Mental Health Services
Oversight & Accountability Commission

Prevention and Early Intervention Project

Final Report Draft V.1 Written Public Comment

Submitted to the Commission on or before September 1, 2022

I think every CA school should have Advancing Parenting's bumper stickers on the office counter so folks can choose one for their cars. Also, the bumper stickers should be given away at meetings and events that support children's health.

I know bumper stickers are low tech and low brow, but they are an in-demand and effective kind of public health messaging tool. Just one will be read thousands of times.

More than one hundred CA schools and organizations are already on the waiting list for sets of our stickers.

Advancing Parenting is a Camarillo, CA nonprofit organization. Visit www.advancingparenting.org.

- David Dooley

Thank you. I have just read through the Well and Thriving PEI report. Thank you for including home visiting and working with families who have young children as key intervention strategies. I do supervise a very small MHSA PEI program in Merced County and we serve children ages birth-five and their families. It has always been an uphill battle to advocate for the needs of these families and try to explain the science behind this. Your report wraps it up perfectly. I hope to see more funding allocated to support at-risk families before severe illness develops. Thank you for getting it!

- Monica Adrian

I hope there's a renewed focus on Medi-Cal to make it more marketable to private practitioners. Many providers will not accept Medi-Cal clients because clients frequently do not show up for appointments. We cannot bill clients for missed sessions, nor does Medi-Cal reimburse for missed sessions. This is not an inviting business model for mental health private practitioners who will lose money on missed sessions. If Medi-Cal were to reimburse for missed sessions, since clients cannot be charged, this would likely provide Medi-Cal recipients with a wider variety of options besides CBOs for their mental health care.

Furthermore, MFTs are not permitted to treat Medicare clients, which is also a gap that could be fixed if Congress would pass two of the laws going through congress to permit MFTs to treat Medicare clients; thus providing more Medicare clients with access to a wider range of mental health practitioners.

I hope this was helpful.

- Deborah Licurse, MFT

It is essential to prevention and early intervention for the seriously mentally ill who would otherwise end up in jail without adequate care and treatment that they be treated by qualified professional staff in locked high quality psychiatric facilities when needed. The following in my view as a concerned citizen should be recommended to make available for these purposes the massive annual funds raised by the tax authorized by the MHSA:

1. Amend Welfare and Institutions Code section 5801(b)(9) to add: "Programs and/or services provided with Mental Health Services Act funds shall be designed for voluntary and involuntary participation. 9 California Code of Regulations section 3400(b)(2) is expressly declared inconsistent with and contrary to law in stating that programs and/or services provided with Mental Health Services Act funds are designed for voluntary participation to the exclusion of involuntary participation."
2. Amend Welfare and Institutions Code section 5891(a) after the first sentence thereof to add these two sentences to the section: "Programs and/or services provided with Mental Health Services Act funds shall be designed for voluntary and involuntary participation. 9 California Code of Regulations section 3400(b)(2) is expressly declared inconsistent with and contrary to law in stating that programs and/or services provided with Mental Health Services Act funds are designed for voluntary participation to the exclusion of involuntary participation."
3. Alternatively to amending W&I Code sections 5801(b) and 5891(a), issue a proposed regulation for public comment amending 9 California Code of Regulations section 3400(b)(2) to read, “Programs and/or services provided with Mental Health Services Act funds shall be designed for voluntary and involuntary participation.”

I write strictly as a concerned citizen who has had a seriously mentally ill family member. As a retired attorney, I am not authorized to practice law and am not holding myself out as available to provide attorney services. Nothing herein should be construed as legal advice. My suggestions should be reviewed with a practicing attorney.

- Daniel O. Jamison

Thank you for the work on this report and the comprehensive approach to prevention and early intervention.

My comment is that I feel the report and the state’s strategy should move beyond an important – but overly broad – focus on “depression and anxiety” to specifically address mental health conditions that develop in children, youth and teens. My experience comes from losing my 14-year-old daughter to Borderline Personality Disorder (BPD) and suicide.

The medical establishment has recently agreed that BPD can begin in adolescence. The latest version of the DSM (DSM-5) has a provision for diagnosis of BPD in people under 18 years old. Some clinicians have moved away from the DSM, relying instead on the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems (ICD). The ICD-10, the 10th edition of the ICD, became effective October 1, 2019. Its concise definition of BPD includes this, “Severe personality disorder that develops in early childhood; characterized by a lack of control of anger, intense and frequent mood changes, impulsive acts, disturbed interpersonal relationships, and life-threatening behaviors.”

While the DSM-5 and the ICD-10 make it clear that BPD develops in early childhood, nearly all of the mental health professionals we encountered espoused the outdated belief that BPD

doesn't occur in children and teens and would not diagnose our daughter (and therefore she didn't receive the treatment she needed). The National Institute of Health summarizes the issue this way, "Recognizable symptoms and features of BPD appear during adolescence. However, there has been resistance to diagnose or research this disorder prior to adulthood because of clinical lore that BPD is a long-standing illness and that personality traits are not stable until adulthood."

California's PEI strategy should specifically address the stigma and misinformation that continues to keep young people with BPD (and other serious mental illness) from receiving the life-saving services and supports they need.

- Harry Bruell

Some of the issues that I would like to improve:

- Increase funding for operations and QI services for CBOs, especially those contracted with Los Angeles County Department of Mental Health. Many CBOs lack good management, customer services, and quality improvement services. More audits need to be completed to help organizations identify strength and weaknesses.
- Increase salary and benefits for clinicians for recruitment and retention. Offer more loan forgiveness and incentives.
- Offer good compensation for clinicians who speak other languages, especially those who work with CBOs.
- Invest in good customer service and QI.
- Improve streamlining access to PEI funds by helping contracted CBOs with operations and reducing bureaucracy.
- Invest in good mental health pipeline projects/ programs. Many organization are closing because they do not have clinicians.

- Carmen Perez

Dear Ms. Patterson and MHSOAC Leadership,

Thank you for the opportunity to review and provide comments on the PEI draft report, Well and Thriving: Prevention and Early Intervention in California. My name is Janet Frank and I am a Faculty Associate with the UCLA Center for Health Policy Research, and an appointed commissioner to the California Commission on Aging. My educational background includes a master's in gerontology from the University of Southern California and a doctorate in public health from the University of California, Los Angeles. I served as principal investigator for a MHSOAC-funded project from 2014-2018 that focused on the MHSA impact on services to older Californians (14MHSOAC016). My comments below represent my individual viewpoint, not that of either UCLA Center for Health Policy Research or the CCoA.

I would like to applaud the Commission for their hard work and the inclusive focus of the report, specifically, the whole community approaches, calling out issues of root cause and inequities, the use of a population health approach and a life course perspective. I also appreciated that the report addresses outreach, workforce development, use and expansion of data, integrated

care and racial, ethnic, socioeconomic and other disparity issues. The framing of the report is spot-on, given the above comprehensive focus.

However, as an advocate for older adults, I am concerned that the report missed a number of opportunities to focus on important issues of this vulnerable population group. SB 1004 includes older adults as a priority population in need of expanded services and PEI programs. I know from years of working in the field of aging, that the words "prevention" and "older adults" are not often paired. Yet, older adults with behavioral/mental health problems benefit greatly from prevention. I was so glad to see the three types of prevention called out in the report – and older adults benefit from every type: primary, secondary and tertiary prevention. I would never want to pit one age group against another, and I totally agree that children and youth are very important population groups for mental health prevention programs. But let's not forget about older Californians, soon to be 20 percent of our state's population.

That said, I believe there are ways to adjust the report to provide a more balanced discussion of PEI needs and program and policy opportunities across the lifespan. Actually, let's start with the photos associated with the report and the flyer inviting comment. Please consider a more *intergenerational approach*, rather than showing a family with young children (kudos for selecting African Americans). We know language is important, and I noted in the report that words depicting youth (children/child/youth/young) were included 269 times; whereas older adults (adults over 60, aging adults) were mentioned 16 times). Of the 20 boxed "Opportunity Spotlights", seven focused on children's programs/issues and one on older adults. The report tilts in the direction of much focus on the younger age groups, and little on adults and older adults.

In addition, there are places to strengthen the report by calling out issues and programs for older adults. For example, on page 22 in the discussion of the possibility of state standardized data, such as a uniform data set, part of our MHSOAC work identified assessment and outcome data most appropriate for older adults behavioral health data (Policy Brief: Mental Health Services for Older Adults: Creating a System That Tells the Story). On page 53, inconsistent mental health screening could certainly include a nod to issues about older adult screening discussed in our work. Depression is one of the most prevalent mental health problems for older adults, and there are a number of evidence-based programs that have shown very positive outcomes (e.g. IMPACT, PEARLS, Healthy Ideas) that are being delivered as prevention programs through health care clinics and aging network providers.

Other areas of the report would be enriched by including some examples and data about older adult behavioral health issues. In discussing the need to expand the behavioral health workforce, our older adult workforce study was cited, but not discussed (citation 565, *California's Behavioral Health Services Workforce Is Inadequate for Older Adults*). The need for workforce development regarding the special issues of older adult behavioral health is critical. In discussing the basis of discrimination, age should always be included as a factor (page 31, 1.2b) since ageism continues to be a major issue. Older adult suffering and increased isolation during Covid-19 should be highlighted on page 31 when Covid is discussed. I believe the headers that focus on childhood trauma and childhood poverty do not embrace the inclusive life-course framing at the outset of the report. Some of the poorest and most vulnerable people in California are older adults from racial and ethnic minority groups, living in rural areas, are from immigrant and/or LGBTQ+ groups, and the report should also highlight these disparities and challenges to mental/behavioral health services.

For additional resource material, I wanted to share our study's deliverables/reports housed at the MHSOAC (14MHSOAC016), one of which was a secondary analyses of data about older adult programs and services, many funded by MHSA that might be very helpful. In addition, we have these products available on the UCLA Center for Health Policy Research website, links provided here for easier access:

- Fact Sheet: California's Public Mental Health Services: How Are Older Adults Being Served?
- Policy Brief: Older Californians and the Mental Health Services Act: Is an Older Adult System of Care Supported?
- Policy Brief: Mental Health Services for Older Adults: Creating a System That Tells the Story
- Fact Sheet: Servicios públicos de salud mental en California: ¿Cómo están siendo atendidos las personas de tercera edad?
- California Mental Health Older Adult System of Care Project Deliverable 4 Report: Focus Groups
- Promising Older Adult Mental Health Programs
- Fact Sheet: MHSA and Older Adult Study Policy Recommendations
- California Mental Health Older Adult System of Care Project

Thank you for this opportunity to provide feedback to improve the life course perspective of the report, and include a bit more focus on issues of prevention for older Californians. The report framing and the four recommendations are excellent and will greatly improve prevention services throughout California for all age groups. Please let me know if I may provide any additional information. Below is my contact information.

- Janet C. Frank, DrPH

Dear Commission,

I would like to thank you for the work you are doing re: transforming the PEI component of MHSA. I have the following comments:

1. It is important to incorporate a Population Health lens, however, that approach is incomplete. I suggest using an Ecological Health Model approach as a more comprehensive model that highlights both **individual** and **systemic** factors in its focus.
2. Partner with the private sector, specifically tech companies in the State, to develop cutting edge data platforms and use data as a key part of future key decision-making for the State as well as for Counties.
3. **Accountability!** While the mental health system, let alone PEI-funding programs and services are insufficient to address our worsening health outcomes and inequities, Counties are not being held accountable for developing and implementing effective strategic plans to address disparities, particularly among Black, Latinx, Native and Indigenous, Asian American,
LGBTQ+, rural, and disabled communities.

- Dr. Luis Guzman

Thank you MHSAOAC team for the draft PEI report. There is much to appreciate and applaud in this document and the efforts you've made toward effective and integrated PEI services. Thank you for championing this effort. Among the many things to like....

1. The scope of your recommendations, limited to 4 is right sized. Far too often these reports are so vast/broad as to be unreadable, let alone actionable. Four is the right number.
2. Each of the recommendations is thoughtful and I think, accurate.
3. Your context and background section is thoughtful and complete.
4. I particularly appreciate your framing of the need for interconnected systems to solve the complex family and community issues, and the importance of state decision makers understanding that **structural transformation** must be included. It's not enough to suggest more or better collaboration. We've been attempting that for four decades in California. I do think your recommendations could go further and should include creation or adaptation of current state departments to an integrated state System of Care--at least for children and youth and an integrated Prevention Services division within it.

Overall--Well done! I would offer respectfully, some additional recommendations for your consideration.

1. Much of what your recommending is presently afoot via the AB 153 FFPSA Comprehensive Prevention Planning process, sponsored by CDSS as part of its federal FFPSA requirements. I recommend that your report elaborate on this connection, and that your recommendations include doing much of this work in partnership with the Systems of Care locally and with the DSS administration of their whole person prevention planning under CPP. See Cheryl Treadwell or Hillary Konrad at DSS for more information. Your suggested reforms would be even more powerful, if done in alignment with the DSS's CPP work in community.
2. I suggest you also connect your recommendations more explicitly to the local interagency collaboration now present in the AB 2083 Local Systems of Care. While framed as a "foster youth System of Care", many counties have constructed Interagency Leadership teams that are primed to collectively administer *whole child/whole community prevention frameworks* you describe. Recommend you cite AB 2083's local System of Care rollout in 2018 as the seed of your efforts to recommend a new ecosystem.
3. State level interagency prevention should and must be held in a larger Department of Child Family and Services. Create a Division of Prevention Services for Children and Youth--within a new larger Children's System of Care at the state level and similar division for Adults. This requires structural change and likely administrative or legislative action, but it necessary to sustain any efforts your report seeks to support.
4. In light of your recommendation to expand place-based supports, I'd recommend you anchor or connect this concept to the CDE sponsored Community schools grants. CSPP

grants from CDE are seeding the type of community, parent led efforts that you recommend. Build on and connect to that effort.

5. Finally, I'd recommend a greater emphasis on Resilience and Advantageous Childhood experiences. The research is becoming more clear, that focusing only on Trauma mitigation is insufficient. Children are actually insulated from trauma when advantageous experiences are present. Building advantageous childhood experiences is predictively more impactful, according to the research, than trying to simply offset the existing traumatic conditions or experiences. See these two papers for examples of the emerging critical distinction and impact of using community and government to build highly resilient families.
   https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-021-10732-w

   https://www.childandadolescent.org/positive-childhood-experiences/

Prevention is most effective when it is provided simultaneously across

individuals, families, communities, and societies in ways that respond to their unique and fluid needs.

- Richard S. Knecht

REMHDCO

Racial and Ethnic Mental Health Disparities Coalition

September 1, 2022

Mara Madrigal-Weiss
Commission Chair and Project Chair
PEI Subcommittee of the
Mental Health Services Oversight and Accountability Commission
1812 9th Street
Sacramento, CA 95811

Re: PEI Subcommittee Meeting of September 7, 2022

Dear Chair Madrigal-Weiss,

Thank you for this opportunity to comment before the first hearing on the recently released PEI Subcommittee Report, "Well and Thriving". We hope our letter will be published as part of the materials for the meeting on September 7, 2022 in San Diego as outlined in the email sent by Kali Patterson of the MHSOAC.

The Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) and others have consistently requested that the public is made aware at meetings of the PEI Subcommittee that SB 1004 (Wiener) – Chapter 843, Statutes of 2018, gives authority to the MHSOAC to add to the list of priorities for PEI funding at the county level. We are once again requesting that this is explained to the public at and before the September 7th meeting.

In addition, we strongly urge that the PEI priorities in SB 1004 under Section 5840.7. (a) are listed and provided to the public at the meetings. Then members of the public should be asked whether they believe there should be any additional priorities added or any language added to clarify these priorities.

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(916) 705-5018 shiramoto@remhdco.org

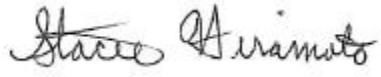
This aspect of SB 1004 is just as important as asking the public their general comments about the PEI Subcommittee report or general comments about PEI programs at the local level.

REMHDCO and others have recommended on more than one occasion to the PEI Subcommittee that an additional priority needs to be added to the list that includes **programs for transition age youth who are *not* attending college** to balance the current priority that prioritizes programs that serve transition age youth on college campuses.

REMHDCO and others have also recommended that language be added to the priority of "culturally competent and linguistically appropriate prevention and intervention" to highlight and prioritize ***community defined evidence practices*** as consumers and families from BIPOC and LGBTQ communities favor programs that utilize these. In addition, the use of community defined evidence practices has shown to be effective in reducing mental health disparities.

Once again, we urge the PEI Subcommittee to accept our recommendations to expand the current list of PEI priorities as SB 1004 allows the Commission to do. We will make additional comments on the general recommendations made in the PEI Subcommittee report at a later date. Thank you.

Sincerely,



Stacie Hiramoto, MSW
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September 1, 2022

Mara Madrigal-Weiss, Chair
Mental Health Services Oversight and Accountability Commission
1812 9th Street
Sacramento, CA 95811

RE: Initial Comments on Draft PEI Report

Dear Chair Madrigal-Weiss,

Mental Health America appreciates the opportunity to provide our initial comments on the Commission's Draft PEI Report, *Well and Thriving, Prevention and Early Intervention in California*. We may submit more detailed comments at a later date.

The mission of Mental Health America of California (MHAC) is to ensure that people of all ages, sexual orientation, gender identity or expression, language, race, ethnicity, national origin, immigration status, spirituality, religion, age or socioeconomic status who require mental health services and supports are able to live full and productive lives, receive the mental health services and other services that they need, and are not denied any other benefits, services, rights, or opportunities based on their need for mental health services.

MHAC truly appreciates the work that was put into creation of this Draft Report. The report includes extensive and meaningful recommendations to the State that, if implemented, could substantially improve the mental health of Californians. Our comments at this time are not related so much to what is *included* within the report, but to an element of SB 1004 (Wiener, 2018) that is *not included* within the report.

RECOMMENDATION: The Draft Report should add, as an additional priority, Recommendation #1 adopted by the Commission's Cultural and Linguistic Competence Committee (CLCC) on December 8, 2021

Senate Bill 1004 mandates the Commission to establish priorities for the use of county MHSA PEI funds, which must include the priorities listed in the bill, and may include additional priorities (WIC Section 5840.7. (a)). Yet nothing in the Draft Report mentions which priorities the Commission has chosen to establish. In addition, the Draft Report mentions that the MHSOAC's own committee, the CLCC, approved 4 recommendations (2 of which are specifically related to the priorities listed in SB 1004), yet the Draft Report does not state whether those 2 recommendations will be adopted by the MHSOAC as additional PEI priorities.

SB 1004 included, as a priority for PEI funding, youth outreach and engagement strategies that target secondary school and transition age youth, *with a priority on partnership with college mental health programs*. The CLCC's first adopted recommendation is to: "Emphasize transition age youth generally under the identified

priorities in Senate Bill 1004 (Wiener, 2018).” We agree wholeheartedly with this recommendation.

The California Youth Empowerment Network (CAYEN), a youth-led program of MHAC has consistently advocated for access to behavioral health services, including MHSA PEI services, for all youth regardless of whether or not they are enrolled in college or university. Along these lines, we agree with the CLCC that prioritizing youth who are enrolled in college disadvantages transition age youth of color. Furthermore, youth who are enrolled in college have access to on-campus mental health resources that are not available to those who are not enrolled, and these youth are often privately insured, while youth not enrolled in college are less likely to have private insurance. Additionally, youth enrolled in college who temporarily leave school due to mental health challenges will not only lose access to on-campus services, under SB 1004, they would also not be prioritized for community PEI services. If they are University of California students enrolled in the campus insurance program, they lose both their health insurance and access to on-campus resources if they take any time off of school, which is not uncommon for students who live with mental health challenges.

The MHSA was written to increase community-based mental health services for everyone who needs them, not just those who are fortunate enough to attend college, and we respectfully request the Commission to broaden the existing priority to include all Transition Age Youth regardless of college enrollment status.

Again, we appreciate the opportunity to provide our comments on the Draft Report and we are grateful for the tireless efforts of Commission Staff in drafting the report. Please feel free to contact me or our Interim Public Policy Director, Karen Vicari (kvicari@mhaofca.org) if you have any questions or would like more information.

In Community,

Heidi L. Strunk
President & CEO