Mental Health Services
Oversight & Accountability Commission

Research and Evaluation Committee Meeting

May 12, 2022
9:00 am to 12:00 pm

Chair Itai Danovitch
Vice Chair Steve Carnevale

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Mental Health Services
Oversight & Accountability Commission

Research and Evaluation Committee Meeting/Teleconference Agenda

Thursday, May 12, 2022, 9:00 AM – 12:00 PM

Link to meeting: https://mhsoac-ca-gov.zoom.us/j/86949557630
Call-in Number: 669-900-6833, 408-638-0968
Meeting ID: 869 4955 7630
Password: No password, Waiting room access
Note: The meeting audio will be recorded.

Meeting Location:
Mental Health Services Oversight & Accountability Commission Office
1812 9th Street, Sacramento CA 95811

Additional Public Locations

UC Davis Medical Center
2315 Stockton Blvd
Sacramento, CA 95817

Noe Café
1299 Sanchez St.
San Francisco, CA 94114

Pacific Clinics
251 Llewelyn Ave
Campbell, CA 95008

North Berkeley Library
1170 The Alameda
Berkeley, CA 94707

Live & Learn, Inc.
1163 Main Street
Morro Bay, CA 93442

New York Athletic Club
180 Central Park South
New York, NY 10019

Rand Corp.
1776 Main Street
Santa Monica, CA 90407

World Financial Center
19112 Gridley Rd., Ste 224
Cerritos, CA 90703

Stanford Sierra Youth & Families
8912 Volunteer Lane
Sacramento, CA 95826

OC Health Care Agency
405 W. 5th Street
Conference Room 512
Santa Ana, CA 92701

UCD Center for Reducing Health Disparities
2921 Stockton Blvd, Ste 1408
Sacramento, CA 95817

Cedars-Sinai Medical Ctr.
Thalians Health Center
8730 Alden Drive
Los Angeles, CA 90048

Meeting purpose and goals:

- Provide an update on the Commission's Research and Evaluation Division activities and the Committee's advisory role, accomplishments, and next term.
- Advise the Commission on the evaluation of the Mental Health Student Services Act (MHSSA).

TIME	TOPIC	Agenda Item
9:00 AM	**Welcome** *Commissioners Dr. Itai Danovitch, Chair & Mr. Steve Carnevale, Vice Chair* Welcome, opening remarks and review of the agenda.	
9:10 AM	**Action: Approval of Meeting Minutes** *Commissioner Dr. Itai Danovitch, Chair* The Research and Evaluation Committee will consider approval of the minutes from the February 16, 2022 meeting teleconference. • **Public comment** • **Vote**	**1**
9:20 AM	**Information: Status Report on the Commission's Research and Evaluation Portfolio** ***Presenters:*** *Commissioner Dr. Itai Danovitch, Chair* *Toby Ewing, PhD, Executive Director* The Committee Chair and Executive Director will provide a status update on the Commission's Research and Evaluation Division projects and activities. Leaders will also discuss the Committee's advisory role, accomplishments and next term.	**2**
9:40 AM	**Information: The Commission's Evaluation of the Mental Health Student Services Act (MHSSA)** ***Presenters:*** *Tom Orrock, MA, MFT, Chief of Stakeholder Engagement and Grants* *Latonya Harris, PhD, Research Scientist* Commission staff will provide an overview of the MHSSA grant program implementation and facilitate discussion about draft research questions to guide evaluation of the MHSSA. • **Question and Answer**	**3**
10:20 AM	**Break**	
10:30 AM	**Breakout Groups (*Continuation of Agenda Item #3*)**	**3**

	The Committee and members of the public will break out into small groups for an in-depth, discussion of the MHSSA evaluation.	
11:30 AM	**Breakout Groups Report Out** *Commissioner Dr. Itai Danovitch, Chair* • **Public Comment**	
11:50 AM	**Wrap-Up** *Commissioners Dr. Itai Danovitch, Chair & Mr. Steve Carnevale, Vice Chair*	
12:00 PM	**Adjourn**	

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AGENDA ITEM 1

Action

Approval of February 16, 2022 Meeting Minutes

May 12, 2022 Research and Evaluation Committee Meeting

Summary: The Commission's Research and Evaluation Committee will review the minutes from the February 16, 2022 Committee teleconference meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting.

Presenter: None

Enclosures (1): February 16, 2022 Meeting Minutes.

Proposed Motion: The Committee approves the February 16, 2022 meeting minutes.

Research and Evaluation Committee Teleconference Meeting Summary

Date: Wednesday, February 16, 2022 | Time: 1:00 p.m. – 4:00 p.m.

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

****DRAFT****

Committee Members:	Staff:	Other Attendees:
Itai Danovitch, Chair Steve Carnevale, Vice Chair Rikke Addis Sergio Aguilar-Gaxiola Robert Brook Sharon Ishikawa Bridgette Lery Gustavo Loera April Ludwig Belinda Lyons-Newman Mari Radzik Katherine Watkins	Toby Ewing Kai LeMasson Sheron Wright Anna Naify Kallie Clark	Laurel Benhamida Ken Berrick Fatima Clark Theresa Comstock James Martin Driskill Lishaun Francis Elia Gallardo Lynn Thull

Committee members absent: Eleanor Castillo Sumi, Jonathan Freedman, Laysha Ostrow, Ruth Shim, and Lonnie Snowden, Jr.

Welcome

Commissioner Itai Danovitch, Committee Chair, called the meeting to order at approximately 1:00 p.m. and welcomed everyone.

Kai LeMasson, Senior Researcher, called the roll and confirmed the presence of a quorum.

Chair Danovitch stated, since the September meeting, Commissioner Ken Berrick departed the Commission and will no longer be serving in his role as Committee Vice Chair. Chair Danovitch thanked and honored Commissioner Berrick for his service to the Committee and wished him well in his new endeavors. Chair Danovitch stated former Commissioner Berrick has recently been appointed by Commission Chair Madrigal-Weiss to serve on the Children and Youth Subcommittee.

Chair Danovitch announced that Commission Chair Madrigal-Weiss appointed Commissioner Steve Carnevale as the new Vice Chair of the Committee. He welcomed Vice Chair Carnevale to the Committee.

Chair Danovitch announced that Dr. Dawnte Early, former Chief of the Research and Evaluation Division, was named president and CEO of United Way California Capital Region last November. He asked for the Committee's help and support in the recruitment of a replacement for this position through their professional networks.

Executive Director Ewing stated the position for the Research Director is posted on the Commission's website.

Chair Danovitch reviewed the meeting protocols, purpose, and agenda.

Agenda Item 1: Action – Approval of September 1, 2021, Meeting Minutes

Chair Danovitch asked for a motion to approve the meeting minutes for the September 1, 2021, Research and Evaluation Committee teleconference meeting.

Committee Member Loera made a motion to approve the minutes as presented. The motion was seconded by Committee Member Ishikawa.

Vote recorded with participating members as follows:

- Approve: Committee Members Addis, Brook, Ishikawa, Lery, Loera, Ludwig, Lyons-Newman, Radzik, and Watkins, and Chair Danovitch.
- Abstain: Vice Chair Carnevale

Agenda Item 2: Information – The Commission's Research and Evaluation Division's 2022 Strategic Portfolio

Presenters:

- Commissioner Itai Danovitch, Chair
- Toby Ewing, Ph.D., Executive Director

Chair Danovitch stated the Committee will hear a presentation on the Research and Evaluation Division's Strategic Portfolio and activities underway, highlighting Commission-mandated evaluations and "big picture" questions centered on children and youth. He stated Deputy Director Sala was unable to be in attendance and invited Executive Director Ewing to present this agenda item.

Executive Director Ewing provided an overview of the role of research and evaluation in the Commission's broader portfolio, current contents in the portfolio that are tied to Commission goals, and the opportunity to establish statewide goals and measures. He stated, as part of the mandated work to review and approve County innovation plans, the Commission is trying to put together better fiscal accounting of County innovation funds to help counties avoid congestion during the Commission approval process just prior to the statutory deadline.

Executive Director Ewing stated part of this conversation is trying to get clear program goals and metrics that show that progress is being made. Data systems have rarely been designed to support inquiries on how people are doing but were instead designed to track spending and support reimbursements. As a result, most data is not conducive to the level of detail being looking for in this work. Although the need to improve outcomes is obvious, it is difficult to measure the return on investments in programs, treatments, or outreach strategies.

Executive Director Ewing stated the Commission's portfolio is broad and includes mandatory work, Commission-directed work, discretionary work that is designed to support broader goals, and activities designed to provide information as part of the effort to create trust and understanding. The immediate opportunity is to create a core set of indicators that will

support conversations around the outcomes being achieved for children and youth with mental health needs.

Discussion

Committee Member Loera stated many measures are quantitative. He asked for additional details on looking at data from a qualitative perspective.

Executive Director Ewing stated detailed evaluation outcome goals are rarely articulated in the direction that is included in the budget or in legislation beyond generic verification of program success. The idea is to create clarity about the decisions to be influenced and how to think about information, analysis, reporting, and communication to support those decisions.

Executive Director Ewing stated a quantitative measure to help answer whether individuals have access to care may look at penetration rates, i.e., the number of individuals receiving services. Qualitative measures look at the individual's experience. Perhaps the reason they did not access care was not because of long waiting lists, but because they did not know that care was available or that they needed it or where to get it. There are many ways to listen better to the customer in that instance and, for the Commission, sometimes the customer is the county. Sometimes barriers prevent access to care that we did not realize were there because we had not asked.

Committee Member Loera stated quantitative data has limitations. Experiences captured in qualitative data help strengthen the quantitative data.

Committee Member Brook stated the presenter opened the presentation indicating that there was little budget and many statutory limitations of what can be done, and then went on to describe an extraordinary, extensive, elaborate evaluation plan. He suggested enumerating precisely to the governor what the statutory and budget limitations are that would prevent the Commission from completing the evaluation.

Committee Member Brook stated, although everything described in the presentation is important, he was concerned about focus. He asked about actionable items that will change something, that will make a difference, and is meaningful, based on what the Commission and the evaluation have done, and who will be involved in those changes so they will not be surprised by what the Commission says. He asked at what level these changes will occur. He noted that these things should be precisely laid out.

Executive Director Ewing agreed that there is a mismatch between the opportunity and the resources.

Committee Member Brook suggested enumerating these issues in writing to the Governor now so he can better understand the amount of funding required to accomplish these goals. Helping the Governor to understand the need for more funding to complete the mandated evaluations may do more to improve the mental health of children than other things.

Executive Director stated identifying achievable opportunities, garnering the right kind of data, and putting it together in a package that is easily accessible can shape behavior, if done in a strategic manner. He gave the example of the Commission's Fiscal Transparency Suite of dashboards that provide high-level statistics showing county and statewide demand for mental health service programs, where money gets spent, programs offered, and

associated outcomes. Due of the Fiscal Transparency Suite, more attention is being seen on the adequacy of resources relative to the need.

Executive Director Ewing stated part of this opportunity is to create a similar tool on key metrics. He asked Committee Members for feedback on what those metrics should be and how they could be used to shape understanding and decision-making.

Chair Danovitch stated prior discussion about these challenges have contributed to the Committee's decision to focus on school-age youth, specifically on initiatives that have arisen through the Mental Health Services Act (MHSA) and where the Commission has mandated requirements to conduct effective and impactful evaluations. Feedback received from Committee Members is that areas where there are critical evaluations that the Commission would like to conduct but should be elevated to create awareness of the opportunities and gaps in order to take advantage of the resources available to do the work and evaluations needed.

Agenda Item 3: Information – Update on the Commission's Triage Summative Evaluation Plan

Presenter:

- Kallie Clark, Ph.D., Senior Research Data Analyst

Chair Danovitch stated the Committee will hear an update on how Committee and public member feedback was incorporated into the Triage Summative Evaluation Plan, and the progress made in data collection and implementing the evaluation. He asked staff to present this agenda item.

Kallie Clark, Ph.D., Senior Research Data Analyst and Lead of the Triage Summative Evaluation Project, provided an update, with a slide presentation, of the progress to date, feedback received from Committee Members and the public, data received so far and the status of that data, and the percentage of grantees that are reporting. She stated there were four major themes in the feedback given at the last meeting: evaluation design, data quality and source, equity, and workforce capacity and systems. She reviewed the work being done to address each theme.

Chair Danovitch asked Dr. Clark to define triage and what this evaluation is trying to achieve.

Dr. Clark stated Senate Bills (SB) 82 and 833 allocated funds to increase personnel for grantees, particularly targeted around crisis services for individuals experiencing unmet mental health needs. In order to ensure that grantees, which are typically counties, are able to meet the needs of individuals in their regions, flexibility has been built in to allow those grantees to develop the types of programs to target the different populations that they feel would benefit them most from this infusion of additional funds.

Dr. Clark stated the Commission is in the second round of triage grant funding and is mandated to do a statewide assessment on potential impacts that the infusion of additional funds may have had on reducing disparities and increasing access, along with improving longitudinal outcomes for individuals who receive those services.

Chair Danovitch asked Dr. Clark to discuss the categories of grants that focus on schools, given the focus on school-age youth.

Dr. Clark stated there are three types of grants: grants that focus on adults and transition age youth (TAY), grants that focus on children that are not necessarily embedded within schools, and grants for school-county collaborations.

Discussion

Committee Member Loera referred to the demographic characteristics listed on the Equity presentation slide and asked how the various ethnicities will be disaggregated. He also asked about the urbanicity demographic and whether it also captures individuals in rural parts of the state.

Dr. Clark stated the team is looking at broad racial and ethnic categories and is also looking at other important variables, such as country of origin and primary language, which allows the data to be more granular.

Committee Member Loera asked how individuals who are already getting services will be captured and if the prevention and early intervention components prior to services will be included.

Dr. Clark stated the team can review service histories prior to triage. It is anticipated that a number of years of data can be reviewed before someone has a triage encounter. This will allow questions such as if they experience triage services earlier in their trajectory and if that has a different impact than someone who has had a longer history of previous services.

Committee Member Watkins asked if the team attempted to see whether this infusion of funding has impacted crisis services at the population level rather than at the program level.

Dr. Clark stated the evaluation is a two-fold approach because counties often do different things with different populations. The team plans to first look statewide to see if a positive impact has been seen from this additional infusion of funds called triage grants.

Committee Member Watkins asked how this will be done.

Dr. Clark stated an analysis is being used that will compare individuals who receive triage funds to compare individuals who did not receive triage funds. The team will then look at a number of outcomes.

Committee Member Watkins asked about the data being collected and where that data is coming from for the individuals who did not receive triage funds.

Dr. Clark noted that this information is not just gathered from county data but that the team will work with a number of state agencies to collect behavioral health, education, and employment data in order to have a much deeper understanding of what is going on for individuals who are seeking out crisis services. She stated not all of those individuals will encounter a service provider who received a triage grant. The goal is to see if individuals who received services from a triage grant provider had a different outcome from individuals who did not. That is what this evaluation has been about. It answers detailed questions about how these individuals have been identified and how they are matched up, using a number of methodologies.

Committee Member Watkins asked where the data will be gleaned from for the countywide data, the population-level data, and how the evaluators will be able to use it to do the matching analysis.

Chair Danovitch suggested continuing this conversation offline. He asked Dr. Clark to provide Committee Members with the detailed evaluation plan and asked Committee Members to provide feedback on areas of opportunity and where the methodology may not answer the questions. It is also important to be clear about the levels of questions being asked at the program level, the service provision, and impact outcomes at an individual level, but it is also important to answer the higher-order question about the levels of success seen as a result of the infusion of funds.

Break

Agenda Item 4: Information and Discussion – Transforming California's Mental Health System and the Need for Robust, Comprehensive Metrics

Presenters:

- Lishaun Francis, MPP, Director of Behavioral Health, Children Now
- Fatima Clark, MSW, Associate Director, Health & The Children's Movement Equity Fellowship, Children Now

Chair Danovitch stated the Committee will hear a presentation on children's mental health measures collected in California, the importance of comprehensive and unified measures to tell the story about how children are faring, and measurement gaps and opportunities, particularly in light of the transformation underway in the children's mental health system.

Chair Danovitch stated the presenters are the authors of the Children Now report entitled, *Robust Data Systems Needed for California's Child Behavioral Health*, which was included in the meeting materials. This report examines the current data metrics collected in California on children's mental health and substance use. The report identifies major gaps that must be closed if California is to successfully track its progress and achieve is goals to improve outcomes for children and youth. This report is relevant, given the large investments being made in California on children, youth, and school mental health. It also has implications for the Commission's work. He asked the speakers to give their presentations.

Fatima Clark, MSW, Associate Director, Health & The Children's Movement Equity Fellowship, Children Now, provided an overview, with a slide presentation, of the background of Children Now and the purpose and methodology shown in the recent Children Now report. She noted that Children Now found that there are approximately 80 metrics that met the criteria of analysis across various agencies, which were grouped into two distinct buckets: population indicators and system performance indicators.

Ms. Clark stated the metrics in these groups were further stratified into types of domains. Children Now found that there are many measures that focus on early identification and systems use. Within the general domain of population indicators, a gap was seen in the system performance in publicly available data and what can be gleaned from currently available sources in terms of how the system is functioning for children and youth.

Ms. Clark provided a demo of a platform created for organizations to use. She showed a searchable, filterable table of indicators. She showed that conditions can be filtered by domain, focus measure area, organization, latest time that that data is available, and

whether race and ethnicity is reported. She stated the hope that this database will allow individuals to stratify the information to their needs.

Lishaun Francis, MPP, Director of Behavioral Health, Children Now, continued the slide presentation and discussed the findings and opportunities for better data, as shown in the recent Children Now report. She stated, although race and ethnicity are important, data by age is missing for the 0-5 and TAY populations, because each of these populations have different developmental needs than school-age youth.

Ms. Francis stated consumer experiences and satisfaction data are also missing. Program success cannot be assured without hearing from consumers that it is working. She stated the need to focus on quality and outcomes rather than on process measures. Penetration data is often discussed because it is important, but there is also a need to better understand the gap between who is getting services and who wants services. That is the missing piece.

Discussion

Committee Member Aguilar-Gaxiola asked about the definition of children and youth.

Ms. Clark stated Children Now defines children and youth as ages 1 to 26.

Committee Member Aguilar-Gaxiola asked if Children Now looked for older databases such as the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), which has been collecting data on 400 individuals annually since 1984.

Ms. Francis stated she is familiar with the CDC data, but the focus was on what the state is publicly reporting for several reasons, such as that it is a statewide responsibility to collect data on the California children's population and Californians need to determine the measures most important to them, which may or may not include some of what the CDC is reporting on.

Committee Member Aguilar-Gaxiola stated there have been other attempts in California to determine the right measures and metrics for children and youth and where those should be housed. He asked if Children Now looked at barriers to a unified system of measurement that is comprehensive and timely.

Ms. Francis stated there was discussion about barriers and why this data has been difficult to collect. It is one of the reasons the report includes the Cradle-to-Career Data System that is being created by the state as a potential opportunity. Their goal is cross-sector data.

Committee Member Aguilar-Gaxiola stated the presenters indicated that they restricted their data review to the last three years, but two out of the three years were during the COVID-19 pandemic, which has had a tremendous negative impact on the mental health of children and youth. He asked about data related to the pandemic in terms of the impacts on children and youth mental health.

Ms. Francis stated there unfortunately are no new metrics being collected that are unique to the COVID-19 pandemic.

Committee Member Brook asked if the Commission staff used the Children Now report to identify the data sources. This is the first comprehensive report he has seen of the data sources involving children's mental health in different areas. He asked if the report was useful and if other sources of data about children was found independent of this report.

Committee Member Brook suggested determining which recommendations in the report are useful for answering questions about data collection – collecting, correcting, how, how long it will take, and how much it would cost – so that three years from now discussions will not still be centered around having no data to answer important questions.

Committee Member Brook thanked Children Now for putting together the impressive set of tables. Now that all the hard work has been done to identify the data sources, he suggested that the Commission take the recommendations and begin to ask what ought to be done and what it would cost to really evaluate the important questions about children's mental health on a population level.

Chair Danovitch agreed and stated those are the reasons that this was put on today's agenda. The goal of this discussion is to gather feedback on what is feasible to measure, based on the findings in this report.

Ms. Francis stated when putting this report together and looking at the metrics, her favorite metrics came from the Commission. She noted that the Commission is the only entity evaluating their current programs. No one else is evaluating the programs, such as how full-service partnerships (FSPs) are working. That is an important question. The problem is that FSP is limited to the MHSA, is not truly widespread, and does not include all children. She stated she would love for schools to evaluate themselves on how well they are doing with some of their own programs.

Committee Member Brook stated Children Now uncovered an enormous amount of effort that has been done to look at this problem. There is a marvelous opportunity and synergy here that ought not be missed. He suggested that the Commission write a paper that will produce an actionable item from the Children Now report that would not be labeled as advocacy but as an independent Commission activity highlighting this outline of what needs to be done at a specific level in order to understand how the mental health of children will or will not improve over the next decade. He suggested giving this a higher priority than doing an inadequate evaluation of a program because of the lack of data, even if that is the statutory requirement.

Chair Danovitch agreed that that is a compelling call to action.

Discussants:

- Lynn Thull, Ph.D., President, LMT & Associates, Inc.
- Katherine Watkins, M.D., MSHS, Senior Physician Policy Researcher, RAND Corporation

Chair Danovitch thanked Ms. Francis and Ms. Clark for their excellent presentation and stated Committee Member Dr. Katherine Watkins and discussant Dr. Lynn Thull were invited to add their thoughts to this presentation and begin the discussion portion of the meeting.

Katherine Watkins, M.D., MSHS, Senior Physician Policy Researcher, RAND Corporation agreed that the Children Now report is very useful. She made suggestions to make it even more so.

- It is important to look outside the California system.
    - One of the main designs to add in is the Difference-in-Difference (DID) design, which depends on getting data from places that did not get this infusion of funds.

- The next step is to begin mapping these data systems to the evaluation questions to create a logic model.

Lynn Thull, Ph.D., President, LMT & Associates, Inc., provided five overarching reminders for effective quality evaluations:

1. Integrate key stakeholders into every component of the evaluation.
2. Develop the evaluation design prior to launching the project.
3. Focus on measuring outcomes related to what you want to see.
4. Start with what you can control.
5. When measuring things like equity, do not confuse "equal" with "equity." Giving everyone the same thing may be the furthest distance away from equity.

Dr. Thull suggested mandating the use of the Child and Adolescent Needs and Strengths tool, so everyone is looking at the same type of data and all speaking the same language.

Dr. Thull agreed with Children Now and stated they have good quality materials; however, there are data sources missing from the report. She agreed with Committee Member Watkins that going to national studies, such as the CDC, would be important and grounding, but there are also privately-funded evaluation studies in the state, which include information that public resources cannot get because of their connections with the individuals.

Dr. Thull stated the Performance Outcome System at the Department of Health Care Services (DHCS) is designed to look at the qualitative measures; however, this was stalled because there was not agreement on what those qualitative measures should be.

Dr. Thull agreed with the need to focus on and prioritize what individuals and their family members are saying. She stated concern about how satisfaction information is currently gathered for the Satisfaction Survey. Individuals who are dissatisfied with their treatment will be disengaged and unavailable to fill out the survey form. Also, there are cultures that would never say anything negative about their service provider. She suggested gathering satisfaction information through focus groups run by community cultural leaders rather than government entities.

Dr. Thull provided categorical recommendations as follows:

<u>What should be measured</u>?

- A holistic view should be taken of what is important to youth and families. Move away from the medical-model scales.

<u>Elements that Should be Tracked that are Often Forgotten for Children in School</u>

- Ensure that children who are not in school are reached.
    - Find a way to connect with the education system and the department in charge of independent study. Children are often in independent study because of behavioral health issues.
    - Schools need to find, in their evaluation plans when funding is released, how they will identify and engage children that have disappeared from the school district and children who are on independent study. How can these children get

school-based mental health services when the school does not even know they exist?

- Children need continuity of care. Find out what happens to children during school breaks. Therapists do not see children during school breaks.
- Ensure that providers are where the children are. Special education teachers and school psychologists cannot go into the home. Community-based goes beyond school-based.
- Colleges and Universities need to find a way to identify and engage with students and help them have the supports they need to enroll. Youth with the biggest mental health needs do not get into colleges and universities.
    - What happens when, through the therapeutic relationship, it is decided that a youth needs to take a break from academics because of their mental health needs? Do they lose their therapist? These things need to be measured and addressed.

<u>Short-Term Recommendations</u>

- Develop the evaluation strategy before the Request for Proposals (RFP) is released.
- Consider the reasons that the funding source is providing the funding. Policy Bill Fact Sheets outline the problem that the policy is trying to address. This gives a good indication of what should be measured.
- Start with what you can control.
- Find out from county mental health boards what they hear about children and youth mental health.
    - Are they empowered to get the information? Act on that information.
    - Do a survey of their involvement, control, or responsibility over mental health services.

<u>Long-Term Recommendations</u>

- Data integration. It is important to be involved in this outcome system or this Cradle-to-Career Data System that is being established.
- Start now to identify sources of data we want to see.
- Work with the other entities such as the DHCS and the CDE. Learn what their barriers are and help them, as their partner at the state, to overcome those barriers. There is too little funding to take it all on. Partnering with other entities and helping them get their needs met so they can give better data would be helpful.
- The measure of overall improvement of the system is some indication that the community overall is improving. Look at adverse childhood experiences (ACEs) data. Does putting more services in place make the community in which the child is living healthier?

<u>Caution and Frustration as a Grant Writer</u>

- Consistently post the data.
    - Whatever data you have, it must be kept updated, it must be kept on the website because, if someone goes to the website for that data and it is not there, they will not come back to the website to look for data.

Dr. Thull asked everyone to remember that obtaining and reporting the data is not about Committee Members or Commissioners, it is about the youth and family being served. They need to be at the forefront in all the work being done in developing evaluations and reporting on data.

Committee Member Discussion

Chair Danovitch invited Anna Naify, Ph.D., MHSOAC Consulting Psychologist, to facilitate the discussion.

Dr. Naify asked a series of questions to guide the discussion. Committee Members provided feedback as follows:

1. What are the most important community indicator domain areas in children and youth behavioral health that the Commission can contribute to?
    - It is individual and about that child's basic functioning in life and how the child sees their ability to function in life. It needs to be culturally relevant. It is about what the individual sees as a success and wellness versus what the clinician thinks is success and wellness.
    - The young adult's view of their success in life will probably be different than their parent's view of what they want their young person to be. The clinician's job is to navigate the different desires between the two.

Dr. Naify agreed that valuing the client perspective and the family perspective and focusing on functioning rather than more clinical indicators are important.

Committee Member Watkins stated, while she did not disagree with the previous feedback about individualizing the goals of treatment while working as a provider, but stated this kind of outcome is not usable or workable in a largescale evaluation. Choose indicators that are common such as days missed from school, homelessness, suicidal thoughts, if the child is involved in the juvenile justice system, or if the child is in foster care – something that is applicable to every child and that every family can report on.

- Look at the National Academies of Sciences, Engineering, and Medicine report, released in 2019, entitled *Vibrant and Healthy Kids: Aligning Science, Practice, and Policy to Advance Health Equity*. It identifies key domains for the healthy development of children.
- Another brainwork that would be helpful is entitled *Vital Signs*, which provides vital indicators.
- There is a helpful document released by the CDC about long-term recovery and experience for social behavior and community health that also has domains of indicators for healthy development of children and youth.

Dr. Naify agreed that it is important to learn how to organize all of this and develop a strategy that would be thoughtful, given all of the data that is available.

- Set the goal to be the first state to reduce post-traumatic stress disorder (PTSD) in children by two-thirds within a few years.
- Do everything possible to reduce the stress, whether it is from COVID, opioids, crime rate, or prison rate.

2. What are the biggest near-term opportunities for the Commission to improve public access to and understanding of key children and youth behavioral outcomes? Should outcomes be defined for specific subpopulations (e.g., foster youth)?
   - Yes, focus on subpopulations.
   - Expand subpopulations to include maltreated children.

Public Comment

Theresa Comstock, Executive Director, California Association of Local Behavioral Health Boards and Commissions (CALBHB/C), stated the CALBHB/C has an issue brief that identifies suggested data points for children and youth for performance outcomes data. It is posted on the website at calbhbc.org/performance. She noted that data should include outcomes specific to culture, race, ethnicity, and age. The three areas of data points that were identified and suggested to be tracked were school-based wellness, including attendance, grades, and classroom behavior, standardized screening and assessment, and reporting by self and family.

Steve Leoni, consumer and advocate and former Research Committee Member, agreed with the importance of qualitative approaches, including focus groups and in-person interviews, etc. He spoke in support of Dr. Thull's comments and outlook.

Steve Leoni agreed with Committee Member Radzik's point that it is about what the individual sees as a success and wellness versus what the clinician thinks is success and wellness. He suggested finding a way to track, in a broad sense, how prevalent such constructive and open relationships are because it can make a critical difference of whether a program might fail in one place but not in another. It is that relationship that makes the difference.

Steve Leoni stated Committee Member Radzik's comment was followed by the critique from Committee Member Watkins that this is not scalable or doable as outcomes because they are so varied. He made the point that, in fact, the therapist's local outcome and working with the person actually represents a style of interaction with someone. It represents a process metric. Outcomes can then be measured on the broader scale, but, unless the program incorporates the right kind of process, it may not be as successful as it would otherwise.

James Martin Driskill, advocate, shared their experience with being in therapy since he was a child. He has been having trouble accessing care since he moved back to San Bernardino. He stated he cannot get a doctor to have a discussion with him about "gang stalking." He stated he is a targeted individual of gang stalking and has been for 16 years. He reviewed the findings of the research done by the National Institute of Health and suggested a grant or funding to focus on stopping gang stalking.

Laurel Benhamida, Ph.D., Muslim American Society – Social Services Foundation, and on the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) Board, asked for an update at a future meeting on the threshold language data collection analysis and waiting

period. She stated the need to know how the needs of the newly-arrived Afghan refugees, the majority of whom are children, will be addressed in light of the following problem: Afghan is not a Language, Afghan people speak mainly two languages – Dari or Farsi (Persian) and Pashto. If data for Afghans is divided by numbers into Farsi-Dari speaker data and Pashto speaker data, it will take much longer – maybe years longer – for Afghan newcomers to receive the benefits of being speakers of threshold languages in the counties where they are residing.

Dr. Benhamida stated Afghans are almost all at risk of PTSD. Delaying prevention and early intervention perks for being a speaker of a threshold language to many Afghans and treatment as well for those who already have PTSD will be a sad commentary on the system. She stated this Committee and the Cultural and Linguistic Competency Committee (CLCC) would be the best Committees to find out how the threshold language issue with regard to the newcomer Afghans is being addressed.

Steve McNally, family member and Member, Orange County Behavioral Health Advisory Board, spoke on his own behalf and amplified Dr. Thull's comment about getting local county behavioral health boards involved. The 59 boards are made up of over 900 individuals including 59 elected, some of whom are engaged while others are not. As a family member, he stated concern that state agencies feel that they cannot collect data because they are not empowered to do it.

Steve McNally suggested considering local county behavioral health boards as a funding mechanism to what is trying to be accomplished to find county carveouts within existing data. There is a lot of potential funding, if the Commission can help focus the local county boards.

Steve McNally referred to comments about older datasets. A great deal of research is available in the Commission archives. He requested, prior to creating new data, using what little is currently available before the institutional knowledge is lost. He stated he liked the Cradle-to-Career approach and the open data portal but stated there was not much discussion about how to take the raw data in the open data portals and make it usable for counties because most counties will not do this on their own.

Hannah Bichkoff, Policy Director, Cal Voices, stated Cal Voices is interested in the ways in which counties are using their funds. One thing Cal Voices came across recently was that the Fiscal Transparency Tool does not show unspent funds from 2018 and forward. Having that data readily available would be helpful to help track how counties are using their money.

Hannah Bichkoff thanked the presenters for the Children Now report. She highlighted a comment made by Dr. Thull around strength-based metrics. One thing that stood out to Cal Voices is that the measures are largely deficit on where the system is failing youths and families. It would be helpful to look at more recovery strength-based areas of where individuals are growing and excelling within the mental health and social service systems.

Hannah Bichkoff stated the last measure Cal Voices wanted to bring forth and is seen frequently among consumers and stakeholders is the Individualized Education Program (IEP) as a signal of how youth and families are doing within the school system. Children and families have a hard time accessing IEPs and then utilizing them in a way that is useful to their mental health or whatever disability or challenge they are struggling with. The ways in which to focus more attention on who is getting IEPs, how they are being utilized, and what

the outcomes are is critical, especially as youth navigate the virtual to in-person school system.

Elia Gallardo, Director of Governmental Affairs, County Behavioral Health Directors Association (CBHDA), stated the CBHDA has historically used the Transparency Suite data in order to demonstrate some of the work and activity that is happening and are one of the primary users of the tool. One of the main things the CBHDA continues to be concerned about is to ensure that the information is presented as accurately as possible and in a manner that gives a clear understanding of how the MHSA works and how funds are encumbered in the program.

Wrap-Up

Chair Danovitch invited Vice Chair Carnevale to share comments or observations from today's meeting.

Vice Chair Carnevale stated everything discussed today was interesting and helpful in different ways for the Commission, in particular the report on the data, which is foundational to the Commission's efforts to improve outcomes for everyone who accesses the system. Shared data is critically important to understanding where the gaps are and what the opportunities are to improve. He suggested continuing to move the importance of data forward at the Commission level.

Chair Danovitch provided a brief summary of take-aways from today's meeting:

- We have an opportunity to make an impact by limiting areas and asking focused questions for greater impacts, preferably in the area that touches the work of the Commission in its subpopulation of school-age youth.
- There is work to do in terms of incorporating the reports that have already been put together, articulating some of the questions and the local models that underpin them, determining what is feasible that is based on existing datasets, and where the Commission can answer impactful questions.
- Staff will present proposals based on today's discussion at the next meeting for Committee feedback.

Adjourn

Chair Danovitch thanked everyone for their participation and feedback. He adjourned the meeting at approximately 4:00 p.m.

AGENDA ITEM 2

Information

Status Report on the Commission's Research and Evaluation Portfolio

May 12, 2022 Research and Evaluation Committee Meeting

Summary: The Committee Chair and Executive Director will provide a status update on the Commission's Research and Evaluation Division projects and activities. Leaders will also discuss the Committee's advisory role, accomplishments and next term.

Background: The Research and Evaluation Division Strategic Portfolio, developed in October 2021, organizes the divisions activities into five primary, interrelated activities that support the Commission's mission. A summary of the division's activities and achievements is presented.

The Research and Evaluation Committee provides guidance and expertise to the Commission in implementing the Research and Evaluation Division Strategic Portfolio, with a focus on children/youth and legislatively mandated evaluations (e.g., S.B. 82 Triage Crisis Services).

The Committee is nearing the end of its two-year term, and we will discuss reappointing Committee members and future opportunities for enhancing Committee engagement.

Presenters: Commissioner Itai Danovitch, Chair
Toby Ewing, PhD, Executive Director

Enclosures (2): (1) MHSOAC Research and Evaluation Division Strategic Portfolio, October 2021; and (2) Research and Evaluation Portfolio, May 2022 Update.

Handouts (1): PowerPoint presentation.

MHSOAC Research and Evaluation Division Strategic Portfolio
October 2021

The Research and Evaluation Division seeks to improve outcomes, promote opportunities for prevention and effective intervention, and reduce disparities by analyzing data, consulting with experts, and engaging communities to produce information and recommendations that empower community members and inform policymakers and practitioners.

The division has five primary activities that are strategically designed to increase public understanding and reduce stigma, document the impact of existing policies and programs, provide the information required for robust community involvement and continuous improvement in services and outcomes, and inform the Commission's agenda.

1. **Tracking community indicators to increase public understanding and awareness.** The Commission reports population-level data on significant outcomes associated with mental health, including hospitalizations, criminal justice involvement and suicide. These dashboards reveal trends and allow for comparisons across counties and with other states.
2. **Curating an inventory of county plans and programs to improve community planning.** The Commission aggregates data on MHSA-supported programs, including three-year plans and annual reports, data and outcomes reported for Prevention and Early Intervention programs and Innovation projects, program descriptions and outcomes, revenue and expenditures. The information enables community members and practitioners to assess services and the allocation of resources; identify opportunities for prevention and other systems improvements; develop new strategies and partnerships; and, design new programs and services.
3. **Recommending ways to improve mental health strategies and outcomes.** The Commission compiles data and research with public input to align and adapt statewide policies and community programs with effective approaches to improve outcomes. For example, the Commission's recommendations for reducing criminal justice involvement prompted a $5 million investment in county efforts to adapt proven diversion programs. The Commission crafted – and is now implementing – a statewide suicide prevention strategy, resulting an Office of Suicide Prevention and ongoing funding and staffing for statewide suicide prevention. Its school mental health report inspired the Mental Health Student Services Act. Recommendations are being developed to improve prevention and early intervention and workplace mental health strategies.
4. **Linking consumer-level data across service systems to understand the impact of mental services.** The Commission links consumer-level data across service systems to understand how mental health needs and services impact the health, safety, education, and employment of Californians. This information is used to inform the

Commission's own research and the research of others, as well as state and community choices intended to improve outcomes for individuals.

5. **Evaluating new initiatives to accelerate learning, adaptation, and scaling.** The Commission selectively evaluates existing and pilot interventions to determine effectiveness and identify opportunities for prevention, improvement and replication. The Commission is evaluating the impact of $75 million in "Triage" grants provided to communities and will soon begin evaluating $250 million in grants provided by the Mental Health Student Services Act. The Commission also will be launching an effort to assess the collective impact on systems improvements of Innovative projects and collaboratives. The outcomes of these efforts could guide future Commission funding and resource allocation to promote continuous quality improvement and systems change.

Status of Projects and Activities

These projects and activities are intended to improve public understanding, empower all voices to advocate for improvements, and enable decision-makers and practitioners to design and manage strategies and services that improve results for all consumers. Overtime, the division seeks to improve the value of these projects and activities by better understanding and meeting the data and information needs of users, and facilitating learning and continuous improvement among public agencies and service providers.

1. Tracking community indicators to increase public understanding and awareness.

The Commission reports population-level data on significant outcomes associated with mental health, including homelessness, criminal justice involvement and suicide. A series of dashboards are being developed that reveal trends and allow for comparisons across counties and with other states.

A. Who is being served: This information is intended to inform consumers and advocates, to inform the Commission's agenda and engagements, and to guide state and local priorities and actions.

B. Status: The Commission contracted with UCLA to engage a diverse group of experts, conduct a literature search, analyze easily available data sets, and recommend population-level indicators for each of the seven negative outcomes identified in the MHSA.

The Commission staff engaged community members involved in suicide prevention to review possible indicators for that outcome and developed a "beta" dashboard. Community members and working partners were engaged again to determine if the data and presentation captured the lived experience and would accurately inform public discussions and planning, as well as program design and management. The suicide prevention dashboard was posted in September 2021.

A plan is being developed to evolve the balance of UCLA's work product for the other six indicators into public dashboards. The staff is considering how to sequence the development of the dashboards, how to effectively incorporate public engagement into the process, and whether to prioritize this project by reallocating staff resources.

C. Success metrics: Data are being used by advocates and incorporated into community planning and state policy proposals and analysis. Users report the data is valuable to their planning, analysis and advocacy.

For example: Suicide Prevention

In 2019, at the request of the Legislature, the Commission produced and adopt a state strategy for preventing and reducing death by suicide.

The Commission in 2020 was directed to begin implementing the plan.

In 2021, the Commission engaged deeply with community members and evolved the analysis by UCLA to develop a public-facing dashboard tracking one of the seven negative outcomes.

Aspirational goal: Community mental health indicators are reported and discussed on parity with health, employment, safety and other societal measures.

2. Curating an inventory of county plans and programs to improve community planning.

The Commission has begun efforts to aggregate and analyze data on MHSA-supported programs, including information from three-year and annual plans, Prevention and Early Intervention and Innovation plans that captures program descriptions and outcomes, revenue and expenditures. The information would enable community members and practitioners to assess services and the allocation of fiscal resources; develop new strategies and partnerships; and, design new programs and services.

A. Who is being served: Consumers and advocates at the community level; practitioners and county staff responsible for developing community-informed plans; the Commission and county partners interested in working together to develop better practices.

B. Status: The Commission's website has an inventory of all county three-year and annual plans; revenue and expenditure reports, PEI and Innovation plans. The staff piloted an effort to glean data and information from county plans to enable users to use data more efficiently from the reports for planning, advocacy and evaluation. The staff, however, found it extremely difficult and time consuming to glean any consistent and reliable data. While, community members have told the Commission this data would be valuable, the current reporting regulations and practices do not result in usable data.

For example: Fiscal Transparency

Over the last six years, the Commission responded to calls for more transparency regarding the expenditure of MHSA funds, and the size of reservices, in particular.

Dashboards have been developed that show the revenue, expenditure by major program area and reserves for each county over time.

The Commission is now working with state and county partners, which gather and provide the data to the Commission, to reconcile differences in the data and increase the frequency in reporting.

To begin addressing this issue, the staff is developing a template that would improve data the counties report regarding those who receive services funded through the PEI and Innovation components. While this is a narrow data set, it would begin an evolution toward improved data quality and the Commission's ability to identify needs and gaps.

The most recent available financial data is from 2017 and county behavioral health directors and the state Health and Human Services Agency do not agree on the accuracy of key data elements. The Commission is working with the counties and state agency to reconcile the differences and be able to provide more current data.

Community members and working partners have affirmed they would find significant value in high quality data on the quality and outcomes of services that are offered, as well as who is being served by those programs. A long-term plan is needed to evolve the data reporting requirements to support that goal.

C. **Success metrics:** Data are being accessed by consumers, advocates, county staff and policymakers; users report the information is valuable to their planning, analysis and advocacy.

Aspirational goal: Advocates, analysts and practitioners are using the tools and information to inform fiscal and program decisions. The Commission and other governmental and civic partners are using the tools and information to focus technical assistance and capacity building activities.

3. Recommending ways to improve mental health strategies and outcomes.

The Commission compiles data and research with public input to align and adapt statewide policies and community programs with effective approaches to improve outcomes. For example, the Commission recommended ways to reduce criminal justice involvement, which informed significant new spending on mental health diversion programs. The Commission crafted and is implementing a statewide suicide prevention strategy. Its school mental health review and report inspired the Mental Health Student Services Act.

A. Who is being served: Consumers and advocates impacted by intended outcomes; policymakers and analysts concerned about specific outcomes. Public partners concerned with specific outcomes.

B. Status: The Commission has completed three projects that produced comprehensive recommendations for state policy and community practice: Reducing criminal justice involvement, preventing suicide and supporting mental wellness in students. All three reports catalyzed significant implementation efforts. The Commission in the next few months is expected to finalize two reviews requested by the Legislature and issue recommendations on a state strategy for advancing prevention and early intervention in mental health and for improving work-related mental health supports. The Commission staff is developing ways to strengthen internal capacity to develop these reviews and leverage more change.

C. Success metrics: Recommendations are incorporated into policies, county plans and practices; outcome indicators show improvement.

For example:
Reducing Incarceration

The Commission deployed its own recommendations through an "Innovation Incubator" that helped more than two dozen counties develop system-level changes to reduce the arrest and incarceration of people with unmet mental health needs.

The counties participated in one or more of six different collaborative projects that built capacity for data and fiscal analysis, comprehensive crisis response strategies, continuous improvement of FSPs, and deploying psychiatric advanced directives.

Nearly every county in the state participated in follow up webinars and virtual workshops to understand how they could replicate the improvements.

Aspirational goal: The Commission is a trusted source of data, information and analysis and its policy recommendations are driving policy and system changes that improve desired results.

4. Linking consumer-level data across service systems to understand the impact of mental health needs and services.

The Commission links consumer-level data across service systems to understand how mental health challenges and services impact the health, safety, education, and employment of Californians. This information is used to inform the Commission's own research and the research of others, as well as state and community choices intended to improve outcomes for individuals.

A. Who is being served: Consumers and advocates; policymakers and analysts; the Commission and local planning councils.

B. Status: The Commission has assembled the following data sets and is in the process of analyzing and releasing informational dashboards that show the relationship between services and outcomes.

> Health and Human Services Agency mental health consumer data. Every six months, the Commission receives data on individuals who received services through the specialty care (Client Service Information or CSI data set) and Full Service Partnerships (FSPs). The data sets provide a foundation for establishing linkages to other service systems.

> Birth records. The Commission has received birth records for the previous 20 years. The staff needs to clean, match and analyze to surface information regarding for example maternal mental health.

> CA Department of Education student data. The Commission has received three of five requested data sets. The staff is cleaning and matching the data, which will allow a baseline analysis of the educational outcomes of students with mental health needs.

> Employment Development wage data. The Commission has received its first batch of employment data and has requested updated quarterly wage data. The staff is cleaning and matching the data and will then analyze the data to explore the relationship between services and employment.

> Department of Justice arrest and incarceration data. In 2016 the Commission received three decades of data and is in the processing of developing a new data use agreement with the Department of Justice. The data revealed a strong connection between participating with Full Service Partnerships and reducing arrests and incarceration. But the analysis also catalyzed efforts by the

For example:
Full Service Partnerships

The Commission's analysis of "Full Service Partnerships" revealed that individuals who stayed in these comprehensive programs were less likely to be incarcerated.

But the analysis also revealed room for improvement. The Commission engaged a set of counties to pilot better data collection.

The Commission, through its Innovation Incubator, also supported a six-county collaborative to develop Innovation plans crafted to improve outcomes and reduce disparities. Several other counties are considering joining the collaborative effort, with one county establishing its own Innovation project to do so.

Commission, working with counties, to better understand when and how FSPs were effective and how to improve outcomes. Analysis also has revealed that those who have been served in an FSP or by specialty care were, upon arrest, much more quickly found to be incompetent to stand trial. The data also revealed racial disparities, with more time passing for Black defendants before an IST finding was made. The Commission is assessing the implications of the data.

- Death records. The Commission has death records for the previous 20 years. The data needs to be cleaned and will be matched to reveal relationships between mental health services that are offered and the age and manner, such as homicide and suicide, and cause of death, such as by gunshot wound.

The Commission also is requesting the following data sets from other state agencies:

- Department of Social Services Child Welfare Data. This data would begin to reveal the relationship between mental health services and out-of-home placements.
- Hospitalization data from the Department of Health Care Access and Information (formerly the Office of Statewide Health Planning and Development.) The Commission has requested this data, but the department turned down the request. The data would reveal how often mental health clients visit emergency departments and are hospitalized.
- Medi-Cal usage data. The Commission has requested data on who has received mental health services funded by Medi-Cal, which would enable analysis regarding those who have received treatment for mild and moderate conditions.

Success metrics: Data are being accessed and found to be valuable by consumers and advocates; county staff, practitioners and state policymakers and analysts.

Aspirational goal: The Commission's data and analysis are promoting models for whole person care and informing state-level efforts to integrate and coordinate services in ways that improve the quality of life for mental health consumers.

5. Evaluating new initiatives to accelerate learning, adaptation, and scaling.

To drive transformational change, the Commission seeks to accelerate learning by improving evaluations and distributing learnings. Some of those evaluations are required as part of Innovation projects or other community programs. Some of those evaluations include projects managed by the Commission.

A. **Who is being served:** Consumers and advocates impacted by intended outcomes; policymakers and analysts concerned about specific outcomes. Public partners concerned with specific outcomes.

B. **Status:** The Commission selectively evaluates existing and pilot interventions to determine effectiveness and identify opportunities for improvement and replication. The Commission is evaluating the impact of $75 million in "Triage" grants provided to communities and will soon begin evaluating $250 million in grants provided by the Mental Health Student Services Act. The Commission also will be launching an effort to assess the collective impact on systems improvements of Innovative projects and collaboratives.

C. **Success metrics**: Recommendations are incorporated into policies, county plans and practices; recommendations guide future funding decisions; and outcome indicators show improvement.

For example: Evaluating Triage

The Commission administers the S.B. 82/833 Triage grant programs, which funds local capacity for a continuum of crisis services (e.g., crisis intervention and treatment, case management, referral and linkage).

The Commission is conducting a formative/process evaluation to understand barriers and facilitators to program implementation, and a summative evaluation to understand the programmatic impact on client outcomes (e.g., reducing ER visits, inpatient hospitalization, and arrests).

Aspirational goal: Timely evaluations are promoting refinements to policy, supporting continuous improvement in implementation, and enabling the adaptation and replication of effective strategies and services.

RESEARCH AND EVALUATION PORTFOLIO
MAY 2022 UPDATE

I. Tracking Community Indicators

The Commission tracks community mental health indicators to support understanding of opportunities, challenges, and pathways to improved outcomes.

The Commission currently reports on its website the following information:

- Mental Health Services Act (MHSA) funding, expenditures and balances.
- Criminal justice involvement for people with mental health needs.
- Number of people served in county mental health programs.
- Participation in Full Service Partnerships – a form of intensive community-based services.
- Information on suicide.
- Demographic disparities in access to county behavioral health services.

In addition to updating those dashboards as new information is available, the Commission is working on the following initiatives:

- Innovation Investments. The Commission is previewing an innovation dashboard that allows the public to track innovation investments by county, area of focus and status.

- Innovation Revenues. The Commission is previewing a tool to allow counties and the public to view existing innovation investments and currently available revenues. Discussions are underway to explore the viability of forecasting future innovation revenues to facilitate improved innovation planning.

- Expanding Demographic Data Relating to Suicide. The Commission is exploring opportunities to release detailed demographic data relating to suicide.

- County Spending on Full Service Partnerships. The Commission is analyzing county spending on Full Service Partnerships and comparing that information against minimum expenditure requirements outlined in the law.

- MHSA Prudent Reserves. The Commission is documenting prudent reserve balances held by county mental health programs to increase public understanding of revenue volatility and strategies to address fiscal risks.

II. Curating Community Mental Health Resources

The Commission gathers information from county mental health plans and shares that information publicly to support broad public understanding of the availability of mental health services in communities statewide.

The Commission is working on the following initiatives:

- Documenting Innovation Projects. The Commission is building a data dashboard to display high-level information on current Innovation projects, including information on the location on projects, target populations, and project descriptions.

- Building a Prevention and Early Intervention Dataset. The Commission is analyzing information on county prevention and early intervention projects to explore and document patterns in county investments, their goals and anticipated outcomes. Data are being validated for FY16/17 along with budget and expenditure data for FY16/17 through FY19/20.

III. Policy Research to Improve Policies and Practices

The Commission undertakes policy and related research to understand what is working, what is not and opportunities for improvement. Based on that work, the Commission provides guidance to the Governor and Legislature on strategies to improve California's mental health system and the outcomes it supports.

The Commission recently released policy recommendations on school mental health and suicide prevention. Earlier reports covered fiscal reversion and strategies to reduce criminal justice involvement among mental health consumers. Work is underway to implement the recommendations in those projects.

The Commission is currently working on the following initiatives:

- Mental Health in the Workplace. Senate Bill 1113 (Monning) in 2018 directed the Commission to establish a framework and voluntary standards for promoting mental health in the workplace. The standards for workplace mental health are intended to reduce mental health stigma, increase public, employee, and employer awareness of the significance of mental health, and create avenues to treatment, support, and recovery.

- Prevention and Early Intervention. Senate Bill 1004 (Wiener, 2018) directed the Commission to establish priorities for prevention and early intervention investments. This project is identifying strategic opportunities for those investments to improve mental health and related outcomes. The project includes the development of data monitoring and technical assistance strategies to improve prevention and early intervention opportunities.

IV. Evaluating New Initiatives to Accelerate Learning, Adaptation, and Scaling

The Commission conducts program evaluations in response to statutory direction and to support its broad mission.

The following evaluations are underway:

- Mental Health Student Services Act. The Commission has invested more than $200 million to fund partnerships between county mental health programs and local education agencies to support school mental health. Funds have been released to partnerships in 54 counties to support a range of needs. The Commission is currently negotiating access to data, exploring evaluation questions, and designing an evaluative approach.

- SB 82/Investment in Mental Health Wellness Act. The Commission has released $83 million in grants to 20 counties to improve county response to mental health crises. The Commission has contracted with the University of California, Davis and the University of California, Los Angeles to conduct formative and process evaluations of these Triage investments. The Commission is working with a team from the University of California, San Francisco to conduct a summative evaluation of these investments.

- Innovation Incubator. In 2019, the Commission released $5 million in grants to facilitate multi-county collaboration on innovations to reduce the justice involvement of mental health clients. Funds support a range of initiatives. Commission staff have conducted 26 key informant interviews to better understand

- Full Service Partnerships. As required under Senate Bill 465 (Eggman), the Commission will report biennially (beginning in November 2022) on outcomes (e.g., incarceration, hospitalization, and homelessness) for individuals receiving community mental health services under a Full Service Partnership model.

V. Building Data Infrastructure to Support Accountability

To support the Commission's research and evaluation work, it negotiates data sharing agreements and is building the data infrastructure to link mental health data to other high-value data sets, including education, employment, criminal justice, public health, and related data.

The Commission currently has data sharing agreements in place with the following agencies:

- California Department of Education. The Commission recently obtained datasets from the California Department of Education for consumers of MHSA funded services including student demographics, 4 year-adjusted graduation rates, student attendance, student discipline, and assessment data. These data will be used to establish a school performance profile and assess outcomes of students who have received community mental health services.

- California Department of Justice. The Commission has Department of Justice data that includes demographics, arrests, type of charge, disposition, and disposition outcomes. These data have been linked to mental health data to assess the effect of specific service on arrest history.

- California Department of Health Care Services. The Commission receives data from the department twice yearly from a range of data sets, including information on mental health services, demographics and self-reported data on housing, employment, justice system involvement, hospitalization, health status, substance abuse, and related issues.

- California Department of Public Health. The Commission receives birth and death records from the California Department of Public Health. Data linked to death records include cause of death, ethnicity, race, age, sex, marital status, level of education, military status, and related information. The birth files includes age, race, ethnicity of parents, sex of child, gestational age, labor or pregnancy complications, and prior pregnancy loss.

- California Employment Development Department. The Commission receives quarterly wage data from the Employment Development Department.

The Commission is working to establish data sharing agreements in the following areas:

- Department of Health Care Access and Information. The Commission is negotiating a data use agreement to access data on hospitalizations to improve understanding of how involuntary treatment tools and related strategies result in hospital utilization.

- California Department of Public Health. The Commission is negotiating expanded access to public health data, including vital statistics data to improve its capacity to understand maternal mental health needs, suicide risks and rates, and related inquiries.

- California Department of Justice. The Commission is negotiating access to additional data held by the Department of Justice to explore trends in court rulings related to Incompetent to Stand Trial determinations and how those rulings are related to issues such as access to early care for psychosis, participation in FSPs, and racial and ethnic disparities.

- California Department of Social Services. The Commission plans to initiate a data sharing agreement with the Department of Social Services to improve understanding of the mental health needs of children and adults receiving social and protective services.

AGENDA ITEM 3

Information

The Commission's Evaluation of the Mental Health Student Services Act

May 12, 2022 Research and Evaluation Committee Meeting

Summary: Commission staff will provide an overview of the Mental Health Student Services Act (MHSSA) grant program implementation and facilitate discussion about key considerations and draft research questions to guide evaluation of the MHSSA.

***Background*:** Senate Bill 75, 2019, established the Mental Health Student Services Act (MHSSA). The MHSSA incentivizes partnerships between county behavioral health departments and local education agencies for the purpose of increasing access to mental health services in locations that are easily accessible to students and their families. MHSSA funding has been released by the Commission in multiple rounds, based on funding availability.

To date, the Commission has disbursed MHSSA funds to support school mental health partnerships in 54 of California's 58 counties. To support the successful implementation of MHSSA programs and continued learning, the Commission has established a MHSSA Learning Collaborative that meets quarterly to discuss barriers, challenges, and successes. The Commission also is collecting data from grantees on students served and is developing a strategic data reporting and monitoring plan.

A key first step in developing an MHSSA data reporting and monitoring plan is to determine what is meaningful and valuable to learn for various groups of stakeholders. The Commission has developed an MHSSA engagement plan to gather feedback from grantees, students, families and various stakeholders on what matters to them and what questions regarding MHSSA they would like to have answered. Today's discussion is one in a series of public engagement activities the Commission plans to hold to discuss the evaluation of the MHSSA.

Presenters: Tom Orrock, MA, MFT, Chief of Stakeholder Engagement and Grants
Latonya Harris, PhD, Research Scientist

Enclosures (1): (1) Mental Health Student Services Act, 2019

Handout (2): (1) Report to the Legislature on the Mental Health Student Services Act; (2) Draft Categories & Guiding Research Questions for the Evaluation of the Mental Health Student Services Act; and (3) PowerPoint Presentation.

MENTAL HEALTH STUDENT SERVICES ACT

WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 5. COMMUNITY MENTAL HEALTH SERVICES [5000 - 5952]

(Division 5 repealed and added by Stats. 1967, Ch. 1667.)

PART 4. THE CHILDREN'S MENTAL HEALTH SERVICES ACT [5850 - 5886]

(Part 4 repealed and added by Stats. 1992, Ch. 1229, Sec. 2.)

CHAPTER 3. Mental Health Student Services Act [5886- 5886.]

(Chapter 3 added by Stats. 2019, Ch. 51, Sec. 67.)

5886.

(a) The Mental Health Student Services Act is hereby established as a mental health partnership competitive grant program for the purpose of establishing mental health partnerships between a county's mental health or behavioral health departments and school districts, charter schools, and the county office of education within the county.

(b) The Mental Health Services Oversight and Accountability Commission shall award grants to county mental health or behavioral health departments to fund partnerships between educational and county mental health entities.

(1) County, city, or multicounty mental health or behavioral health departments, or a consortium of those entities, including multicounty partnerships, may, in partnership with one or more school districts and at least one of the following educational entities located within the county, apply for a grant to fund activities of the partnership:

(A) The county office of education.

(B) A charter school.

(2) An educational entity may be designated as the lead agency at the request of the county, city, or multicounty department, or consortium, and authorized to submit the application. The county, city, or multicounty department, or consortium, shall be the grantee and receive any grant funds awarded pursuant to this section even if an educational entity is designated as the lead agency and submits the application pursuant to this paragraph.

(c) The commission shall establish criteria for the grant program, including the allocation of grant funds pursuant to this section, and shall require that applicants comply with, at a minimum, all of the following requirements:

(1) That all school districts, charter schools, and the county office of education have been invited to participate in the partnership, to the extent possible.

(2) That applicants include with their application a plan developed and approved in collaboration with participating educational entity partners and that include a letter of intent, a memorandum of understanding, or other evidence of support or approval by the governing boards of all partners.

(3) That plans address all of the following goals:

(A) Preventing mental illnesses from becoming severe and disabling.

(B) Improving timely access to services for underserved populations.

(C) Providing outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

(D) Reducing the stigma associated with the diagnosis of a mental illness or seeking mental health services.

(E) Reducing discrimination against people with mental illness.

(F) Preventing negative outcomes in the targeted population, including, but not limited to:

(i) Suicide and attempted suicide.

(ii) Incarceration.

(iii) School failure or dropout.

(iv) Unemployment.

(v) Prolonged suffering.

(vi) Homelessness.

(vii) Removal of children from their homes.

(viii) Involuntary mental health detentions.

(4) That the plan includes a description of the following:

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

(B) The proposed use of funds, which shall include, at a minimum, that funds will be used to provide personnel or peer support.

(C) How the funds will be used to facilitate linkage and access to ongoing and sustained services, including, but not limited to, objectives and anticipated outcomes.

(D) The partnership's ability to do all of the following:

(i) Obtain federal Medicaid or other reimbursement, including Early and Periodic Screening, Diagnostic, and Treatment funds, when applicable, or to leverage other funds, when feasible.

(ii) Collect information on the health insurance carrier for each child or youth, with the permission of the child or youth's parent, to allow the partnership to seek reimbursement for mental health services provided to children and youth, where applicable.

(iii) Engage a health care service plan or a health insurer in the mental health partnership, when applicable, and to the extent mutually agreed to by the partnership and the plan or insurer.

(iv) Administer an effective service program and the degree to which mental health providers and educational entities will support and collaborate to accomplish the goals of the effort.

(v) Connect children and youth to a source of ongoing mental health services, including, but not limited to, through Medi-Cal, specialty mental health plans, county mental health programs, or private health coverage.

(vi) Continue to provide services and activities under this program after grant funding has been expended.

(d) Grants awarded pursuant to this section shall be used to provide support services that include, at a minimum, all of the following:

(1) Services provided on school campuses, to the extent practicable.

(2) Suicide prevention services.

(3) Drop-out prevention services.

(4) Outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as lesbian, gay, bisexual, transgender, or queer, and youth who have been expelled or suspended from school.

(5) Placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services.

(e) Funding may also be used to provide other prevention, early intervention, and direct services, including, but not limited to, hiring qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth, as determined by the commission.

(f) The commission shall determine the amount of grants and shall take into consideration the level of need and the number of school age youth in participating educational entities when determining grant amounts.

(g) The commission may establish incentives to provide matching funds by awarding additional grant funds to partnerships that do so.

(h) Partnerships currently receiving grants from the Investment in Mental Health Wellness Act of 2013 (Part 3.8 (commencing with Section 5848.5)) are eligible to receive a grant under this section for the expansion of services funded by that grant or for the inclusion of additional educational entity partners within the mental health partnership.

(i) Grants awarded pursuant to this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, city, or multi-county mental health or behavioral health departments, or a consortium of those entities, or educational entities that receive a grant.

(j) (1) The commission shall develop metrics and a system to measure and publicly report on the performance outcomes of services provided using the grants.

(2) (A) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation of this section no later than March 1, 2022. The report shall address, at a minimum, all of the following:

(i) Successful strategies.

(ii) Identified needs for additional services.

(iii) Lessons learned.

(iv) Numbers of, and demographic information for, the school age children and youth served.

(v) Available data on outcomes, including, but not limited to, linkages to ongoing services and success in meeting the goals identified in paragraph (3) of subdivision (c).

(B) A report to be submitted pursuant to this paragraph shall be submitted in compliance with Section 9795 of the Government Code.

(k) This section does not require the use of funds included in the minimum funding obligation under Section 8 of Article XVI of the California Constitution for the partnerships established by this section.

(l) The commission may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis in order to implement this section. Contracts entered into or amended pursuant to this subdivision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(m) This section shall be implemented only to the extent moneys are appropriated in the annual Budget Act or another statute for purposes of this section.

(Added by Stats. 2019, Ch. 51, Sec. 67. (SB 75) Effective July 1, 2019.)