Prevention and Early Intervention Project

Final Report Draft V.2 Written Public Comment

Submitted to the Commission on or before September 30, 2022

Thank you for the opportunity to comment on this well-written & researched report. As a parent of two children with severe mental disorders, I am grateful for the immense amount of attention and work placed on this critical issue for my children and the multitude of other children and youth as well.

My comments are focused specifically on RECOMMENDATION THREE.

1. <u>EDUCATION IN SCHOOLS</u>

Mental Health education starting at a <u>very young age</u> is the key to long term elimination of stigma surrounding mental health. The majority of young people experiencing mental health challenges are AFRAID to speak up due to stigma from adults and their own peers. Once our youth understand the basics surrounding mental health challenges and that they are simply no different than physical health challenges - just affecting a different part of the body, the fear will be eliminated.

Mental health education is critical to administration and educators in the schools as well. At age 12, my daughter started experiencing anxiety, depression & psychosis. My daughter was a straight A student who participated in sports and many school activities. She was a student leader. She received enormous support from her immediate teachers and they reached out to us - and we ensured she received EARLY psychosis prevention therapy. But, the administrator at her school did not support her. My daughter had spent all her K-8 school years at this one small school and they removed her 5 months shy of her middle school graduation. This one action, which was based on the ignorance of the administrator, was far more detrimental than any symptom my daughter was experiencing. Once my daughter entered high school a few months later with a well-constructed IEP Plan from the counselors at her middle school - she received great support from a few key teachers & counselors. But, again she did not receive support from the principal of that public high school. The only symptom my daughter demonstrated was "crying" and based on that one symptom they wanted to transfer her to a severely disabled facility due to insufficient funds to support my daughter. We had to transfer again to a Charter School, where she flourished with minimal attention. My daughter is now the quintessential poster child for early intervention...her symptoms are under control and she has started her own Youth Mental Health Advocacy Program. The only issue my daughter has had to this day is her absence of friends due to the dismissal from her schools.

Early & continued education has the power to eliminate all stigma in one generation.

Senate Bill 224 is a "start" - but, the Bill is too limited in its scope. The age of mental health education needs to start in Kindergarten. In fact, instead of Physical Education - there should be a WHOLE HEALTH education curriculum at every grade level that teaches physical education, mental health education, nutritional education, economic education, conflict resolution education, personal coping skills development & basic self-suffiency to prepare children for all life's challenges. (Ideally these educational parameters would be met by parents at home, but unfortunately with most households needing to maintain multiple incomes for both parents - it is no longer being handled at home & the one location all our children are to receive this type of comprehensive education is in our schools.)

2. YOUTH-LED PEER PROGRAMS.

The report mentions the effectiveness of youth-led school based programs. This is absolutely critical. Once young people understand mental health challenges, they are the first ones to reach out & support their friends. We have to remember that our youth first & foremost look to their friends for support - far more quickly than any adult. Youth-Led Peer Programs for Mental Health empower our youth - they allow for diverse population interaction, sustainability as it is student-led, and are financially low-cost & low-maintenance using limited support human resources. Engaging students who want to help their peers is a productive mechanism for both the students wanting help & the student giving help. Additionally, peer supports learn more active listening & counseling skills - which creates a much needed pipeline for mental health occupations. It's a win-win everywhere you look.

Thank you for listening to my comments.

Debbie Dennison

09/06/22

MHSOAC
Mental Health Services
Oversight & Accountability Commission

It's such a beautifully comprehensive, clearly laid out plan that encompasses so many elements of what people need to be well. I greatly appreciate the scope of the report and the direct linkage made between historical oppression and today's needs as well as the descriptions of how systems must learn to interact with one another to truly make change.

A few thoughts...

Grammatical

1. Page 2 of the Executive Summary, para. 1 = "finding" should be "findings"
2. Page 15, second to last paragraph = consider re-wording "...education**al system**, justice system **and** social services sectors..."
3. Page 16, last paragraph = missing "s" on "bicyclist"
4. Page 53, para. 3 = "unnecessarily" should be "unnecessary"

Content - Specific

1. Finding/Recommendation #2: I wonder about adding in language or history that highlights why certain marginalized groups may distrust the healthcare system and include language about rebuilding trust in our healthcare systems as an action item. Increasing resilience is important and the details on increasing resilience in the wake of the pandemic/fires/racism, etc...clearly highlight this need. I also believe that in addition to individual and community resilience, the healthcare system must understand the role it has played (and continues to play) in the oppression of certain groups through policies, practices and implicit biases and work to remedy this past to invite these groups back into a trusting relationship (ex. studies demonstrating that doctors believe black people feel less pain than white people subsequently impacts their quality of care, leading to mistrust of the system - and so many more historical examples...). This may not fit at all, but it came to mind when I read about increasing resilience - there is a balance, I believe, between increasing resilience while also giving communities a reason to trust in and return to our healthcare system.
2. Page 13, para. 1 = I wonder if this section might be strengthened by discussing the lasting impacts of redlining and how we see those impacts playing out in today's neighborhoods, instead of focusing on the practice of redlining and then naming it no longer exists. It might be beneficial to give more attention to the impacts the practice has had in limiting the accumulation of generational wealth and ensuring under-resourced neighborhoods have remained so, even today, to strengthen this section.
3. Pages 14-15 = In these sections, the terms "systemic racism" and "structural racism" are used both interchangeably as well as independently. Depending on who the audience is, it might be helpful to define the terms or state they will be used interchangeably.

4. Page 24, para. 2 = this sentence: "Through ongoing data monitoring and evaluation, technical assistance, public engagement, and transparency, the State can ensure its strategies meet the needs of communities" might be strengthened by adding "...by building capacity for local leadership/community control".
5. Page 29, para. 4 = this sentence: "...people who cannot afford high-speed internet or digital devices, or who lack the necessary skills to navigate technologies, are excluded from the quickly evolving digital landscape" might be strengthened (and would preview upcoming arguments) by adding "leading to increased social isolation and lack of necessary information needed to support a high quality of life" (or something like that).
6. Page 29, last para. = might add "generational trauma, community trauma" to the introductory list since these come up in subsequent paragraphs
7. Page 24, para. 3 = this sentence: "...by helping disadvantaged individuals and communities acquire and retain wealth and achieve economic mobility" might be strengthened by adding "to alleviate the impacts of structural racism and histories of systemic oppression”
8. Page 38, Opportunity Spotlight - ECMHC: Is there any additional data that supports an increase in equitable outcomes in these programs for students of color who tend to be disproportionately disciplined in early childhood education settings, leading to a strong connection with the school to prison pipeline? If so, this might be compelling data to include since interrupting biases and oppression early on may have a positive impact on educational outcomes/job opportunities/SDOH specifically for the groups named as most marginalized in this report.
9. Finding/Recommendation #4: I was curious about two potential additions to this section... 1) a recommendation to increase the availability of mental health support in schools, where kids are, to increase early identification and access to care; and 2) a recommendation to increase the availability of virtual care services - thinking about just my own experiences trying to get two of my daughters to weekly counseling sessions across town and the amount of time, scheduling and coordination that took that was really only manageable because I had the privilege of having an extremely flexible job. Increasing virtual care access might be very beneficial to addressing access to care for communities most in need (as well as access to culturally and linguistically responsive providers) and aligns with the prior recommendation of increasing access to high-speed internet and other virtual care opportunities.

Content - General

1. I am thinking about those who believe in the "pull yourself up the bootstraps" mentality and wondering if that is something to address in this report. There is research demonstrating that when resources are provided to those most in need, all of society benefits. It's like thinking about special ed in a way...when we design a lesson that incorporates scaffolds and supports for those at the lowest and highest levels of the class, by default, we also meet the needs of the students in the middle. If this idea or research were explicitly named in the report, it might give context to

and strengthen the arguments for explicit government support of those most in need as a strategy that will also benefit those "in the middle".

2. The call for community involvement and control reminds me of schools' LCAP processes or at least the original theory behind it - give schools money to spend in the way they determine is most needed as long as the needs are in line with state priorities. Schools then report on how they identified their needs, how they spent the money to support those needs and what the results were. While our LCAP model is deeply flawed these days, the theory is good and could be a starting point for a community health model with local control.

I really appreciate the opportunity to dive into such a big picture analysis of the problems and potential solutions. It was both insightful and heartwarming to read about the amazing work being done and the incredible potential for solving some of CA's most important problems.

Rachel Wegner, M.Ed.

9/12/22

To the MHSOAC Commissioners, 9.29.22

I write to demonstrate support for funding and expansion of relapse prevention/early intervention, PEI, for people living with severe mental illnesses. These services are especially helpful to ward off onset of relapses even after years of trying to stay stable.*

*My daughter qualified for some PEI services in 2008, but as soon as she was past her 3rd relapse she was no longer prioritized to receive PEI services, and once she turned 30 years old, the services declined further. During times when symptoms were so strong that the illness itself prevented her capacity to volunteer (as opposed to a person who has access to willpower and rational decision making), again the services were not delivered. She has battled Schizoaffective Disorder for more than 10 years, and spent the last 3 years in revolving doors of hospitals, streets, group homes, our home, streets, interactions with the law, ER visits, hospitals and back to streets and now is housed in jail for trying to survive on streets. This could have been prevented in 2020 with better funding and better implementation of PEI funds for individuals like her who become detached from reality to the point deteriorating on the streets.

I also support funding for diversion and reentry programs for SMI arrestees/jail inmates.

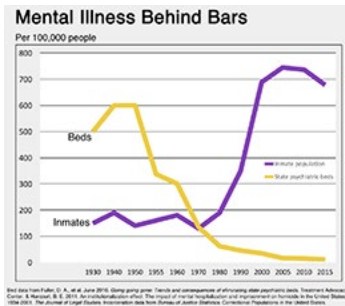
*Now that daughter is housed in Sacramento County Main Jail and is found Incompetent to Stand Trial (IST) with a wait list of over 1,500 that may take months or years to receive a bed, I am more aware of the need for funding for programs that can, for some individuals, lead to court supervised diversion and reentry programs. Sacramento now has a justice involved reentry program that includes housing and mentoring and other supports known as El Hogar. This program is reportedly showing success, and expanding successful programs requires funding. I hope she qualifies and is accepted to this diversion program. Meanwhile, daughter receives care for her illnesses at the jail-- the care that is legally possible in that setting. Alternative settings where her anxiety, her past traumas (PTSD from a rape) and non-medication therapies can be delivered, along with competency training would be more economical to counties and to CA, and increase her chances of survival. When she is stable and stays in treatment she gets her brain back, her life back—but she needs extra help.

***I write with my daughter's permission and encouragement to "do anything you can, Mom, to get things changed so others' stories won't go like mine."**

Please follow the letter of the wording of the MHSA Funding laws stating that PEI and Diversion/reentry services SHALL be provided.

Sincerely,

Elizabeth Kaino Hopper, MFA Design (focus on disability). 916-204-3138
6929 Grant Ave, Carmichael, CA 95608 / ekainohopper@gmail.com
NAMI Sacramento member (past volunteer in family programs)
Advisory Board for 988 (WCCCRT) Sacramento (current)
Primary Caregiver to daughter* living with SMI



Mary Ann Bernard
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September 29, 2022

THE PEI VISION MUST NOT IGNORE TWO MHSA MANDATES FOR PEI SERVICES THE VOTERS INTENDED FOR THE SEVERELY MENTALLY ILL, LACK OF WHICH IS NOW A STATEWIDE MENTAL HEALTH CRISIS

To the Commission:

Your draft of "Well and Thriving," while it gives lip service to the need for "tertiary prevention," is defective because it focuses entirely on upstream prevention, thereby ignoring two Voter-imposed MHSA mandates (meaning they are mandatory—you have no choice about them) requiring downstream *relapse* prevention and early intervention services for consumers with existing severe mental illnesses ("SMI"). Both of these mandates were imposed by the Voters when the Mental Health Services Act was first passed as Proposition 63, almost twenty years ago. Both derive from the central focus of the MHSA: care for and prevention of/early intervention in *severe* mental illness as that term is used in the MHSA, which incorporates Welf. & Ins. Code §5600.3.[1]

The first of these mandates is in the subsection that is the heart of the PEI provisions. While the first clause focuses on upstream prevention (as does "Well and Thriving"), the last clause says this:

> [PEI] **shall also** include components similar to programs that have been successful in **reducing the duration of untreated severe mental illnesses** and assisting people in quickly **re**gaining productive lives. Welf. & Inst. Code §5840(c), last clause. (Emphasis added.)[2]

Despite the above mandate--half of the heart of the MHSA PEI provisions--your draft defines "tertiary prevention" as relapse prevention/early intervention at p. 19 but makes no mention of

[1] Universally recognized principles of statutory construction treat the word "shall" as mandatory. See, e.g, *Tarrant v Superior Court,* 247 P.3d 538 (2011) and cases cited therein. The MHSA and its Purpose and Intent provisions repeatedly state that PEI funds *shall* only be used for preventing "mental illness" from becoming "severe mental illness"—essentially, for "secondary" and "tertiary" prevention as defined at p. 19 of your report. Welf. & Inst. Code § 5600.3 requires both a serious DSM diagnosis that is not solely developmental or SUD, plus evidence of disability caused by that illness, proof of which varies by age. There may be legal funding sources that would allow the Commission to address poverty, racism and the other causes of mental "health" issues identified as "primary prevention" in the Commission's "vision," but MHSA is not one of them. The Commission risks rekindling the scandals and repeated criticisms from the State Auditor, the Little Hoover Commission and others from years past, see, e.g., https://mentalillnesspolicy.org/states/california/mhsa/californias-mental-health-service-act-a-ten-year-10-billion-bait-and-switch-pdf.html, if it goes back to funding happy-making activities for the general public in the hope this will somehow prevent severe mental illness, instead of using PEI funds to help the desperately ill Californians who urgently need the relapse prevention services mandated by the Voters.

[2] While SB 1004 (2018) focused its clarification on upstream prevention and children, the Legislature had no power to ignore the downstream mandate and did not try. Indeed, they provided for "mental health needs of older adults" and a "mood disorder and suicide prevention program that occurs across the lifespan" as well as for youth. Welf. & Inst. Code § §5840.7(a)(2) and (5).

it whatsoever in the priorities that follow. The discussion of crisis services at p. 35—which does not even belong in a document about prevention and early intervention *unless* it focuses on relapse prevention—mentions that stabilization of existing severe mental illnesses is part of the Wellness Act, but does not even acknowledge that it has always been part of the MHSA as well. The resounding quote of Dr. Thomas Insel at the end of the "Well and Thriving" draft is ironic, because he placed more emphasis on relapse prevention/early intervention than on "upstream" prevention. Your draft does the opposite.

The second MHSA mandate the "Well and Thriving" draft overlooks is one for services now desperately needed to resolve a statewide crisis that has recently come to a head. Though mandated by the Voters nearly twenty years ago, this Commission and derivatively, nearly all counties have ignored the MHSA mandate set forth here:

> Welf. & Inst. Code 5815.3(f) Each county plan and annual update pursuant to §5847 **shall** consider ways to provide services similar to those established pursuant to the **Mentally Ill Offender Crime Reduction Grant Program**. Funds shall not be used to pay for persons incarcerated in state prison. *Funds may 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****….*(Italicized clarification added by Stats. 2019, Ch. 209, Sec. 1. (SB 389) Effective January 1, 2020.)(Emphasis added.)

To summarize briefly, the Mentally Ill Offender Crime Reduction Grant Program ("MIOCRGP") is an evidence-based Department of Corrections program, the essence of which is "[m]ental health and substance abuse treatment for mentally ill adult offenders or mentally ill juvenile offenders who are presently placed, incarcerated, or housed in a local adult or juvenile detention or correctional facility or who are under supervision by the probation department after having been released from a state or local adult or juvenile detention or correctional facility" including "[p]rerelease, reentry, continuing, and community-based services designed to provide long-term stability for juvenile or adult offenders *outside of the facilities* of the adult or juvenile justice systems , including services to support a stable source of income, a safe and decent residence, and a conservator or caretaker, as needed in appropriate cases." Penal Code §§6045.2(b)(1) and(c)(2)(emphasis added). Much of MIOCRGP is devoted to data collection[3]

[3] See, for example, Penal Code §s 6045.6-6045.8(a) which include,"The [grant] plan shall describe how the responses and services included in the plan have been proven to be or are designed to be effective in addressing the mental health needs of the target offender population, while also reducing recidivism and custody levels for mentally ill offenders in adult or juvenile detention or correctional facilities. Strategies for prevention, intervention, and incarceration-based services…..The plan as included in the grant application shall include the identification of specific outcome and performance measures and for annual reporting on grant performance and outcomes to the board that will allow the board to evaluate, at a minimum, the effectiveness of the strategies supported by the grant in reducing crime, incarceration, and criminal justice costs related to mentally ill offenders…..The board shall establish minimum requirements, funding criteria, and procedures for awarding grants, which shall take into consideration… The probable or potential impact of the grant on reducing the number or percent of mentally ill adult offenders or mentally ill juvenile offenders who are incarcerated or detained in local adult or juvenile correctional facilities…Demonstrated ability to administer the program, including any past experience in the administration of a prior mentally ill offender crime reduction grant….Demonstrated ability to develop effective responses and to provide effective

and the DOC reports on this program over the years are far more impressive than the amorphous materials this Commission has issued in years past. According to the statute, DOC has already created an "evaluation design" for these programs, see last clause at n. 3.

Your intervention on behalf of the SMI corrections population illustrated in the lefthand graph above is more urgently needed than ever, due to recent legal developments that could soon push thousands of desperately ill and sometimes dangerous SMIs onto California's streets. For decades, California has been warehousing these individuals in jails and prisons without bail or trial, often for status crimes like public urination or talking back to a police officer, and sometimes for periods longer than any possible prison sentence. The California courts recently declared that practice unconstitutional and ordered that mentally ill inmates who are incompetent to stand trial must be placed in competency restoration programs within 28 days. *See Stiavetti v Clendenin* (2021), 65 Cal.App.5th 691, 280 Cal.Rptr.3d 165, *rev. den.* (Aug. 25, 2021). Because there are insufficient state hospital beds to handle the IST population (and perhaps because "competency restoration" is a primitive and cruel concept), the Legislature has reacted by amending the Penal Code, which as of this year essentially requires diversion and reentry programs for all but the most violent in this SMI population. *See generally*, Penal Code §§ 1370(a)(1)(B)(iv) and 1370.01, as amended. *But few such programs exist, even though the MHSA should have been funding them for the past twenty years.* This is partly the early Commission's fault, because historically it ignored the mandate entirely itself. It's also partly the age-old problem of the great divide between the civil side and the criminal justice side, who are often unwilling to share resources or even talk to one another.

Given the current crisis, it is long past time to bridge that gap. There is a sheriff on the Commisson for a good reason. Part of you "vision" needs to be a partnership with DOC that will make good use of existing data to create the programs the Voters called for twenty years ago, that will prevent and intervene early in the relapses that repeatedly send individuals with severe mental illness into crimes and prison. Such programs represent a wise use of public funds by focusing resources precisely where they are needed. They will benefit not only consumers with severe mental illness, but also their families, the members of the public and businesses they sometimes harm, and the institutions that are presently struggling to help them without adequate resources.

Two MHSA-authorized relapse prevention/early intervention programs worth mentioning in your report are Laura's Law (see MHSA funding authorization at Welf. & Inst. Code §5813.5(f)—in essence Laura's Law is early intervention for individuals with a recent history of dangerousness, who have not yet become dangerous again), and the new Care Court (aimed at

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treatment and stability for mentally ill adult offenders or mentally ill juvenile offenders…The board shall create an evaluation design for adult and juvenile mentally ill offender crime reduction grants that assesses the effectiveness of the program in reducing crime, adult and juvenile offender incarceration and placement levels, early releases due to jail overcrowding, and local criminal and juvenile justice costs. The evaluation design may include outcome measures related to the service levels, treatment modes, and stability measures for juvenile and adult offenders participating in, or benefitting from, mentally ill offender crime reduction grant programs or services."

the psychotic homeless on our streets, dangerous or not—see Welf. & Inst. Code §5982(a)(authorizing MHSA funds for Care Court).

In general, you need to educate counties that they can and should use PEI for relapse prevention/early intervention, especially when CSS funds are scarce. (I was solemnly informed by a county MHSA specialist in my home county that PEI is "only for children.")

A gentle reminder: the only reason that relapse prevention/early intervention is included in the present PEI regs at 9 Code of California Regulations § 3720(d) is that I and the Shiff, Harden law firm took the issue to the Office of Administrative Law when MHSOAC refused to include these mandatory services years ago. OAL agreed with us and not a former Commissioner who was then chair (or at any rate always acted like it) who told me that persons with severe mental illnesses should not get PEI because "*those people* (emphasis his) get CSS." (Though shocked that he would exclude the very group that the Voters enacted Prop. 63/MHSA to help, I managed to politely remind him that *those people* get PEI too.) By letter dated February 19, 2021, I also reminded your former counsel Filomena Yeroshek of the OAL directive, and how easy it would be to enlist OAL's assistance again, given that we have already been down this road. I also put her on notice that I/we would request attorneys' fees if we had to do it again. I have great hopes that the current Commission will do what is morally right and legally required, which will make this warning unnecessary.

Sincerely,

Mary Ann Bernard
Stanford with honors '75
U.Chicago Law '78
SBN 211417(inactive-retired)
Former counsel to state mental hospitals in another state
Plaintiff with MHSA drafter Rose King and counsel in *Bernard & King v CHFFA et al* (Third App Dist. CA—the case that put Prop.2 (2018) on the ballot)

cc: Toby Ewing

FIRST 5
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September 30, 2022

To: Mental Health Services Oversight and Accountability Commission
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Cc: Toby Ewing, Ph.D., Executive Director

Dear MHSOAC Commissioners:

Thank you for the opportunity to provide feedback on the *Well and Thriving* report regarding the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA) per the legislative requirement under Senate Bill 1004.

In order for MHSA PEI to most effectively promote mental health wellness across the life course, it must prioritize early childhood investments and programs that provide whole-family supports, interrupting intergenerational cycles of trauma. First 5 Association of California offers the following comments in reflection to the *Well and Thriving* report that uplift the critical importance of prioritizing early childhood mental health and working with First 5 county agencies as partners to support infants and toddlers across the state.

1. Young children experience mental health concerns differently than older children and adults. Young children's mental health is heavily reliant on caregiver mental health and responsiveness, requiring two-generation interventions.

Young children under age 5 can — and do — suffer from mental health conditions. These conditions are difficult for providers to identify and address because young children respond to emotional experiences and traumatic events differently from adults and older children. During these early years, a child's brain is developing more rapidly than at any other point in their life and this development is foundational for future learning and life-long health.[1] Because of this, prevention science suggests intervening as early as possible on prenatal, infant, and early childhood social-emotional concerns to mitigate risk factors associated with the later onset of mental health disorders.[2] Very young children are also uniquely dependent on the caregivers in their lives to meet their social-emotional needs and bounce back from stressful experiences.[3] **Therefore, it's critical that both young children and their caregivers receive the**

[1] Harvard University Center on the Developing Child. (n.d.). *Early Childhood Mental Health.* https://developingchild.harvard.edu/science/deep-dives/mental-health/

[2] Wakschlag, L. S., Roberts, M. Y., Flynn, R. M., Smith, J. D., Krogh-Jespersen, S., Kaat, A. J., Gray, L., Walkup, J., Marino, B. S., Norton, E. S., & Davis, M. M. (2019). Future Directions for Early Childhood Prevention of Mental Disorders: A Road Map to Mental Health, Earlier. *Journal of Clinical Child and Adolescent Psychology: The Official Journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53*, *48*(3), 539–554. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6750224/

[3] ZERO TO THREE. (2017, August 2). *Infant and Early Childhood Mental Health Consultation: A Briefing Paper.* https://www.zerotothree.org/resources/1952-infant-and-early-childhood-mental-health-consultation-a-briefing-paper

interventions necessary to support their mental health now. With this early intervention, upstream approach, we may be able to prevent children from worsening mental health concerns in the future.

California's infants, toddlers, and their caretakers are under significant and escalating toxic stress, which have been exacerbated by the pandemic. Isolation and severe economic stress, combined with systemic issues like poverty, racism, and community trauma, are contributing to crisis-level mental health concerns among our youngest children and their caretakers. A recent poll conducted by Education Trust-West found that 70% of parents of young children are worried about their family's mental health.[4] Other research suggests that many more young children are experiencing high levels of social and emotional difficulties than in non-pandemic times.[5] Even before the pandemic, young children across the state were dealing with the effects of toxic stress, with forty-two percent of California children having experienced at least one Adverse Childhood Experience (ACE).

The First 5 Association applauds the report's inclusion of early childhood mental health supports into the recommendations to reduce trauma and promote mental health across the lifespan. As highlighted in the report, home visiting and Early Childhood Mental Health Consultation (ECMHC) services are key two-generation strategies that show a commitment to upstream prevention by supporting optimal social-emotional development of young children. First 5s not only have a long-standing commitment to and expertise in home visiting and ECMHC services, but also have a deep familiarity with the counties and families that they serve. First 5s are critical partners in this work in every county.

2. Given the prevalence of early childhood mental health concerns and the lifelong impacts of intervening early, MHSA PEI funding should prioritize young children to effectively promote wellbeing and prevent mental health conditions.

MHSA county departments are not currently required to prioritize or address the needs of children ages 0 to 5 specifically, despite the rapid brain development and vulnerability of young children. The MHSOAC is a special body, with the position and funding to make early childhood mental health a statewide priority, reduce stigma related to seeking out services to address infant and toddler mental health concerns and support local programs that meet community need and diversity. **We recommend that MHSOAC identify children ages 0 to 5 as a priority population, given the unique opportunities for positive development. MHSOAC should direct counties to increase PEI investments in universal, community-based approaches that promote early childhood social-emotional well-being, including broad-based efforts to identify issues early, and culturally-relevant services that meet the needs of a wide range of families and communities.**

3. First 5 county agencies are an important local partner for every county PEI strategy in supporting mental health for children ages 0-5 years old.

First 5 county agencies, focused solely on the needs of children ages 0 to 5 and their families, have flexibility to determine how to invest their funds to best serve the community, though their funding source (a state tobacco tax) is declining. In several counties, ECMH programs are the product of

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[4] The Education Trust-West. (n.d.). *California Parent Poll: COVID-19.* https://west.edtrust.org/california-parent-poll-covid-19-and-early-childhood-2021/

[5] Barnett, W.S., & Jung, K. (2021). Seven Impacts of the Pandemic on Young Children and their Parents: Initial Findings from NIEER's December 2020 Preschool Learning Activities Survey. New Brunswick, NJ: National Institute for Early Education Research. Available at https://nieer.org/wp-content/uploads/2021/02/NIEER_Seven_Impacts_of_the_Pandemic_on_Young_Children_and_their_Parents.pdf

partnerships between the county mental health department and the First 5 county commission.[6] These partnerships take many forms but, in many cases, the First 5 initiated, developed or designed the program that is now funded by MHSA, and in some cases is also administering the services.

For example, in Amador County, the First 5 Executive Director and Program Coordinator designed the county's ECMH consultation program. Through a contract with county mental health and funded by PEI, First 5 identifies and contracts with licensed mental health professionals to provide the services. In Orange County, First 5 allocated seed money to initiate an Early Childhood Mental Health collaborative out of an interest in learning more about reducing the number of children being expelled from preschool programs and to pilot an ECMH consultation program for staff and leadership of ECE centers (see page 14 for more information on this program).[7]

Continued and expanded partnerships between First 5s and county departments of mental health are one avenue to support expansion of programs for children ages 0-5 years old, and ensure these programs are designed at the local level to serve this special population and are connected to additional family-serving systems in the county.

4. Instead of recommending new public communication strategies, MHSOAC should name, align, and link existing state communication efforts such as the Children & Youth Behavioral Health Initiative (CYBHI), Office of the Surgeon General/ACEs Aware, and First 5 California, to educate the public on mental health issues including how mental health impacts young children.

The report could be strengthened by recommending a single cohesive public awareness strategy or campaign, led by the State, to influence the broader narrative about mental health and influence state leaders' responses to the existing crisis. **MHSOAC should identify areas where through convening and coordinating across the Administration, it can leverage and align various state efforts to educate the public on mental health issues, including ongoing efforts through the Children & Youth Behavioral Health Initiative (CYBHI), Office of the Surgeon General/ACEs Aware, and First 5 California.** Linking and leveraging these various public awareness efforts could strengthen a broader narrative about prevention and early intervention being most impactful before mental health conditions typically emerge. This kind of messaging could significantly add to the political will in California to invest in true upstream prevention and early intervention in historically marginalized communities.

Sincerely,

Avo Makdessian
Executive Director, First 5 Association of California

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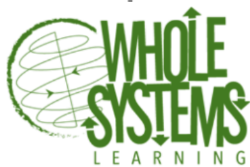
[6] First 5 Center for Children's Policy (October 2021). Addressing infant and early childhood mental health needs: Opportunities for community solutions. https://first5center.org/publications/addressing-infant-and-early-childhood-mental-health-needs-opportunities-for-community-solutions#chapter94920

[7] Ibid.

THE VILLAGE PROJECT, INC

Boa Me Na Me Mmoa Wo
("Help Me and Let Me Help You")



SONOMA COUNTY
INDIAN HEALTH PROJECT

HUMANIDAD
Therapy & Education Services
HUMANIDADTHERAPY.ORG

September 30, 2022

Mara Madrigal-Weiss
Mayra Alvarez
Mental Health Services Oversight and Accountability Commission
Prevention and Early Intervention Subcommittee

Re: Letter for the October 6, 2022 PEI Subcommittee Meeting

Dear Chair Madrigal-Weiss and Commissioner Alvarez,

The undersigned organizations, who work with and advocate for BIPOC and LGTBQ+ communities throughout the state, write to express grave concerns about the Commission's implementation of SB 1004 (Weiner), Chapter 843, Statutes of 2018.

SB 1004 requires the Commission, by January 1, 2020, establish priorities for funding at the county level for the Prevention and Early Intervention (PEI) component of the Mental Health Services Act. Nearly three years have passed since this deadline and the Commission's recent release of a *preliminary* report falls short of meeting SB 1004's mandate, including but not limited to, the timeline.

The language of the statute is clear that in addition to priorities explicitly identified in SB 1004, additional priorities should be identified *with community stakeholder participation*. Last year, a letter dated August 11, 2021 and signed by twenty-five organizations strongly requested the Subcommittee conduct a public meeting ***separate from the one that reviews the PEI Report*** to allow for open and robust discussion of the possible PEI priorities for funding at the local level. According to MHSOAC staff, such a public meeting will not be conducted.

We believe that the provisions of SB 1004 regarding the establishment by the MHSOAC of PEI funding priorities for the counties have not been made clear to the Commissioners or to the public. Does the Commission intend to use the recent preliminary report, once finalized, as compliance with SB 1004? We do not believe the current report meets the legislative mandates and shortchanges the opportunity to adequately address historically racial, ethnic, and LGBTQ+ mental health disparities.

We strongly urge the Commission, pursuant to Welfare & Institutions Code Section 5840.7 (a) (6), to include the following in your list of priorities for adoption:

- ***A priority that adds transition age youth who are not in college***. Although college-bound youth are specifically identified by the *priority on college mental health programs* (Section 5480.7 (a) (3), we recommend adding strategies for transition age youth not enrolled in college. This is vital to avoid discrimination against youth from communities of color and others

who are remain underrepresented on college campuses. Not every youth attends college. Those that do not may follow a different work path, or may be unable to avail themselves of a program to help them attend college.

- ***Community defined evidence practices***. Although the Commission is expected to prioritize "Culturally competent and linguistically appropriate prevention and intervention," (Section 5480.7 (a) (4), growing evidence supports the importance and efficacy of using "community defined evidence practices (CDEPs)." The inclusion of CDEP language provides local jurisdictions with a concrete example of strategies that constitute ***culturally competent and linguistically appropriate prevention and intervention***. Moreover, inclusion of CDEP language will further state policy to reduce disparities for racial, ethnic, LGBTQ+, and other underserved communities.

In December of 2020, your own Cultural and Linguistic Competence Committee (CLCC) voted to support our recommendations. The recent draft report of the PEI Subcommittee, "Well and Thriving", mentions this, yet does not include these two priorities in the report's final recommendations. Is it the practice of the Commission to disregard the suggestions of its own standing committees?

According to the MHSOAC's Strategic Plan, there are levers that enable transformational system change. One of these is: to engage diverse communities to drive changes needed to increase access to high quality services and improve outcomes. We represent diverse communities, and we are asking the MHSOAC to leverage the opportunity to improve the PEI regulations to do exactly that: drive the changes needed – *and recommended by our communities* - to increase access to high quality services and improve outcomes! Furthermore, two core principles of the MHSOAC's Strategic Plan are: **community collaboration** and **cultural competence**. Please say "YES" to following the Commission's own strategic plan and incorporate our specific recommendations to address disparities concretely and within the authority of the Commission. Please realize the principles of transformational change and move the levels within your control.

Almost 20 years after the Mental Health Service Act was enacted, serious mental health disparities for racial, ethnic, and LGBTQ communities continue to exist. It is undeniable that the COVID pandemic exacerbated these disparities. We cannot

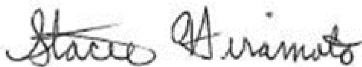
allow another 20 years to pass without disrupting and eliminating the mental health disparities now experienced by the majority of California's population.

The Commission has the opportunity to lead by example and demonstrate systems change that provides a stronger pathway to reducing disparities than what currently exists without usurping the authority of local jurisdictions.

Say "YES" to our communities, say, "YES" to the CLCC of your own commission, and say "YES," to realizing the promise of your own strategic plan. Finally, say "Yes" to meeting the mandates of SB1004 and include our recommended additions to the PEI priorities in the regulations.

We would be pleased to make a brief panel presentation at the MHSOAC meeting at which the PEI priorities are established as mandated under SB 1004. This may move the Commission to adopt our recommendations as additional PEI priorities and demonstrate compliance with the mandate of SB 1004.

Sincerely,



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Director
Racial & Ethnic Mental Health Disparities Coalition (REMHDCO)

Josefina Alvarado Mena
Chief Executive Officer
Safe Passages

Pysay Phinith, LCSW
Program Director
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Kathleen M. Sullivan, Ph.D.
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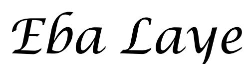
Openhouse



Eba Laye
President
Whole Systems Learning

Mr. KIMTHAI KUOCH, CEO
Cambodian Association of America (CAA)

Tara Pir

Tara Pir, PhD
CEO/Director
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Mel Mason

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Rebecca Gonzales

Rebecca Gonzales
Director of Government Relations and Political Affairs
National Association of Social Workers, CA Chapter (NASW)

Vattana Peong

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Cymone Reyes

Cymone Reyes
Executive Director
San Joaquin Pride Center

Genevieve Flores-Haro, MPA Associate Director
Mixteco/Indígena Community Organizing Project

Yolanda Randles

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Orvin Hanson

Orvin Hanson
Chief Executive Officer
Indian Health Council, Inc.

Sonya Young Aadam

Sonya Young Aadam
Chief Executive Officer
California Black Women's Health Network

Juan Torres

Juan Torres
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Hmong Cultural Center of Butte County

Carolyn Moulton

Carolyn Moulton
Grants Project Coordinator
Sonoma County Indian Health Center

Individual Supporters

Lilyane Glamben

Lilyane Glamben
Advocate for African American Communities
Sacrament

Cc: Members of the Mental Health Services Oversight and Accountability Commission
Toby Ewing, Executive Director of the MHSOAC

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The Village Family Services

CHIEF EXECUTIVE OFFICER
Le Ondra Clark Harvey, Ph.D.

Septemer 30, 2022

Toby Ewing, Ph.D.
Executive Director
Mental Health Services Oversight and Accountability Commission
Sacramento, CA 95814

RE: MHSOAC's PEI Project Report

Dear Dr. Ewing:

The California Council of Community Behavioral Health Agencies (CBHA) appreciates the opportunity to provide comments about the initial draft of the Prevention and Early Intervention (PEI) Project Report, *Well and Thriving*. As a representative of community-based organizations (CBOs) across the state that collectively provide mental health and substance use disorder (SUD) services to over a million Californians, we appreciate that the Mental Health Services Oversight and Accountability Commission (MHSOAC) values our members' perspectives about this critical document.

Below are recommendations and comments pertaining to the draft PEI Project Report we request that MHSOAC consider as it finalizes the report.

Finding 1: California does not have a strategic approach in place to address the socio-economic and structural conditions that underpin mental health inequities or to advance statewide PEI.

Recommendation #1: The State must establish multi-disciplinary leadership, deploy a strategic plan, and build capacity for using data and technical assistance to advance a statewide strategic approach to PEI.

- CBHA believes this recommendation does not appear to acknowledge ongoing prevention services and planning efforts happening in other sectors across the state. For example, how would this recommendation interact and interface with CA DSS's draft five-year Family First Prevention Services Act (FFPSA) Prevention Services Plan?

- How will MHSOAC and the State of California develop one cohesive and comprehensive plan to support prevention services for all Californians that cut across departments and funding streams, as opposed to developing yet another document or stakeholder process? While we agree that this requires an Executive at the Governor's Cabinet who will "champion" this cause, the execution will be challenging given all the initiatives now underway, including California Advancing and Innovating Medi-Cal (CalAIM), FFPSA, Child Youth Behavioral Health Initiative (CYBHI), Community Schools, etc.

- How can we be intentional with the use of data to support communities with the right interventions?

- CBHA suggests that the state leverage existing efforts to develop a statewide plan for prevention services instead of creating additional bureaucracy.

Finding 2: Unmet basic human needs and trauma exposure drive MH risks. These factors will continue to disrupt statewide PEI efforts and outcomes unless they are addressed.

Recommendation #2: The state's strategic approach to prevention and early intervention must ensure that all people have access to the information and resources necessary to support their own or another person's mental health needs.

- Page 17 alludes to the California Department of Health Care Services (DHCS)'s initiative on a Behavioral Health Prevention Plan starting in April 2022. How does the development of another plan interact with all the other DHCS initiatives currently underway?
- Page 29 shows some data on uninsured rates for different groups within the Asian Pacific Islanders subpopulations. Why were these groups not mentioned under Paragraph 1 under Community Disparities?
- Recommendations 2.1, 2.2, and 2.3: How will MHSOAC collaborate, partner, and leverage state resources with local partners?
- On 2.3 E: How will this recommendation intersect with prior efforts like the Master Plan on Aging?

Finding #3: Strategies to increase public awareness and knowledge of MH often are small and sporadic while harmful misconceptions surrounding MH challenges persist. Mass media and social media reinforce these misconceptions.

Recommendation #3: The State's strategic approach to prevention and early intervention must ensure that every Californian has access to effective and appropriate mental health screening and services and supports aligned to their needs.

- How can there be **one cohesive statewide** public awareness campaign to promote mental health care's importance and dispel stigma? CBHA believes the content and medium of information must meet the needs of different populations, especially underrepresented groups.
- Under 2.1.D, it reads, "expand availability of internet and tech based mental health information and resources." Is this recommendation referencing the virtual Behavioral Health Platform proposed under the Child and Youth Behavioral Health Initiative or something else?
- On page 47, there was a discussion about how outreach and engagement (O & E) strategies by community-based resources are often the most effective. How can there be more funding for O and E by these community-based resources at the local level?
- Does FFPSA cover some of the education/awareness as primary prevention?
- Under 2.2.A, the report references increased mental health training and education for staff in nonmental health settings. Are there specific curricula (backed by data) identified that are being promoted across the state?

Finding #4: Strategies that increase early ID and effective care for people with MH challenges can enhance outcomes. Yet few Californians benefit from such strategies. Too often the result is suicide, homelessness, incarceration, or other preventable crises.

Recommendation #4: The State's strategic approach to prevention and early intervention must ensure that every Californian has access to effective and appropriate mental health screening, services and supports aligned to their needs.

- On 4.1 F, is the recommendation directly referencing the "crisis continuum services" plan being done by the California Health and Human Services Agency (CalHSS)?
- On 4.2.b, what is MHSOAC's role in bolstering diverse workforce to deliver more culturally responsive and linguistically appropriate care?
- CBHA agrees that more screening is helpful but believes there needs to be greater capacity and more models to serve individuals at earlier points in their care journeys.
- On 4.2F, what is MHSOAC's role in increasing statewide capacity to provide mental health services and support in community settings?

I thank you for the opportunity to share this feedback to help inform the refinement of the PEI Project Report. If you have any questions about this feedback, please do not hesitate to contact with any questions.

Sincerely,

Le Ondra Clark Harvey, Ph.D.
Chief Executive Officer
lclarkharvey@cccbha.org
(916) 557-1166

September 30, 2022

Ms. Mara Madrigal-Weiss
Commission and PEI Subcommittee Chair

Ms. Mayra E. Alvarez
Commission and PEI Subcommittee Vice Chair

Mental Health Services Oversight and Accountability Commission
1812 9th Street
Sacramento, CA 95811
Submitted via email: reportcomments@mhsoac.ca.gov

Subject: CBHDA Comments – Well and Thriving: Prevention and Early Intervention in California Report, v. 2

Dear Ms. Madrigal-Weiss and Ms. Alvarez:

The County Behavioral Health Directors Association of California (CBHDA) appreciates the opportunity to provide comments on the Mental Health Services Oversight and Accountability Commission's (MHSOAC) *Well and Thriving*, *Prevention and Early Intervention in California* report. We truly appreciate the work that the MHSOAC Commissioners and staff have engaged in to hear from a broad range of stakeholders and communities to develop this draft report.

While we appreciate the report's overall call to action to ensure a coordination of prevention and early intervention services across all health care sectors and other systems providing care in order to ensure the wellbeing of all Californians, we are concerned that this report does not closely enough align with the charge outlined in SB 1004, directing the MHSOAC to identify additional priorities for the Prevention and Early Intervention (PEI) funding stream through the Mental Health Services Act (MHSA), and develop a statewide strategy for implementing these new priorities, including developing metrics for assessing the effectiveness and outcomes of PEI funded programs. For example, we support various aspects of this report, such as the identification of areas where the MHSOAC could further uplift best practices in PEI programming and bring these to scale or support other statewide prevention initiatives. That said, CBHDA has significant concerns that the majority of the report's recommendations are not within the implementation scope of the MHSOAC, counties, or the direction outlined in SB 1004.

The legislative intent of SB 1004 was clearly outlined as specific to improving guidance for how to improve quality and reduce disparities at the county level, consistent with the overall intent of the Act (emphasis added):

- "Expand the provision of high quality Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) programs *at the county level* in California." WIC 5840.5 (a)
- "Increase programmatic and fiscal oversight of *county MHSA-funded PEI programs*." WIC 5840.5 (g)

- "Encourage *counties* to coordinate and blend funding streams and initiatives to ensure services are integrated across systems." WIC 5840.5 (h)
- "Encourage *counties* to leverage innovative technology platforms." WIC 5840.5 (i)

Throughout, CBHDA did not read counties as the intended audience for this report. Rather, the report focuses much of its attention at providing recommendations for much broader coordination around prevention and early intervention across state agencies and departments in a variety of program areas, as well as private industry and the public sector, and across all populations in California. While this may be a laudable goal, the report's broad focus does not support an understanding of the MHSOAC's priorities for counties in implementing PEI funding consistent with the Act.

CBHDA provides specific recommendations below for your consideration to better align the report with the legislative intent of SB 1004. These recommendations build upon and reflect the experience of counties over the past seventeen years in the development and delivery of prevention and early intervention programs, in partnership with the MHSOAC and our local community stakeholders.

Recommendations 1.1-1.3

In Recommendation 1.1, the report suggests that "The California Governor must designate leadership to guide and coordinate planning for state and local multisector prevention and early intervention initiatives, in consultation with a broad coalition of private and public partners."

Arguably, the MHSOAC has been directed to serve in this capacity as it relates to MHSA PEI funding priorities. Statewide multisector prevention and early intervention initiatives that are developed across private and public partners are actively underway and under development by the Administration in the form of the Health and Human Services Behavioral Health Task Force, and the Children and Youth Behavioral Health Initiative. Under Medi-Cal, with the CalAIM Population Health Management Initiative, and DHCS' Comprehensive Quality Strategy, the state has launched large-scale initiatives to improve coordination and integration of prevention and early intervention across populations with an eye toward improving primary care integration with behavioral health services and reducing disparities.

The SB 1004 report offers an opportunity for the MHSOAC to align with and support these efforts through the identification of effective PEI programs currently serving marginalized and underserved communities with services that cannot be covered through insurance, and to support scaling up of these models at the county level. In particular, CBHDA recommends the Commission focus on identifying ways to further uplift counties' investments in community defined evidence practices (CDEPs) with MHSA funding. CDEPs are currently not fundable under Medi-Cal or other insurance, and yet California has a tremendous opportunity to target PEI funding to more robustly invest in and support the expansion of CDEPs to improve quality and reduce disparities for county behavioral health clients.

CBHDA also has strong concerns regarding Recommendation 1.1.c, suggesting that prevention services should be brought to all communities through leveraging MHSA and other public funds. It is critical that this programming continues to be driven by the local stakeholder process and that funds remain at the local level, consistent with the intent of SB 1004. While CBHDA is supportive of ensuring that all Californians have access to preventative care services, the MHSA provides a unique opportunity for local community-driven input and expertise to inform investments that make meaningful impact on specific local communities. California counties understand that disparities exist in access to mental health, and

vary across communities in California; however, a state-level standardization may result in watering down or reduce the effectiveness of certain targeted disparities reduction efforts at the local level. While the report mentions the need to ensure all state-level partners are working towards the same prevention goals, it would be inappropriate to attempt to direct MHSA public mental health dollars to supplement care that should otherwise be provided by other payers or systems.

- **Recommendation: The MHSOAC should be the leader in uplifting successful PEI programming and interventions, identifying best practices developed at the local level, including community defined evidence practices, and support opportunities to disseminate and scale these practices throughout California.**

Under Recommendation 1.2.c. the report provides a recommendation that the state (emphasis added): "*Require all State-funded programs and agencies*, including but not limited to those directly involved in mental health, to develop and deploy strategic equity plans to assess and remediate bias and discrimination within their systems, procedures, and practices. The State must hold grantees accountable for implementing equity plans including the collection of data to demonstrate how disparities are identified and addressed." Again, this focus on "all state-funded programs and agencies" is far beyond the scope of SB 1004 and PEI funding rules.

In addition, the suggestion for the state to hold "grantees" accountable for implementing equity plans is unclear. Is the report referring to organizations who are funded by counties through MHSA funding, or other grant-based programs? If this recommendation refers to the work of county behavioral health, counties have been required to develop Cultural Competence Plans focused on data collection and disparities reduction for decades and are currently in the process of updating those requirements with funding allocated by the Legislature, in coordination with the California Department of Public Health and Department of Health Care Services. As such, this recommendation appears duplicative of existing efforts to coordinate across departments at the state level, supporting the goal of targeted, data informed, accountable disparities reduction requirements for county behavioral health agencies.

Recommendation 3

The Commission's report identifies barriers of stigma and lack of education to receiving support for mental health needs, also finding that this information is often best received from trusted members of the community. CBHDA is perhaps most dismayed at the ways in which the report fails to accurately reflect lessons learned from the counties' and the MHSOAC's own historic partnership with the former Department of Mental Health to fund statewide campaigns to reduce stigma around mental health, reduce racial and ethnic disparities, and address student mental health. With MHSOAC approval, counties invested $160 million into three statewide initiatives over four years.[1] In fact, this report cites the 2019 RAND study which evaluated the effectiveness of this MHSA funded effort, but does not in any way refer to the fact that the statewide public education campaign it studied was funded as a joint county and MHSOAC partnership.

In addition, an independent peer reviewed study published this year found that, thanks to the total $20 billion in funding invested in local and statewide efforts under the MHSA, California successfully reduced its statewide rate of death by suicide and likely prevented 5,500 deaths by suicide.[2] The collective public

[11] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3698820/#bib16
[2] Thom M (2022) Can additional funding improve mental health outcomes? Evidence from a synthetic control analysis of

health impact of the MHSA is profound and should be acknowledged throughout this report.

Since funding for these initiatives expired, counties have continued to build on the lessons learned to invest in successful, more locally targeted stigma reduction and public awareness campaigns, which CBHDA believes should be considered as a part of this report. For example, Solano County recently designed a culturally responsive, suicide prevention campaign targeting demographic groups identified to be the most as risk for suicide in their community. This campaign was developed jointly with representatives of the target communities and disseminated through multiple mediums (i.e., television, social media, printed materials). The campaign not only identified subpopulations at highest risk for death by suicide in their community, it then placed materials in locations that the target population was most likely to view those materials (e.g. locating materials in hardware stores to target construction workers). CBHDA encourages the MHSOAC to identify effective local campaigns such as these, and support opportunities for learning across the state and development of additional programming, in consultation with local stakeholders.

Regarding the MHSOAC's recommendation to target investments in workplace wellness, CBHDA would request for a more data-informed approach to this recommendation. For example, what evidence is there to suggest that workplace related stress is a major driver of mental illness, or death by suicide in California? Given the fact that private corporations, including some of those lifted up in the report, are multi-billion for-profit entities, what value is there in diverting scarce public dollars to support the work they should be doing with their own funding to improve culture, working conditions, and support workforce mental health? CBHDA strongly recommends a more equity-focused emphasis on those safety net populations already targeted through counties' work, such as the Solano County campaign targeting construction workers at high risk for death by suicide in their community.

Further, in response to Finding 3, the MHSOAC could take a leadership role in supporting the development of programming that promotes resiliency in communities prone to natural disasters, assessing for effectiveness and scaling up as appropriate.

Recommendation 4

CBHDA agrees with a majority of the Recommendation 4 suggestions, including the need for improved mental health and substance use disorder screenings, but again would challenge the MHSOAC about whether this sort of action is within the scope of SB 1004? DHCS is investing hundreds of millions of Medi-Cal dollars into "equity practice transformation" grants for primary care, with an emphasis on behavioral health integration. Arguably, the state is already moving in this direction. Statewide access to more standardized screening for mental health and substance use disorders would likely improve primary care physicians' understanding of the signs and symptoms, in addition to improving access to early intervention services, including outpatient mental health services and decrease reliance on crisis services. Insurance regulators are in a good position to impose and enforce these sorts of requirements.

There are other county-driven, MHSA funded approaches funded through MHSA PEI funding that have shown promise in supporting individuals from historically underserved communities to seek care through county access lines, rather than through crisis services. These sorts of efforts should be lifted up through the report, as they are proven to both address disparities in meaningful ways and improve access.

California's millionaire tax. PLoS ONE 17(7): e0271063. https://doi.org/ 10.1371/journal.pone.0271063

- **<u>Recommendation</u>: Identify best practices in culturally responsive outreach and education materials targeting marginalized and underserved populations, including county behavioral clients, and support the dissemination and scaling up of promising programs across the state.**

<u>Substance Use Disorders</u>

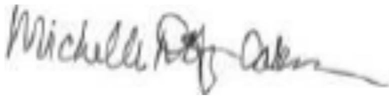
With the passing of AB 2265 and AB 638, MHSA PEI funds are now better able to address the continuum of behavioral health prevention. While the report makes mention of substance use disorders (SUD) several times, we believe it was also a missed opportunity to spotlight and provide guidance on the ways that counties can begin to better integrate SUD prevention and early intervention into the MHSA PEI funding priorities outlined in SB 1004, particularly given the stronger co-occurrence of SUD and mental health conditions among children and youth. As we continue to align our specialty mental health and substance use delivery systems, the MHSOAC could further support these efforts through identifying and uplifting best practices.

<u>Overarching Recommendation</u>

Overall, CBHDA is concerned that instead of providing counties with direction on how to structure PEI investments pursuant to SB 1004, the draft report appears to be providing a confusing and broad array of guidance *<u>to the state</u>* about a variety of possible statewide initiatives it should consider. Broad statewide initiatives that cut across a multitude of public and private sectors like those outlined in the report may have merit but would likely require much more investment than what is available through MHSA PEI funding, and would circumvent the core intent of the voters in having funding that is locally directed with input from local community stakeholders, leveraged through counties. We urge the commission to revisit the scope of the report, and to more clearly focus the findings and recommendations to support counties in addressing PEI programming, consistent with the goals of the Act and SB 1004.

We thank you for your consideration of our comments and recommendations and are eager to work with the MHSOAC to offer proposed alternative priorities beyond those mentioned in this correspondence. Please contact our team directly at efeld@cbhda.org or mcabrera@cbhda.org if we can answer any questions or provide any additional information to clarify our comments in this letter.

Sincerely,



Michelle Cabrera
Executive Director

September 30, 2022

To: Mental Health Services Oversight and Accountability Commission
1812 9th Street
Sacramento, CA 95811

Cc: Toby Ewing, Ph.D., Executive Director

Dear MHSOAC Commissioners:

Thank you for the opportunity to provide feedback on the *Well and Thriving* report on the Prevention and Early Intervention component of the Mental Health Services Act (MHSA) per the legislative requirement under Senate Bill 1004. Thank you in particular to the Chairs of the PEI Subcommittee, Mayra E. Alvarez and Mara Madrigal-Weiss for shepherding this effort to identify opportunities for promoting preventive and early intervention efforts through and beyond the MHSA. We represent a group of children's mental health, education, and health advocates in California who are committed to the well-being of children and their families, particularly those from historically marginalized communities. We have synthesized our feedback and **recommendations (bolded)** to the Commission on the first and second draft reports in hopes that the final draft approved by the

Commission reflects what we see as the critical, immediate opportunities for preventing and intervening early in mental health disorders and distress in children and youth. We believe that greater investments in children, youth, and their families are essential to any state strategy in mental health prevention and early intervention given that early investments will reap benefits across the lifespan, before mental health conditions develop or trauma calcifies into severe pervasive distress. Below are some overall observations followed by specific reflections and recommendations on each section of the report.

Overall observations:

Overall, we agree with one of the primary conclusions of the *Well and Thriving* report that moving California's systems of care toward prevention and early intervention requires significant time, leadership, and investment. The report is laduably ambitious in its effort to be comprehensive with respect to existing efforts in mental health prevention and early intervention, including its discussion on social drivers of racial/ethnic disparities in mental health. However, **the report misses an opportunity to identify where the Mental Health Services Oversight and Accountability Commission (MHSOAC) can and should be leading to drive additional state and local investments in time and resources toward true upstream prevention and early intervention where it can be most impactful - in the lives of children, youth, and their families, particularly low-income households and families of color.** As an example, in the report's definitions section on page 3, "recovery" is defined and largely applies to the adult population. **We recommend the addition of resilience and well-being (both of which are used throughout the report but not defined) along with definitions that are inclusive of the experiences of children, including young children who are uniquely dependent on their parents and caretakers to have their social-emotional needs met and establish a trajectory of positive mental health, as well as children and families of color who require adapted interventions that are culturally-responsive and affirming based on shared histories of community and historical trauma.**

Furthermore, the report's recommendations are very lofty and aspirational in nature. In order for the state to achieve its ambitious goals, which we largely concur with, it is essential for this report to include practical next steps and an implementation plan - one that clearly articulates the essential aspirational role of the MHSOAC as a prominent leader in the state's mental health prevention and early intervention ecosystem. The MHSOAC is unique in the state's constellation of social and human service bodies in that it was established by a state ballot initiative and oversees a categorical revenue stream in the form of a millionaire's tax. **The MHSOAC should leverage its unique level of independence to convene and influence other state and local policymakers to lead implementation of this report across the Administration and throughout local governments, and we stand ready to support the MHSOAC in engaging communities, families, and youth in its efforts to align prevention and early intervention across the state.**

Well-established historical national data notes that nearly half of all mental health disorders begin before age 14, and nearly three-fourths before age 25. Current PEI regulations require counties to spend *at least 51% of their PEI dollars on children and youth 25 and younger.* While this goal is laudable, advocates at the state and local level have consistently observed that the vast majority of PEI funds, particularly Prevention funds, are not targeted to true upstream prevention, such as in infant and early childhood mental health programs, where the benefits can be reaped over a lifetime and across child health domains, including their physical health and education success. **In response, we recommend the**

report's language be more specific on how the OAC plans to incentivize, encourage, and support counties, as well as its peers within the Administration, in investing more in true upstream prevention and children and youth services.

Finding 1: California does not have a strategic approach in place to address the socio-economic and structural conditions that underpin MH inequities or to advance statewide PEI.
Recommendation #1: The State must establish multi-disciplinary leadership, deploy a strategic plan and build capacity for using data and technical assistance to advance a statewide strategic approach to PEI.

We agree that the state lacks a strategic approach to addressing the root causes of mental health disparities for marginalized communities in California, therefore limiting its ability to truly advance prevention and early intervention. However, there are a multitude of efforts undertaken across sectors and by the Administration that center prevention and early intervention, including CA Department of Social Services draft Family First Prevention Services Act (FFPSA) Five-Year Prevention Services Plan, the Children and Youth Behavioral Health Initiative and the Governor's Master Plan for Kids' Mental Health, Medi-Cal initiatives such as Cal-AIM's Population Health Management Strategy, and the Department of Health Care Services' (DHCS) Comprehensive Quality Strategy and Strategy to Support Health and Opportunity for Children and Families, the Department of Education's Community Schools Initiative, and finally the Master Plan for Early Learning and Care. The report also references a previously un-advertised Behavioral Health Prevention Plan from DHCS. Instead of creating yet another plan and stakeholder process, **the MHSOAC should propose and lead one cohesive and comprehensive plan on prevention for all Californians that cuts across funding streams and departments.** We would be glad to work with the Administration and the legislature to ensure that the state's efforts to align prevention and early intervention across agencies is sufficiently resourced.

While we agree that this requires an Executive in the Governor's Cabinet who will "champion" this, the MHSOAC, with its statutory independence and administrative and oversight relationship to counties, could play an essential leadership role to synthesize and align these efforts with a focus on reducing disparities across the state's most marginalized communities. For example, the state's FFPSA Five-Year Plan and the state's Medi-Cal Children's Quality Strategy identify home visiting as a prevention service, and this service is administered by several agencies (e.g. CalWORKS, Medi-Cal, First 5 county agencies, etc.), with little coordination or alignment in terms of intended outcomes or prioritized populations, though the families served are often one and the same. Additionally, the FFPSA Five-Year plan also includes key mental health services such as Motivational Interviewing and Parent Child Interaction Therapy. Both programs are prevalent in California with compelling results. Alignment could strengthen the networks delivering these Evidence Based Practices and increase the number of families served, regardless which door brought them into services. To achieve this, **the MHSOAC should utilize data to invest in the right communities with the right interventions, and then propose and facilitate implementation of these interventions and strategies through leveraging as many resources and initiatives as appropriate.** On Page 21, the report acknowledges that "State requirements are not explicit in the ways counties should define, measure, and report program outcomes" and uplifted requests from county mental health agencies to provide more technical support and guidance to report data effectively. **The MHSOAC, with its relationship to county agencies, could take a leadership role in meeting counties' identified need for greater support on data collection and reporting over the**

continuum of county-administered mental health programs, including but not limited to MHSA-funded efforts, since MHSA funds often supplement and complement a variety of county- and community-led programs targeting low-income communities of color. We again recognize a unified mental health data system would require significant resources as well as expanded oversight jurisdiction for the MHSOAC, and we would look to partner with champions in the Legislature and Administration to support efforts to simplify and make more transparent county mental health data. In the interim, one practical step toward this goal would be for the MHSOAC to publish the new proposed standardized template for county reporting on PEI spending for public comment and feedback with the goal of requiring counties to adopt the final approved template by April 2023.

Finding 2: Unmet basic human needs and trauma exposure drive MH risks. These factors will continue to disrupt statewide PEI efforts and outcomes unless they are addressed.
Recommendation #2: The state's strategic approach to prevention and early intervention must ensure that all people have access to the information and resources necessary to support their own or another person's mental health needs

Overall, Recommendation 2 seems like an extension of Finding 1 and Recommendation 1 - it is clear that the lack of system coherence and coordination, particularly at the local level, confuses consumers, families, communities, and even service providers, and we are glad to see this reality acknowledged in the report. While we generally agree with Recommendation 2, **we would like to see an explicit role for the MHSOAC in leading local implementation of Recommendation 2, particularly Recommendation 2.2 and 2.3 (promoting inclusive, safe, nurturing environments and reducing trauma through supporting parent and caretakers).** For example, **the MHSOAC could, through its authority granted in SB 1004, adjust the regulations governing PEI spending at the county level to ensure greater and more effective investments in activities highlighted in Recommendation 2,** such as enhanced partnerships between community-based organizations and schools or home visiting for families with infants and toddlers - efforts that have strong evidence for preventing poor outcomes for communities and children of color, and are currently woefully underfunded (as evidenced by the historic multi-billion dollar one-time investments in the CYBHI and Community Schools Initiative).

Finding #3: Strategies to increase public awareness and knowledge of MH often are small and sporadic while harmful misconceptions surrounding MH challenges persist. Mass media and social media reinforce these misconceptions
Recommendation #3: The State's strategic approach to prevention and early intervention must ensure that every Californian has access to effective and appropriate mental health screening and services and supports aligned to their needs

We fully agree and support Recommendation 3 - the State must ensure that every Californian has access to effective and appropriate mental health screening, services, and supports based on their unique needs. We also recognize this is not a problem that the MHSOAC can directly intervene in or solve, especially without resources and support from the public and the Administration. For example, on page 47, the report acknowledges that localized outreach and engagement strategies are most effective at combating stigma, dispelling myths, and increasing service utilization in marginalized

communities. We agree. However, the report could be strengthened by recommending a single cohesive public awareness strategy or campaign, led by the State, to influence the broader narrative about mental health and influence state leaders' responses to the existing crisis. For example, an MHSOAC-led statewide communications campaign could link the various communications efforts, from ACES Aware in the Office of the Surgeon General to local anti-stigma work in schools in communities of color, to a broader narrative about prevention and early intervention being most impactful before mental health conditions typically emerge. This kind of messaging could significantly add to the political will in California to invest in true upstream prevention and early intervention in historically marginalized communities. Additionally, the report highlights the opportunity for online initiatives to increase awareness and access to digital care like tele-mental health and should **name the initiative that could potentially resource such efforts - the Virtual Behavioral Health Platform being administered by DHCS under the CYBHI.** Finally, the recommendations around increased mental health training and education for staff in non-mental health settings is well-received; however, **we recommend an additional recommendation on how to fund or sustain that level of workforce and community-level capacity-building - perhaps through ongoing local education investments (such as the Local Control Funding Formula) in social-emotional learning or parent engagement, with MHSA dollars as supplements or complements to these investments**. Overall, this section presents a compelling vision for community-level work and could be strengthened by identifying the resources or the leadership necessary to execute new strategies or coordinate existing efforts.

Overall, the MHSOAC should identify areas where through convening and coordinating across the Administration, it can leverage and align various state efforts to educate the public on mental health issues, including ongoing efforts through the CYBHI, Office of the Surgeon General/ACES Aware, and First 5 California. While acknowledging that the MHSOAC's statutory oversight and accountability roles are limited in scope, we believe that through partnerships with advocates, communities, families, and youth, the MHSOAC could become a multi-sector mental health convener and build the necessary political will across the state to strengthen and align investments in prevention and early intervention. **More immediately, we recommend the MHSOAC develop and require counties to utilize a template to assess the reach, effectiveness, and cultural-appropriateness of their outreach and engagement strategies funded by PEI in order to ensure that local Prevention dollars are meeting the needs of communities, particularly those for whom mental health stigma intersects with other forms of discrimination such as race, ethnicity, income, immigration status, gender, or sexual orientation. Lastly, the MHSOAC should leverage the expertise of its Youth Innovation Committee to ensure state and local efforts are informed by young people, including high-school aged youth, particularly as it relates to online communications and campaigns.**

Finding #4: Strategies that increase early identification and effective care for people with mental health challenges can enhance outcomes. Yet few Californians benefit from such strategies. Too often the result is suicide, homelessness, incarceration or other preventable crises.
Recommendation #4: The State's strategic approach to prevention and early intervention must ensure that every Californian has access to effective and appropriate mental health screening, services and supports aligned to their needs

We agree with Finding and Recommendation 4 that there are demonstrable gaps in preventive and early intervention mental health services in California, particularly in light of new data on children in Medi-Cal. Only 14% of the state's low-income teenagers receive a depression screen *and* a follow-up plan, despite the reality that 1 in 3 California teens have signs of serious psychological distress, with teens living below the federal poverty level having disproportionately higher levels of distress than their peers. Even more alarming, while the suicide rate decreased in California during the first year of the pandemic (2020), youth, girls, Black, and Latinx youth all showed increases in suicide during that time. A recent State Auditor's report noted that nearly three-quarters of 2-year-olds on Medi-Cal did not receive the required number of preventive services, including developmental screenings (a key opportunity to assess a child's social-emotional development and therefore early mental health). This is a dismaying level of neglect for our state's most marginalized children and families, and it is reasonable to guess that children with commercial health plans do not fare exceptionally better, given the reality that children are seen as low-need and low-cost to insure, despite the reality that half of all mental health disorders appear before a child turns 14. **We agree that the state must work to hold both public agencies and public and commercial health plans accountable to providing the services that children and youth need to be healthy and mentally well.**

Anecdotally, advocates and community members report that local MHSA prevention and, in particular, early intervention resources are often used to bridge gaps in medically necessary care, particularly for adults with severe mental illness whose care has often been neglected or poorly-coordinated with necessary social services by commercial or public health plans. Those few PEI resources which are dedicated to early intervention for children and youth, where they could be most impactful, are typically highly specialized clinical services which are difficult for county contractors like small nonprofit community-based organizations to provide at scale. Community stakeholders indicate that PEI dollars are frequently bridging gaps in healthcare rather than supplementing, innovating, or expanding on the investments of healthcare in mental health prevention and early intervention.

While its accountability and oversight roles are limited, we believe there are opportunities for the MHSOAC to play a role in improving access to mental health care provided by health plans and county agencies in California, and moving the state's healthcare system toward true prevention and child-focused early intervention where it can be most impactful. Specifically, in the report, the MHSOAC could clarify its role in diversifying the workforce and expanding the available options of culturally-responsive care at the community-level through providing technical assistance, facilitating learning communities, or providing additional state grant funding to counties and community-based agencies who supplement one-time funding, such as CYBHI funds for Behavioral Health Coaches or youth peers, with county PEI dollars. **By re-imagining local PEI spending as complementary to, rather than a substitute for, adequate individual health and mental health care, the MHSOAC, counties, and community-based agencies could focus their efforts on community-level interventions, establishing an evidence base for community-defined evidence-based practices (CDEPs), and enhancing existing social support and services.**

For example, classroom-based models of infant and early childhood mental health consultation, where a clinician provides ongoing support to a child care provider rather than temporary support for a child in distress, show incredible promise for reducing disparities in preschool suspensions and expulsions for Black children, and can support the social-emotional development of all children in the

classroom. Likewise, a campus-wide high school peer support program could intervene in behavior incidents, bringing classrooms or peer cohorts together to heal through circles or other restorative justice practices rather than punitive school discipline measures like suspensions or expulsions. These mental health interventions are not readily available through the traditional healthcare system because there is not an identifiable client or patient, but these are the types of culturally-responsive early intervention support that marginalized children and youth require. **Where PEI investments could be most impactful could be in re-defining the standard of care for marginalized communities, with advocates and state leaders like the MHSOAC supporting or even authoring legislation that would require health plans to adopt these models, and endorsing policy actions that strengthen health plan funding for these prevention programs. Current opportunities and examples of this include publicly supporting and advocating for expansions of Cal-AIM reform efforts such as Medi-Cal's Population Health Management and the expansion of covered mental health services across public and private health plans of evidence-based practices, such as dyadic care, and culturally-affirming practices like youth peer-to-peer support.**

Conclusion

In 2021-22, the Mental Health Services Act tax on millionaires generated $3.5 billion for counties to allocate to local priorities and programming under a fairly broad definition of prevention and early intervention mental health strategies - **this is an unparalleled source of ongoing revenue in mental health prevention and early intervention that could be leveraged, along with other state efforts, to ensure all California's communities, including marginalized children and families can achieve whole-person well-being in such a rich state.** In thinking about how to reimagine the state's prevention and early intervention efforts, particularly through the MHSA, **prevention dollars could be made more impactful by being more aligned with a local public health approach to improve community and population health, particularly through investing in upstream programming in children and their families to reap the benefits across an entire lifespan. Likewise, the MHSA's early intervention dollars should supplement, not supplant adequate and required mental health care from our public and private health plans in California. Likewise, early intervention services should be dedicated to piloting and innovating culturally-responsive and community-defined evidence based practices for children and youth - where early intervention can be most impactful across the lifespan.**

In practice, this would mean our state should prioritize traditional health care resources to right-sizing long-underfunded infant and early childhood mental health programs, sustaining existing and expanding school-based early intervention strategies, and broadly implementing more community-defined evidence-based practices that are culturally-concordant with the needs and experiences of marginalized communities. **Policy levers, led by the MHSOAC as a statewide convener and key agency in mental health policy development and advocates, could then be deployed to broaden the standard of mental health care that our state and county health plans should be obligated to fund sufficiently and in perpetuity. This aspirational vision of the MHSOAC would enhance our state's ability overall to sufficiently resource true upstream prevention and early intervention at the state and ultimately, the local level.,**

We thank you again for the opportunity to provide feedback on the *Well and Thriving* report and would welcome the opportunity to engage with the PEI Subcommittee chairs or staff to discuss any of our recommendations in more detail. We look forward to working together to achieve the ambitious vision laid out in the report for mental health prevention and early intervention in California. If you have any questions or would like to discuss further, please contact Angela M. Vázquez (avazquez@childrenspartnership.org) or Adrienne Shilton (ashilton@cacfs.org).

Sincerely,

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