Bill 43 (Gloria)

Title: Mental health.

Summary: This bill would require the commission, in consultation with specified state, local, and private entities, to develop a strategy for the collection, organization, and public reporting of information on mental health funding, mental health programs, services, and strategies, funded by the Mental Health Services Act or other sources, and mental health outcomes, as specified. By authorizing a new use of MHSA moneys, this bill would amend the act. The bill would require the commission to make the information available as prescribed to the public and policymakers. The bill would authorize the commission, subject to available funding, to develop an innovation challenge and utilize one or more hackathons, open coding initiatives, or other approaches to an effective strategy to collect, display, and make publicly available relevant information to support the intent of the provisions.

Status/Location: 7/8/19 In committee: Referred to APPR. suspense file.

Assembly Bill 512 (Ting)

Title: Medi-Cal: specialty mental health services.

Summary: Current law requires the State Department of Health Care Services to implement managed mental health care for Medi-Cal beneficiaries through contracts with mental health plans, and requires mental health plans to be governed by various guidelines, including a requirement that a mental health plan assess the cultural competency needs of the program. This bill would require each mental health plan to prepare a cultural competency assessment plan to address specified matters, including disparities in access, utilization, and outcomes by various categories, such as race, ethnicity and immigration status.

Status/Location: 7/10/19 From committee: Do pass and re-refer to Com. on APPR. (Ayes 7. Noes 1.) (July 10). Re-referred to Com. on APPR.

SUPPORTED LEGISLATION

Assembly Bill 713 (Mullin)

Title: Early Psychosis Intervention Plus (EPI Plus) Program.

Summary: Current law establishes the Early Psychosis and Mood Disorder Detection and Intervention Fund and authorizes the commission to allocate moneys from that fund to provide competitive grants to counties or other entities to create or expand existing capacity for early psychosis and mood disorder detection and intervention services and supports. Currently, implementation of the grant program is contingent upon the deposit into the fund of at least $500,000 in nonstate funds for those purposes. This bill would delete the prohibition on General Fund moneys being appropriated for purposes of those provisions and would delete the requirement that the minimum $500,000 deposit be from nonstate funds.

Status/Location: 7/12/19 Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/6/2019)(May be acted upon Jan 2020).

Assembly Bill 1126 (O'Donnell)

Title: Mental Health Services Oversight & Accountability Commission.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, by January 1, 2021, to establish technical assistance centers and one or more clearinghouses to support counties in addressing mental health issues of statewide concern, with a focus on school mental health and reducing unemployment and criminal justice involvement due to untreated mental health issues.

Status/Location: 5/16/19 In committee: Held under submission.

Assembly Bill 1352 (Waldron)

Title: Community mental health services: mental health boards.

Summary: The Bronzan-McCorquodale Act governs the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Current law generally requires each community mental health service to have a mental health board consisting of 10 to 15 members who are appointed by the governing body and encourages counties to appoint individuals who have experience with and knowledge of the mental health system. This bill would require a mental health board to report directly to the governing body, and to have the authority to act, review, and report independently from the county mental health department or county behavioral health department, as applicable.

Status/Location: 6/20/19 From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 0.) (June 19). Re-referred to Com. on APPR.

SUPPORTED LEGISLATION

Assembly Bill 1443 (Maienschein)

Title: Mental health: technical assistance centers.

Summary: Would require, subject to available funding, the Mental Health Services Oversight and Accountability Commission to establish one or more technical assistance centers to support counties in addressing mental health issues, as determined by the commission, that are of statewide concern and establish, with stakeholder input, which mental health issues are of statewide concern. The bill would require costs incurred as a result of complying with those provisions to be paid using funds allocated to the commission from the Mental Health Services Fund. The bill would state the finding and declaration of the Legislature that this change is consistent with and furthers the intent of the act.

Status/Location: 7/8/19 In committee: Referred to APPR. suspense file.