



# BEHAVIORAL HEALTH

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# HEALTH SERVICES AGENCY

**NOTICE OF PUBLIC MEETING – County of Santa Cruz**  
**MENTAL HEALTH ADVISORY BOARD**

**SEPTEMBER 21, 2023 ♦ 3:00 PM-5:00 PM**

**HEALTH SERVICES AGENCY**

**1400 EMELINE AVENUE, BLDG K, ROOMS 206-207 SANTA CRUZ, CA 95060**

**THE PUBLIC MAY JOIN THE MEETING BY CALLING (831) 454-2222, CONFERENCE ID 637 403 975#**

Xaloc Cabanes Chair 1 <sup>st</sup> District	Valerie Webb Member 2 <sup>nd</sup> District	Michael Neidig Co-Chair 3 <sup>rd</sup> District	Antonio Rivas Member 4 <sup>th</sup> District	Jennifer Wells Kaupp Member 5 <sup>th</sup> District
Laura Chatham Member 1 <sup>st</sup> District	Dean Shoji Kashino Member 2 <sup>nd</sup> District	Hugh McCormick Member 3 <sup>rd</sup> District	Celeste Gutierrez Member 4 <sup>th</sup> District	Jeffrey Arlt Secretary 5 <sup>th</sup> District

Felipe Hernandez Board of Supervisor Member	
Tiffany Cantrell-Warren Behavioral Health Director	Karen Kern Behavioral Health Deputy Director
Stella Peuse – Youth Representative	

**IMPORTANT INFORMATION REGARDING PARTICIPATION IN THE  
 MENTAL HEALTH ADVISORY BOARD MEETING**

The public may attend the meeting at the Health Services Agency, 1400 Emeline Avenue, Room 207, Santa Cruz. Individuals interested in joining virtually may [Click here to join the meeting](#) or may participate by telephone by calling (831) 454-2222, Conference ID 637 403 975#. All participants are muted upon entry to prevent echoing and minimize any unintended disruption of background sounds. This meeting will be recorded and posted on the Mental Health Advisory Board website.

If you are a person with a special need, or if interpreting services (English/Spanish or sign language) are needed, please call 454-4611 (Hearing Impaired TDD/TTY: 711) at least 72 hours in advance of the meeting in order to make arrangements. Persons with disabilities may request a copy of the agenda in an alternative format.

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## MENTAL HEALTH ADVISORY BOARD AGENDA

ID	Time	<b>3:00 Regular Business</b>
1	15 Min	<ul style="list-style-type: none"> <li>• Roll Call</li> <li>• Public Comment (No action or discussion will be undertaken today on any item raised during Public Comment period except that Mental Health Board Members may briefly respond to statements made or questions posed. Limited to 3 minutes each)</li> <li>• Board Member Announcements</li> <li>• <i>Approval of August 17, 2023 minutes*</i></li> <li>• Secretary's Report</li> </ul>
<b>3:15 Presentation</b>		
2	35 Min	Centering Wellness: The Role of Schools in Addressing Behavioral Health Santa Cruz County Office of Education – Farris Sabbah, County Superintendent of Schools; Hayley Newman, School Climate & Wellness Coordinator; Lauren Fein, Behavioral Health Director; Michael Paynter, Student Support Services Director
3	15 Min	Address Board Members and Public concerns regarding RI International Georgea Madeira, Senior Principal Consultant – RI International
<b>3:55 Standing Reports</b>		
4	5 Min	Patients' Rights Report – George Carvalho, Patients' Rights Advocate for Advocacy, Inc.
5	5 Min	Board of Supervisors Report – Supervisor Felipe Hernandez
6	5 Min	Behavioral Health Report – Tiffany Cantrell-Warren, Director of Behavioral Health
7	20 Min	Ad Hoc Committees – Discuss committees for the upcoming year. Committee suggestions: Site Visit, Peer Support, Budget, Publicity/Community Engagement, Roadmap to Ideal Crisis System
<b>4:40 New Agenda Items</b>		
8	15 Min	<ul style="list-style-type: none"> <li>• 2023 Data Notebook</li> <li>• SB326 briefing on how it may impact the County – Hugh McCormick</li> </ul>
<b>4:55 Future Agenda Items</b>		
<b>5:00 Adjourn</b>		

*Italicized items with \* indicate action items for board approval.*

**NEXT MENTAL HEALTH ADVISORY BOARD MEETING IS ON:**  
**OCTOBER 19, 2023 ♦ 3:00 PM – 5:00 PM**  
**HEALTH SERVICES AGENCY**  
**1430 FREEDOM BLVD, SUITE A, ATRIUM**  
**WATSONVILLE, CA 95060**



# BEHAVIORAL HEALTH

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# HEALTH SERVICES AGENCY

**MINUTES – Draft**

## **MENTAL HEALTH ADVISORY BOARD**

AUGUST 17, 2023 ♦ 3:00 PM - 5:00 PM

1400 EMELINE AVENUE, ROOMS 206-207, SANTA CRUZ

Microsoft Teams (831) 454-2222, Conference 633 220 968#

**Present:** Antonio Rivas, Celeste Gutierrez, Dean Kashino, Hugh McCormick, Jeffrey Arlt, Jennifer Wells Kaupp, Laura Chatham, Valerie Webb, Xaloc Cabanes, Stella Peuse  
**Excused:** Michael Neidig, Supervisor Felipe Hernandez  
**Staff:** Tiffany Cantrell-Warren, James Russell, Jane Batoon-Kurovski

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- I. Roll Call – Quorum present. Meeting called to order at 3:03 p.m. by Chair Xaloc Cabanes.
- II. Public Comments
  - BJ Nadeau – stated the need for same day or next day appointments with clinicians trained to treat the thoughts and the drivers that make people want to end their lives, as appointments in an outpatient setting that has early intervention can potentially avoid crisis situations. BJ said the board may wish to consider inviting Bill McCabe to discuss the effectiveness of the CANS treatment model to learn how to encourage other healthcare systems in our county to provide suicide focused evidence-based treatment.
  - Richard Gallo – stated he sent an email about the amendment to SB326 relating to the Mental Health Services Modernization Act. Richard said it's unfortunate that the counties are stuck with this and how the state is handling this, especially with the changes of the Mental Health Services Act which was not intended for Care Court. Richard said it is going to take away money for current programs that are being funded by MHSA and less funding for the counties. Richard announced that he will be joining the rally on August 22<sup>nd</sup> supporting better changes.
  - Coral Brune – asked the following questions: 1) How many were held on 5150 holds from January 1, 2022 to the present? 2) How many requested Riese hearings? 3) How many Riese hearings were held? 4) What were the outcomes of these hearings, such as how many were granted the right to refuse or modify medication? 5) How many requested writs of habeas corpus hearings? 6) How many of these were held? 7) How many were released by the court, by psychiatric authorities before the 5150's, 72-hour hold? 8) How many clients were transferred out of the county, but how many was this an involuntary action?
  - George Carvalho – suggested that the lobby at 1400 Emeline should have postcards with the 211 number making it available for clients.
  - Perry Spencer – stated that the August 4<sup>th</sup> event was a busy day with amazing healing.
- III. Board Member Announcements
  - New Mental Health Advisory Board Member – Dean Kashino, retired physician.
  - Chair clarified AB2449 states board members can attend meetings virtually if there is an emergency circumstance or just cause.

- Chair provided clarity on RI – County did not go out to find RI. MHSOAC contracted with RI in 2019 to provide technical assistance to the county when proposals were approved by the MHSOAC. Tiffany Cantrell-Warren added: The services that RI have provided to the County so far have been paid for through the state or the MHSOAC. The state provided this opportunity through RI as a way for the County to look at the current crisis system and to develop a stronger model.

IV. Business / Action Items

A. Approve July 20, 2023 Minutes

Motion/Second: Jeffrey Arlt / Valerie Webb

Ayes: Antonio Rivas, Jeffrey Arlt, Jennifer Wells Kaupp, Laura Chatham, Valerie Webb, Xaloc Cabanes

Abstain: Celeste Gutierrez, Dean Kashino, Hugh McCormick

Absent: Michael Neidig, Supervisor Hernandez

Motion passed.

B. Approve August 1, 2023 Minutes

Motion/Second: Jeffrey Arlt / Celeste Gutierrez

Ayes: Antonio Rivas, Celeste Gutierrez, Jeffrey Arlt, Jennifer Wells Kaupp, Xaloc Cabanes

Abstain: Dean Kashino, Hugh McCormick, Laura Chatham, Valerie Webb

Absent: Michael Neidig, Supervisor Hernandez

Motion passed.

V. Presentation: Building Hope & Safety Santa Cruz Grant and Suicide Prevention Activities - Carly Memoli, Program Director of Applied Crisis Training and Consulting, Inc.

- The original intent of the SAMHSA Grant was to implement a couple of the key areas of the strategic plan, including providing rapid follow-up services through the county's Rapid Connect program, conducting screening and assessment activities, providing a wide range of trainings, working on public awareness of and access to crisis level resources, including the newly minted suicide crisis line become 988. One of the features of this grant is that it provided and required about 25% of funds be spent and dedicated to supporting populations that are at disproportionate risk for suicide. This included not only suicide loss survivors, but in particular services for survivors of domestic and intimate partner violence, child abuse and their dependents.
- One of the strategies that was utilized through the grant is looking at some of the resources that could be drawn in from the state. Separate from Building Hope and Safety, Santa Cruz was selected as a grant recipient from the CA Department of Public Health and their comprehensive Suicide Prevention Program. Several of the resources that are on the landing page of the Striving for Zero Learning Collaborative were used, which Santa Cruz County continues to receive, in addition to support and technical assistance through at least June of 2024.
- The SAMHSA grant is a training heavy grant which was very prevention, education, connection services focused. Eight safeTALK trainings were done during the grant period. Ten trainings of the Applied Suicide Intervention Skills Training (ASIST) were provided during the grant period, which is step two after safeTALK. Mental Health First Aid was another component in the contract and provided four trainings. The Counseling on Access to Lethal Means training was also provided.
- The Striving for Safety website is a resource both for community members and professionals that is a soft introduction to means and safety. There is useful information on firearm safety and different resources related to overdose. Through the current grant with the CA Dept of Public Health, there is access to toolkits to help engage local pharmacists as supporters for suicide prevention.
- Another component of the grant included developing a more robust approach to how support is provided to those who have lost loved ones to suicide. Through this grant, Loss packets were produced, which is a collection of helpful information, materials and resources for folks who have recently lost someone to suicide.
- Currently, Santa Cruz Behavioral Health's goal is putting in place some ways to utilize the Columbia Suicide Severity Rating Scale and the safety plan in the

electronic health record system. At minimum, they are looking at ways to ensure that the training is available ongoing and on demand for folks. The second round of Loss packets have been produced and distributed along with cards for folks which inform where somebody should be sent if they need support. The host of trainings and mean safety activities are also continuing.

[Click here to view the presentation slides.](#)

## VI. Reports

### A. Secretary's Report

- No attendance issues.
- No recent training has been recorded for any of the Board members.
- SB326 – Jeffrey reported that it is an important piece of legislation that will be taking 3% of the funding away from MHSA funds and changing the structure, bringing in substance use disorder as a service that must be provided when it is not a co-occurring disorder. Jeffrey stated there's a reduction in funding and an increase of services that must be provided. Jeffrey advised that folks look at the Legislative Office of Analysis to see what they are recommending.

### B. Report from Celeste Gutierrez, on behalf of Supervisor Hernandez

Celeste mentioned the Point-In-Time has gone down by 21.5% in Santa Cruz County. All cities and unincorporated areas have shown a decline except for Watsonville, which shows an increase of 15%, and an increase of people that identify as Hispanic/Latino. Nearly one quarter have been in the foster care system and reported having substance use disorder, emotional, PTSD or physical disability and more than one fourth are currently unemployed. The City of Santa Cruz received \$14 million from the state, and no other city last year in the entire county received that money. Celeste said she is mentioning this because sometimes issues are addressed that are only visible and in the City of Santa Cruz, some of those issues are a lot more visible, whereas in Watsonville, it often ends up not getting noticed unless you live in Watsonville.

### C. Behavioral Health Report: Close Public Comment for MHSA Innovation Project Tiffany Cantrell-Warren, Behavioral Health Director

Tiffany opened Public Comment on the MHSA Plan.

–No comments were made on the MHSA Plan.

Tiffany shared some of the capacity issues and what Behavioral Health is currently facing. Tiffany reminded everyone that County Behavioral Health is a managed care health plan. The primary mandate and obligation is to provide specialty mental health services and substance use disorder services to Medi-cal beneficiaries who are diagnosed with a severe mental illness, and where funding allows, the County also serves clients in crisis regardless of their financial resources. This fiscal year, there will be a need for more funding than last year because of the transition to CalAIM payment reform implementation. This means that the County is no longer reimbursed for the cost of services, but will be reimbursed for the actual services provided, which is based on the type of staff or licensure of the person who is providing the service. Tiffany said Behavioral Health would be relying on County general funds or other reserves just to meet the budget.

Tiffany also mentioned that the Behavioral Health Information Notice (BHIN) 23-025, which is a directive from the Department of Health Care Services, is a mandate to implement a mobile crisis response for Medi-cal beneficiary by January 1, 2024. This allows for reimbursement by Medi-cal for crisis services that are provided to Medi-cal beneficiaries. Tiffany stated that CAHOOTS does not adequately address this BHIN and the County would not be able to be reimbursed for Medi-cal for the services provided. If this model was used, then it would have to be mostly funded by non-billable sources and grants. The innovation funding can't be used for CAHOOTS because it doesn't comply with the BHIN.

D. Ad Hoc Committees

The board did not have time to discuss the Ad Hoc Committees. Discussion to be held next month.

E. Patients' Rights Report – George Carvalho, Patients' Rights Advocate

A report was not provided due to technical difficulties. George attended the meeting. George mentioned he will look into posting this report on the Advocacy, Inc. website so folks can easily access the information.

VII. New Agenda Items – none.

VIII. Future Agenda Items – none.

IX. Adjournment

Meeting adjourned at 5:00 p.m.



# Proposal to County of Santa Cruz

## MOBILE CRISIS RESPONSE SCALE-UP AND TRAINING

## Contents

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## Introduction

The County of Santa Cruz and many other parts of the State have been working toward developing mobile crisis teams to respond to mental health, substance use, and homelessness-related crises. The goal has been to remove law enforcement and EMS (emergency medical services) from those types of calls for service. An additional goal has been to ensure that people are met with compassionate crisis responders when in the midst of a distressing experience. Santa Cruz City and County have attempted to meet these needs with two teams MERT/Y and MHL. These teams have struggled to maintain staffing, respond to relatively low amounts of calls when compared to other models, and do not divert law enforcement in any meaningful way. They also are outside the new requirements for mobile crisis response as outlined by the State in BHIN 22-064.

It is a material reality that the City of Santa Cruz hired a consultant, Ben Adam Climer of CRISIS Consulting, the producer of this proposal, to help create a mobile crisis team for the City. Simultaneously, the County of Santa Cruz hired RI International to help with their development. Part of this proposal is an effort to save the County significant amounts of money (over \$250,000) while producing a better end product. CRISIS Consulting offers more robust training, including field training on a busy mobile crisis team in similarly-sized



cities in the Bay Area in addition to field officer training from consultants who have worked for more than 15 combined years on mobile crisis teams and in developing teams based on the model proposed herein.

## Make-up

In order to meet the demands of the State, a two-person, multi-disciplinary team is required. A multi-disciplinary team that includes medical staff would enable them to respond to the widest variety of calls and divert EMS from unnecessary responses. We propose a team made up of:

1. Community Health Worker, Peer Support Specialist, or Masters level Mental Health worker (as crisis intervention specialists)
2. EMT, AEMT, Paramedic, or Nurse

A team like this would satisfy the needs of the Medi-Cal funding and would be easier to staff than the current system. With three teams (see below), to be 24/7/365, there would need to be 13 crisis intervention specialists and 13 medical staff.

This staffing model circumvents many of the problems that are currently faced by clinician-based mobile crisis teams. The pool of unlicensed mental health workers and EMTs is substantially larger than the pool of licensed clinicians. They also do not demand salaries as high as licensed staff. The majority of types of calls that they respond to do not require licensure. The matter of licensed oversight is addressed below. The promise of this proposal is also rooted on the fact that it may not be necessary to hire *any* new licensed clinicians while still developing a robust mobile crisis team.

## Boundaries

In this proposal, we envision be three teams operating 24/7. One would be located in the City of Santa Cruz, another would be in Watsonville, and the third would respond to the smaller cities and all unincorporated areas. Because it is a County program, the teams could respond beyond the borders of their respective regions, but it would only be when absolutely necessary. For example, if there were two suicidal calls simultaneously in Santa

Cruz, and the Unincorporated team was not currently responding, they could handle the second suicidal call. The teams could also be regionally deployed based on where the other teams were located at the time of call. For example, if the Unincorporated team was out in Boulder Creek on a call at the same time a request for service was made in Live Oak, the City of Santa Cruz team could respond.

## Access

Access for mobile crisis teams is one of the most under-conceptualized components of mobile response. There are debates about what is the best form of accessing mobile response teams. A term that is used often in this conversation is the “No Wrong Door” approach. While we agree with the concept of “No Wrong Door,” this term is an exclusive term that assumes that the only role of the mobile crisis team is to meet with someone and transition them into County-based mental health care. While this is a component of mobile crisis teams, it is not the goal of teams based on CAHOOTS and SAFE. The goal of these teams is always to de-escalate and connect the person-in-crisis to whatever they believe is most appropriate for their needs. The other goal is to divert law enforcement and EMS as often as possible on calls for service that do not fit the criteria for those two service types. As a result, access could be handled in one of two ways.

1. One, there is a mobile crisis dispatcher who is co-located at the County dispatch center. They receive and dispatch the calls that come into the call takers.
2. Two, each city law enforcement dispatcher and County dispatcher would dispatch their respective teams. The team would be identified on the system as a unit similar to how SAFE operates.

A couple considerations to make. First, employing a dispatcher exclusively for the mobile teams is an added expense. However, as has been shown in other jurisdictions, by putting a person associated with the crisis team into the dispatch center, responses will increase and more calls will be diverted from law enforcement. Co-locating the dispatcher with the LEA and EMS dispatchers is something that is relatively novel. At least at this point, we have never heard of this occurring. This could be an opportunity to pilot a new model that has a lot of upside.

Conversely, it might not be worth the time considering that they would only be supporting three units at any given time. This is a relatively small amount for any dispatcher to manage, especially if they have call taker support. Operating like SAFE or CAHOOTS might be more cost and labor efficient. It should be stated here that both of the above proposals include diverting calls at the source of the call and not when officers arrive on scene. Both of these proposals also include calls for service that are not explicitly “mental health.”

## Scale-up and Training

SAFE in Sonoma and Marin Counties has developed a 6-week training regimen. It would be possible to hire staff for the City of Santa Cruz team, send them to train with the SAFE team for four weeks, launch in Santa Cruz at the end of those four weeks, and have them complete their six-week course with two weeks of supervised field training by experienced training consultants. This training period could be replicated consecutively with the Watsonville and Unincorporated teams. By doing this, the teams could scale up to full County coverage in 18 weeks, 12 hours per day.

Once these teams are established, SAFE would no longer be necessary as a training ground, and the teams could train in Santa Cruz County to get to 24/7/365.

## Detailed Plan for Training and Scaling – One Year Plan

Action	Timeframe
Hire Santa Cruz dedicated team	4 weeks
Send Santa Cruz dedicated team to train with SAFE; hire Watsonville dedicated team	4 weeks training (1 via Zoom; 3 in field); 4 weeks for hiring
Santa Cruz dedicated team launches with oversight from consulting trainers	2 weeks for launch and training in SC
Watsonville dedicated team sent to SAFE to train; Unincorporated team is hired	4 weeks training with SAFE (1 via Zoom; 3 in field); 4 weeks for hiring

Watsonville dedicated team launches with oversight from consulting trainers	2 weeks for launch and training in Watsonville;
Unincorporated team sent to SAFE to train	4 weeks training with SAFE (1 via Zoom; 3 in field)
Unincorporated team launches with oversight from consulting trainers	2 weeks for launch and training in Unincorporated areas
Operate 12 hours per day for 3 months	3 months
Hire overnight staff for Santa Cruz dedicated team	4 weeks
Train Santa Cruz dedicated team; hire Watsonville overnight team	6 weeks for training; 4 weeks for hiring
Launch Santa Cruz dedicated overnight team with oversight from consulting trainers; train Watsonville overnight team; hire Unincorporated overnight team	2 weeks for launch and training; 6 weeks training Watsonville; 4 weeks for hiring
Launch Watsonville overnight team with oversight from consulting trainers; train Unincorporated team	2 weeks for launch and training; 6 weeks training Unincorporated team
Launch Unincorporated team with oversight from consulting trainers	2 weeks for launch and training
<b>Totals</b>	<b>55 weeks to full coverage of County with two city-dedicated teams and a County-based team.</b>

## Budget for Training and Consulting

Service	Cost
SAFE Training Costs	\$75,000
Lodging and Stipend	\$28,350
Consulting Trainers	\$90,000
<b>Total</b>	<b>\$193,350</b>

## Clinical Oversight

The State requirements mandate an LPS-designated licensed clinician be available 24/7/365. This means that the current LPS-designated staff that make up MERT and MHL could be retained as either on-call or mobile responders. One idea could be to co-locate the LPS-designated staff at the CSP where they could perform assessments, respond via telehealth to the requests of the crisis teams, or respond into the field when necessary. By using a staffing model of four 10-hour shifts, the total staffing needs for LPS-designated supervision would be four staff members on shift for a total of 20 hours per day. The remaining four hours would be handled by on-call requests only. The cost for this would fall exclusively on the County, but it would enable them to retain their current mobile crisis staff. This would help meet the demands of the Grand Jury Report which is calling for more response.

## Contracting

One major component of the Grand Jury report is the lack of outreach to the Latine/Hispanic community that makes up such a large portion of Santa Cruz County, especially in Watsonville. Contracting with an organization that has strong ties to this community and centers bilingual staff could do a couple of things. One, it would enable the Behavioral Health Division to meet the requirements laid out by the Grand Jury report. Two, it would establish a positive training program for bilingual and bicultural therapists and medical professionals. Many people who have worked for SAFE and CAHOOTS have gone on to be therapists, nurses, physician's assistants, doctors, and more. Well-paying jobs as mobile crisis responders serve as great training grounds for professional degrees and services. Third, with quality referral portals established between the mobile team and the County's Behavioral Health Division, this mobile response would help create better connections between the people who need help and are not currently able to access it.

## Costs

SAFE in Sonoma and Marin Counties has demonstrated that a 24/7/365 service costs approximately \$1.3 million. Three of these would therefore cost roughly \$3.9 million. Purchasing and upfitting enough vehicles would be another \$500,000 on the outset (half of this could be covered by the money saved by this proposal). The actual costs for year one would be different because of the scale up. Nonetheless, a generous estimate for the inaugural year would be approximately \$4.4 million. In terms of funding, there is the current money allotted for mobile crisis. Because the cities are interested in having their own teams, it would be worthwhile to request that the funding they planned to spend on their own teams be spent on this program. If \$1.85 million could be contributed by the four incorporate cities, equitably among them, and the remaining \$1.85 million could be covered by the County, funding these teams would be a simple exercise and would alleviate the cities' needs to divert calls away from law enforcement.

## Why This Model?

It is important to note that the Crisis Now model does very little to divert calls away from law enforcement agencies. As a useful example of what we mean, when the SAFE team launched in San Rafael, a city of approximately 62,000 people, they responded to nine calls per day in the first month. At that point, almost no advertising for the team had been done. This means that those nine calls per day were all originally police requests. That means that over the course of a year the team would be responding to approximately 3,285 calls for service that otherwise would have gone to police. With overnight coverage, that number likely climbs closer to 5,000.

Comparing this to Crisis Now in Maricopa County, AZ, the difference is stark. In Maricopa County, there are 27 mobile crisis teams responding to calls for service, 24/7/365. As of 2021, they are only responding to 1,400 calls for service per month. That is 16,800 calls for service per year. If we use 5,000 calls for service as

an estimate for a 24/7/365 team in San Rafael, then the SAFE team is responding to 29.3% of the amount of calls that Crisis Now teams are responding to in Maricopa County, a region that is 72.5 times larger in population than San Rafael. If SAFE were responding to the same calls per capita as is Crisis Now in Arizona, they would take less than one call per day. It would be extremely hard to justify this type of program for the cost in Santa Cruz. That is why we are proposing an alternative that would satisfy the needs of the cities, the County, law enforcement, EMS, and above all, the people experiencing crises.

# Centering Wellness

## The Role of Schools in Addressing Behavioral Health



**Faris Sabbah**, he/him/his, County Superintendent of Schools

**Michael Paynter**, he/him/his, Executive Director of Student Support Services

**Lauren Fein**, she/her/hers, Director of Behavioral Health

**Hayley Newman**, she/her/hers, Coordinator, School Climate and Wellness Coordinator





# Our current climate:

The San Diego Union-Tribune

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Professional help can't keep up with children's mental health needs

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Three leading groups in child and adolescent mental health have declared a state of emergency for the nation's youth.

News From the JAMA Network

October 5, 2021

**Pediatric Depression and Anxiety Doubled During the Pandemic**

**How COVID-19 Stole 'Children's Joy,' Sparking a Mental Health Emergency**

THE WALL STREET JOURNAL

**Loneliness, Anxiety and Loss: the Covid Pandemic's Terrible Toll on Kids**



# The Why

## Student Mental Health: The Landscape:

- Suicide is the second leading cause of death for youth 15-24 (CDC)
- Significant increase in ER visits by youth for MH related issues during the pandemic
- Local county and non-profit service providers report increases in referrals coupled with decreases in staffing
- Schools reporting high need for mental health support on campuses for students, while staff share pandemic and coping exhaustion
- *Governor Newsom's Master Plan for Kids' Mental Health*

# School District Initiatives

Each District's LCAP has identified Wellness and Social Emotional Support as a priority area

## Some examples are:

- Providing professional learning for staff around SEL, Restorative Practices, Trauma Responsive Practices
- Implementing Social Emotional Learning Curriculum
- Hiring Mental Health Clinicians
- District Level Wellness Centers
- Youth-Led Mental Health Support Groups



# COE 101

Student Programs

Tech & Innovation

Business Services

Educational  
Services



## STUDENT SUPPORT SERVICES

- FosterEd (All open on-going CPS cases)
- Students in Transition (without adequate housing)
- TUPE (Tobacco Use Prevention & Education Program)
- Youth Mental Health First Aid
- Court Related (Probation) Diversion
- School Attendance Review Board (SARB)
- **Wellness Centers**
- The Companion Project (TCP)
- Social Emotional Learning (SEL)
- PBIS and School Climate
- School Based Health Services

# School as a Hub



# Where are the Gaps?



**Decentralized Service  
Delivery**

**Limited/Inequitable Access  
(Insurance, location)**

**Organizational Silos**

**Staff Burnout  
Limited pool of Clinicians**

**Complex and inconsistent  
funding sources**

**Stigma**



# Ongoing Efforts

## Staff Training

- Youth Mental Health First Aid
- Trauma/Resiliency Training

## Training for Students

- Teen Mental Health First Aid
- Peer Support (Hope Squad)



## NAMI Training for Parents

- Ending the Silence
- NAMI Basics

## Case Management

- The Companion Project

Wellness Centers at all  
Comprehensive High  
Schools





# COE Initiatives - The Companion Project (TCP)

- **Who We Serve:** Vulnerable youth with higher Behavioral Health acuity
- **What We Do:** Navigation focus with flexibility for direct services, and Professional Development, group work, SERP response, transition planning, and more
- **Status:** Over 200 referrals in first year





# WHAT IS A SCHOOL-BASED WELLNESS CENTER?

A student-focused wellness center:

- Located **on** a K-12 school campus
- Organized through school, community, and health provider **relationships**
- That provides age-appropriate, **behavioral health** care services



SBWCs **may provide** behavioral health services onsite or through mobile or telehealth



# A Continuum of Wellness Spaces

## Calming Rooms

Welcoming, safe drop-in spaces without any clinical services, staffed by some caring adult

## Mental Health only

Calming drop-in space plus on-site clinical behavioral health services and tiered supports, provided by school-employed staff and/or co-located CBOs

## Mental Health+

Centers with mostly clinical behavioral health plus some other services, like a school nurse and/or sexual/repro health

## Comprehensive

Clinics with full-scope of health services, including physical medical care, behavioral health, and oral health

**School-Based Wellness Centers!**



# COE Initiatives - Wellness Centers

- **The Purpose:** Wellness Centers within school districts that will offer universal, coordinated, and timely mental health-related services to all students through an easily accessible location on a school campus.
- **Goal:** Two school-based pilot wellness centers open by Spring 23-24 School Year
- **Long-Term Goal:** Every District High School & Middle School - County Wide
  - **Long term Funding & Sustainability:** Partner with each District to develop, create, and implement a sustainability plan that braids funding to sustain the Wellness Center.



# Multi-Tiered Systems of Support

## Tier 3

- Individual and Group Therapeutic Services
- Restorative Justice Circles
- Crisis Response and Support
- Enhanced Care Management
- Referrals to Community Partner Services and/or The Companion Project

## Tier 2

- Group counseling / social-emotional groups
- Tier 2 Behavioral Interventions
- Restorative Mediations / Conflict Resolutions (IIRP Model)
- Individual Solution-Focused Brief Counseling/Motivational Interviewing

## Tier 1

- Trauma-Informed, Restorative, and Holistic School Culture and Climate
- Social-Emotional Learning and Mental Health Awareness Campaigns
- Drop-in Access to Wellness Center and Use of Calming Corner
- Staff, Student, Family, and Community Wellness Workshops
- Suicide Prevention
- Restorative Conversations

# Wellness Centers - Facilities and Design



Reception Area



Office Spaces



Collaboration Room

# Wellness Centers- Staffing and Partnerships

## Wellness Coordinator

Wellness Peer Advocate

## Wellness Navigator

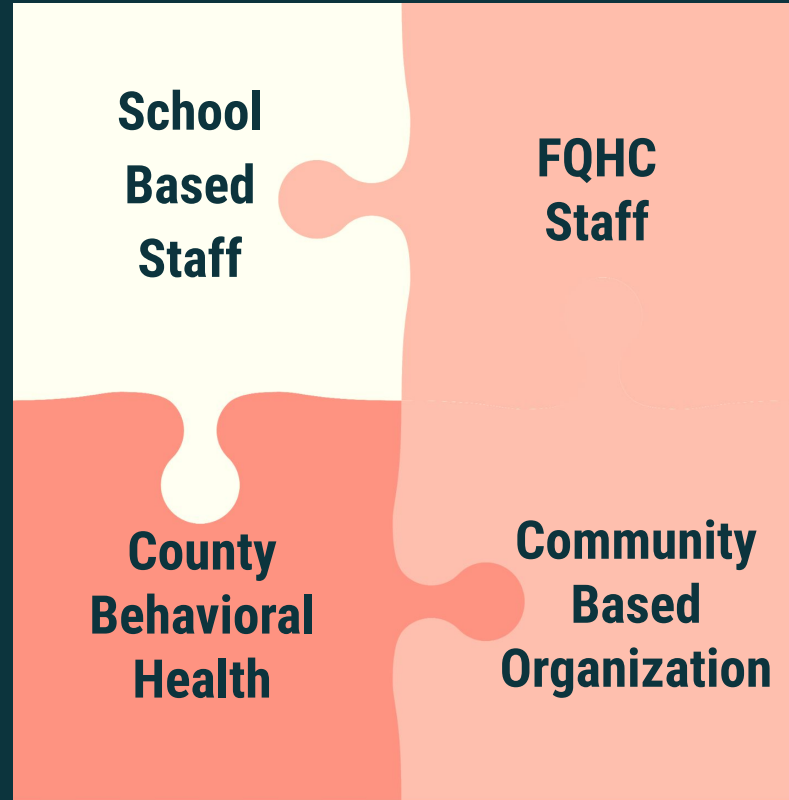
Wellness Community Partners  
(FQHC, CBO, CBH, etc)

Wellness Interns

\*A Wellness Center is only as strong as it's collaboration with Admin, Student Services Staff, School Counselors, School Psychologists, Faculty, and Community Partners



# Delivering Services



# Expected Wellness Center Outcomes

- **Stigma Reduction of Mental Health Care**
- **Open Door to Wellness and Connection to Services**
- **Integrated systems of support that address the social determinants of health**
- **Prevention and Early Intervention**
- **Social and Emotional Skill Building**



# Wellness Center: COE TA Support

- **Planning and Implementation**
  - Facilitate Initial Planning and ongoing Implementation Sessions for Wellness Teams
  - Ongoing Training for Wellness Center Staff
  - Data Collection and Evaluation
- **Billing and Sustainability**
  - Billing Infrastructure: implementation and ongoing
  - Provide expertise on current funding streams/ Tracking new funding sources
  - Support districts in leveraging all billable services



# Moving Forward

Adapt to Changing Landscape  
Commercial Insurance, CalAIM

Continued Investment in  
Behavioral Health  
On-Site Delivery

Developing Workforce  
Pipeline

Breaking Down  
Organization Silos



# Billing and Sustainability

- **Current Options For Schools**
  - **LEA BOP & SMAA - Medi-Cal (Billing Option Program & Schools MAA)**
- **Future Options?**
  - **Multi Payer School-Linked Fee Schedule - Commercial & Medi-Cal**
  - **Other Providers: Wellness Coaches, Peer to Peer, Community Health Workers?**
  - **Enhanced Care Management (ECM)?**

# What is the Multi Payer School-Linked Fee Schedule?

## **A new sustainable funding sources for school-linked behavioral health services that:**

1. Increases access to school-linked behavioral health services for children and youth
2. Creates a more approachable billing model for schools and local educational agencies (LEAs)
3. Eases burdens related to contracting, rate negotiation, and navigation across delivery systems
4. Reduces uncertainty around students' coverage.
5. Schools able to bill for both Medi-Cal and Commercial Insurance

# SCOPE OF SERVICES

**Services included in the fee schedule at launch on January 1, 2024, will include:**

1. Psychoeducation
2. Screening & Assessment
3. Therapy
4. Peer support
5. Care coordination

# Providers (working draft)

\*A final list of providers has not been released.\*

1. Licensed psychologists
2. Licensed educational psychologists
3. Credentialed school psychologists
4. Licensed clinical social workers
5. Credentialed school social workers
6. Credentialed social emotional counselor
7. Licensed marriage and family therapists
8. Associate marriage and family therapists
9. Registered associate clinical social workers
10. Wellness Coach
11. School Counselors



**SANTA CRUZ**  
COUNTY OFFICE OF  
**EDUCATION**  
DR. FARIS SABBAH • SUPERINTENDENT OF SCHOOLS

**Faris Sabbah**

he/him/his

County Superintendent of Schools

**Michael Paynter**

he/him/his

Executive Director of Student Support Services

**Lauren Fein**

she/her/hers

Director of Behavioral Health

**Hayley Newman**

she/her/hers

Coordinator, School Climate and Wellness

Summary

This is a July 2023 Patients' Rights Advocate Report from the Patients' Rights Advocacy program. It includes the following: telephone calls, reports, and emails. It includes a breakdown of the number of certified clients, the number of hearings, and the number of contested hearings. It also includes a breakdown of Reize Hearing activity, including the number of Riese Hearings filed, the number of Riese conducted, and the number that were lost.

Patients' Rights Advocate Report

July 2023

\*\*\*\*\*

**Record 14004**

**7<sup>th</sup> Avenue Center**

On July 14, 2023, this writer received a phone report from the 7<sup>th</sup> Avenue facility. The reporter stated that two females were involved in a verbal exchanged which escalated to on resident spitting water on the other. On June 16, 2023, this writer attempted to speak with both parties but neither wish to speak to me. I placed a call to the conservator of the reported victim and left a message cross reporting the incident.

**Record 14005**

**7<sup>th</sup> Avenue Center**

On July 14, 2023, this writer received a referral from the Long-Term Care Ombudsman program about an allegation of fiduciary abuse. This writer contacted the Wells Fargo representative to obtain the information. This writer also reported to facility administrator, Ms. Kathy Champlin, as well as the client's conservator. The Wells Fargo representative contacted local law enforcement. This writer verified the information and obtained the case number from the Santa Cruz Sherrif.

**Record 14006**

**Telecare**

Telecare-Crisis stabilization Program

On July writer received a phone call from a client requesting assistance. The client felt that his behavior in the community did not warrant a 5150 detention. This writer received permission to speak with the social worker who verified that the client wanted information disclosed to his Patients' Rights' Advocate.



After my interview with staff, I returned a call to the client and informed him of what had been relayed to me. The client accepted this information without comment and thanked me for my assistance.

**Record 14018**

**Telecare**

On July 26, 2023, this writer received a phone call from a client at Telecare-PHF about a lack of prompt medical care. This writer met with the client on July 28, 2023. At this meeting the client's complaints were about a lack of dignity and poor communication on the part of the staff. I offered to set up a meeting with the administrator and obtained the phone number from the client. This writer will reach out to her by 08/11/23.

ADVOCACY INC.

TELECARE CLIENT CERTIFICATION AND  
REISE HEARING/PATIENTS' RIGHTS  
REPORT

July 2023

First Quarter

1. TOTAL NUMBER CERTIFIED	33
2. TOTAL NUMBER OF HEARINGS	29
3. TOTAL NUMBER OF CONTESTED HEARINGS	22
4. NO CONTEST PROBABLE CAUSE	7
5. CONTESTED NO PROBABLE CAUSE	3
6. VOLUNTARY BEFORE CERTIFICATION HEARING	
7. DISCHARGED BEFORE HEARING	4

8. WRITS	0
9. CONTESTED PROBABLE CAUSE	18
10. NON-REGULARLY SCHEDULED HEARINGS	0

Ombudsman Program & Patient Advocate Program shared 0 clients in this month  
 (shared = skilled nursing resident (dementia) sent to behavioral health unit or mental health client placed in skilled at Telecare (Santa Cruz Psychiatric Health Facility))

Reise Hearings. /Capacity Hearings

Total number of Reise petitions filed by the Telecare treating psychiatrist: 3

Total number of Reise Hearings conducted: 3

Total number of Reise Hearings lost: 3

Total number of Reise Hearings won: 0

Total number of Reise Hearings withdrawn: 0

Hours spent on cancelled Reise hearings: 0 hours

Hours spent on all Reise hearings: 2.5 hours

Reise appeal: 0

Hours spent on all Reise Hearings included those hearings that were cancelled by the hospital:  
2.5

Respectfully submitted,

Davi Schill, PRA

George N. Carvalho, PRA

Summary

This is an August 2023 Patients' Rights Advocate Report from the Patients' Rights Advocacy program. It includes the following: telephone calls, reports, and emails. It includes a breakdown of the number of certified clients, the number of hearings, and the number of contested hearings. It also includes a breakdown of Reize Hearing activity, including the number of Riese Hearings filed, the number of Riese conducted, and the number that were lost.

Patients' Rights Advocate Report

Augst 2023

\*\*\*\*\*

**Record 14019**

**Telecare**

On August 7, 2023, this writer received a phone call from a client receiving services at the Psychiatric Health Facility. (Telecare) Client stated that he was prevented from using the internet to conduct research about support services in the community, I contacted staff and advocated for the use of the internet. I was informed that the staff was working on setting things up to make this happen but had not communicated with the client. I placed a return call to the client and informed him of this information. The client was encouraged to call back if access did not happen in a timely manner.

**Record 14043**

**Telecare**

On August 30, 2023. This writer received a call from a client receiving treatment at the Psychiatric Health Facility. The client reported corruption in the jail setting, by guard that permitted beatings and looked away. He also reported this behavior occurred in the State psychiatric facility as well. This writer advised my client that these events outside my jurisdiction and provided the client with the number for Disability Rights California

**Record 14045**

**Telecare**

On August 18, 2023, this writer received a phone call from a client receiving services at the Psychiatric Health Facility. The client stated that he had been treated by a psychiatrist who had accused him of something that wasn't true. The client stated that the psychiatrist had apologized but felt that this last incident was a pattern of reprisal and requested clarification on the means of contacting the Department of Mental Health complaint line. This writer clarified the means of filing a complaint.

**Record 14069****Telecare**

On August 21, 2023, this Patients' Rights Advocate\* received a call from a client about the outcome of the Reise hearing and advised her of the right of appeal. The client wished to exercise this right. The PRA met with the client and completed paperwork which was subsequently submitted to the Superior Court by the PRA\*

\*Ms. Davi Schill

**Record 14026****7<sup>th</sup> Avenue Center.**

On August 14, 2023, this writer received a phone message from the 7<sup>th</sup> Avenue Facility. The reported victim was punched unprovoked by another resident. This writer attempted to speak with the reported victim on 8/31/23. This resident refused to speak with this writer. Placed a call to the conservator about the facility's response. The conservator will not be in the office until after the 5<sup>th</sup> of September.

**Record 14041****7th Avenue Center**

On August 24, 2023, this writer received a phone report of resident-to-resident abuse. On August 31, 2023, this writer met with the reported victim. We discussed events that reportedly happened several years ago. This client seemed unwilling or unable to focus upon the most recent events. This writer placed a call to the conservator for further information and clarification.

**Record 14048****7<sup>th</sup> Avenue Center**

This writer received a phone call from a resident of the 7<sup>th</sup> Avenue Center. This resident advocated for all the residents to be informed of their patients' rights. This writer met with the resident. We discussed several topics, but I was unable to determine what the issue would have caused the resident to reach out to me on behalf of the entire community. We concluded the meeting that I will be back to speak with him the following week.

**14040**

**Opal Cliffs**

On August 17, 2023, this writer received a phone message from a resident of the Opal Cliffs facility. The Client stated that staff were not listening to him or considering his viewpoint on issues or complaints. This writer met with the client on two separate occasions. This writer offered to intervene on his behalf to the staff. Although the resident still feels aggrieved about his situation, this writer does not have permission as of this writing to intervene but will continue to reach out to the resident.

**14044**

**Willow brook**

On August 18, 2023, this writer received a phone message from a resident of the Willow Brook facility.

This resident stated that staff violated her rights. After listening to the resident, this writer concurred and after strategizing with the resident encouraged her to go to staff to exercise her rights and then return a call back to my office. The resident stated that she was able to speak to staff. I asked the resident to return a call back to my office. We spoke later and as of this writing the issue has been resolved. This writer will check in with the resident to assure myself that the resident's rights are continuing to be supported by the staff.

**14056**

**Front Street**

On August 2,2023, the Patients' Rights Advocate\* received an SOC report from the Front Street resident. A resident complained about a community provider. Although the complaint remains unsubstantiated as of this writing Staff committed themselves to accompany the resident and a request for a new provider has been submitted to the agency.

\*Ms. Davi Schill

**14068**

**Front Street**

On August 28, 2023, this Patients' Rights Advocate\* received an SOC report about a resident of the Front Street Residential facility. This incident occurred off site and involved a relative. The PRA Spoke with both the staff and as well as the client. The resident did not wish to press charges. As of this writing, the alleged perpetrator is not permitted on campus and staff will check in with the resident each time they return from a visit with the relative.

\*Ms. Davi Schill

ADVOCACY INC.  
TELECARE CLIENT CERTIFICATION AND  
REISE HEARING/PATIENTS' RIGHTS  
REPORT

August 2023

First Quarter

1. TOTAL NUMBER CERTIFIED	24
2. TOTAL NUMBER OF HEARINGS	23
3. TOTAL NUMBER OF CONTESTED HEARINGS	12
4. NO CONTEST PROBABLE CAUSE	11
5. CONTESTED NO PROBABLE CAUSE	4
6. VOLUNTARY BEFORE CERTIFICATION HEARING	
7. DISCHARGED BEFORE HEARING	1
8. WRITS	
9. CONTESTED PROBABLE CAUSE	8
10. NON-REGULARLY SCHEDULED HEARINGS	0

Ombudsman Program & Patient Advocate Program shared 0 clients in this month  
(shared = skilled nursing resident (dementia) sent to behavioral health unit or mental health client placed in skilled at Telecare (Santa Cruz Psychiatric Health Facility))

Reise Hearings. /Capacity Hearings

Total number of Reise petitions filed by the Telecare treating psychiatrist: 3

Total number of Reise Hearings conducted: 3

Total number of Reise Hearings lost:

Total number of Reise Hearings won: 0

Total number of Reise Hearings withdrawn: 0

Hours spent on cancelled Reise hearings: 0 hours

House spent on all Reise hearings: hours

Reise appeal: 1

Hours spent on all Reise Hearings included those hearings that were cancelled by the hospital:  
4

Respectfully submitted,

Davi Schill, PRA

George N. Carvalho, PRA

# DATA NOTEBOOK 2023

## FOR CALIFORNIA

### BEHAVIORAL HEALTH BOARDS AND COMMISSIONS





Prepared by California Behavioral Health Planning Council, in collaboration with:  
California Association of Local Behavioral Health Boards/Commissions



The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies, and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally, and linguistically responsive and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness.

For general information, you may contact the following email address or telephone number:

[DataNotebook@CBHPC.dhcs.ca.gov](mailto:DataNotebook@CBHPC.dhcs.ca.gov)

(916) 701-8211

Or, you may contact us by postal mail at:

Data Notebook  
California Behavioral Health Planning Council  
1501 Capitol Avenue, MS 2706  
P.O. Box 997413 Sacramento, CA 95899-7413

For questions regarding the SurveyMonkey online survey, please contact Justin Boese at [Justin.Boese@cbhpc.dhcs.ca.gov](mailto:Justin.Boese@cbhpc.dhcs.ca.gov)

## **NOTICE:**

This document contains a textual **preview** of the California Behavioral Health Planning Council 2023 Data Notebook survey, as well as supplemental information and resources. It is meant as a **reference document only**. Some of the survey items appear differently on the live survey due to the difference in formatting.

**DO NOT RETURN THIS DOCUMENT.**

*Please use it for preparation purposes only.*

To complete your 2023 Data Notebook, please use the following link and fill out the survey online:

<https://www.surveymonkey.com/r/DP8XG65>

Please note, if you are working from a PDF, scanned image or photocopy, you will need to Copy/Paste or type the above address into your browser bar.

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# CBHPC 2023 Data Notebook: Introduction

## **What is the Data Notebook? Purpose and Goals**

The Data Notebook is a structured format to review information and report on aspects of each county's behavioral health services. A different part of the public behavioral health system is addressed each year, because the overall system is very large and complex. This system includes both mental health and substance use treatment services designed for individuals across the lifespan.

Local behavioral health boards/commissions are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council). To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for local behavioral health boards to complete and submit to the Planning Council. Discussion questions seek input from local boards and their departments. These responses are analyzed by Planning Council staff to create annual reports to inform policy makers and the public.

The Data Notebook structure and questions are designed to meet important goals:

- To help local boards meet their legal mandates<sup>1</sup> to review and comment on their county's performance outcome data, and to communicate their findings to the Planning Council;
- To serve as an educational resource on behavioral health data;
- To obtain opinion and thoughts of local board members on specific topics;
- To identify unmet needs and make recommendations.

In 2019, we developed a section (Part I) with standard questions that are addressed each year to help us detect any trends in critical areas affecting our most vulnerable populations. These include foster youth, homeless individuals, and those with serious mental illness (SMI) who need housing in adult residential facilities (ARFs) and some other settings. These questions assist in the identification of unmet needs or gaps in services that may occur due to changes in population, resources, or public policy.

## **What's New This Year?**

The topic selected for the 2023 Data Notebook is stakeholder engagement. The Planning Council has long supported upholding the principles of the Mental Health Services Act (MHSA) and encourages consumer and family member participation in the

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<sup>1</sup> W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

stakeholder process for behavioral health services through the Community Program Planning (CPP) process, as well as other stakeholder engagement activities.

### **How the Data Notebook Project Helps You**

Understanding data empowers individuals and groups in their advocacy. The Planning Council encourages all members of local behavioral health boards/commissions to participate in developing the responses for the Data Notebook. This is an opportunity for local boards and their county behavioral health departments to work together to identify important issues in their community. This work informs county and state leadership about local behavioral health (BH) programs, needs, and services. Some local boards use their Data Notebook in their annual report to the County Board of Supervisors.

In addition, the Planning Council will provide our annual 'Overview Report', which is a compilation of information from all of the local behavioral health boards/commissions who completed their Data Notebooks. These reports feature prominently on the website<sup>2</sup> of the California Association of Local Mental Health Boards and Commissions. The Planning Council uses this information in their advocacy to the legislature, and to provide input to the state mental health block grant application to SAMHSA<sup>3</sup>.

### **Example of Statewide Data for Specialty Mental Health and Access Rates**

Tables 1-A and 1-B on the next two pages shows typical data and demographics for California recipients of Specialty Mental Health Services (SMHS) for fiscal year (FY) 2021-2022. These are the most recent data available at the time this document was prepared. SMHS are intended for adults with serious mental illness (SMI) and for children with serious emotional disorders (SED). The category of 'certified eligibles' means those persons (also called beneficiaries) who are eligible and approved to receive Medi-Cal benefits for health care.

These metrics are from datasets developed in accordance with California Welfare and Institutions code § 14707.7 (added as part of Assembly Bill 470 on 10/7/17). Due to recent changes in how AB 470 data is presented by DHCS in the Behavioral Health Demographic Dashboard<sup>4</sup>, demographic metrics presented are not exact, as the dashboard rounds them to the nearest .1 thousand (k) or million (M).

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<sup>2</sup> See the annual Overview Reports on the Data Notebook posted at the California Association of Local Mental Health Boards and Commissions, <https://www.CALBHBC.org>.

<sup>3</sup> SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For reports, see [www.SAMHSA.gov](http://www.SAMHSA.gov).

<sup>4</sup> AB 470 Mental Health Services Demographics Dashboards, published by California Department of Health Care Services (DHCS) at: <https://behavioralhealth-data.dhcs.ca.gov/>

**Table 1-A. California Children and Youth: Access Rates for Specialty Mental Health Services,<sup>5</sup> Fiscal Year 2021-22.**

	Specialty Mental Health Services		
	FY 21-22		
	Number of Clients with MH Visits	Certified Eligibles	Rate
<b>Children 0-2</b>	6.8k	740.9k	0.9%
<b>Children 3-5</b>	15.9k	802.6k	2.0%
<b>Children 6-11</b>	68.5k	1.7m	4.0%
<b>Children 12-17</b>	119.2k	1.8m	6.7%
<b>Youth 18-20</b>	35.1k	79.1k	4.4%
<b>Alaskan Native or American Indian</b>	1k	12.3k	5.5%
<b>Asian or Pacific Islander</b>	7.4k	359.6k	2.0%
<b>Black</b>	23.7k	378.7k	6.3%
<b>Hispanic</b>	146.3k	3.3M	4.4%
<b>Other</b>	12.8k	445.5k	2.9%
<b>Unknown</b>	128.k	548.5k	2.5%
<b>White</b>	40.6k	750.3k	5.4%
<b>Female</b>	130.1k	2.8M	4.6%
<b>Male</b>	114.4k	3M	3.9%
<b>Totals and Average Rates</b>	244.5k	5.8M	4.3%

**Notes:** The first column presents the demographic groups of interest. Next there are three columns. The first column of numbers shows the number of clients who received one or more services, described as Specialty Mental Health Visits. The second column of numbers is labeled ‘Certified Eligibles’, which is the number of clients who were deemed eligible and approved to received health care paid by Medi-Cal. The third column of numbers represents the service penetration rates. These penetration rates are taken as one measure of Access. They are calculated by dividing the total number

<sup>5</sup> In contrast, non-specialty Mental Health Services (i.e., Managed Care (MC), Fee-for-Service (FFS), etc), services generally designed for people with mild-to-moderate mental health needs.

of Clients with MH visits by the total number of Medi-Cal Eligibles, multiply by 100 to express the result as a percentage; this is taken as the “Access Rate.”

**Table 1-B. California Adults and Older Adults, Access Rates for Specialty Mental Health Services, Fiscal Year 2021-22.<sup>6</sup>**

	Specialty Mental Health Services		
	FY 21-22		
	Number of Clients with MH Visits	Certified Eligibles	Rate
<b>Adults 21-32</b>	102.2k	2.8M	3.6%
<b>Adults 33-44</b>	88.2k	2.3M	3.9%
<b>Adults 45-56</b>	71.5k	1.7M	4.1%
<b>Adults 57-68</b>	6.5k	1.6M	4.1%
<b>Adults 69+</b>	14.6k	1.1M	1.30%
<b>Alaskan Native or American Indian</b>	2.1k	38.8k	5.5%
<b>Asian or Pacific Islander</b>	19.4k	1.1M	1.8%
<b>Black</b>	50.3k	706.3k	7.1%
<b>Hispanic</b>	103.9k	4.1M	2.5%
<b>Other</b>	36.9k	977.8k	3.8%
<b>Unknown</b>	29.8k	684.6k	4.4%
<b>White</b>	99.1k	1.9M	5.1%
<b>Female</b>	177.3k	5.3M	3.3%
<b>Male</b>	164.2k	4.2M	3.9%
<b>Totals and Access Rates</b>	341.5k	9.5M	3.6%

**Notes:** The data for Adults and Older Adults were calculated similarly to the data for Children and Youth in Figure 1-A. For example, out of all Adult 9.5M Medi-Cal eligibles, a total of 341.5k individuals, i.e. 3.6% received Specialty Mental Health Services (SMHS).

<sup>6</sup> For comparison, the population of the state of California was **39,029,342** on April 1, 2020, according to the U.S. Census Bureau. <https://www.census.gov/quickfacts/CA>. Of those residents, 24.3% of Californians were adults (age 21 and above) receiving Medi-Cal benefits. Also, 14.9% of Californians were children or youth < 20 who received Medi-Cal benefits. These numbers show that 39.2% of all Californians of all age groups received Medi-Cal in FY 2021-22.

## CBHPC 2023 Data Notebook – Part I:

### Standard Yearly Data and Questions for Counties and Local Boards

In recent years, changes in data availability permit local boards and other stakeholders to consult some Medi-Cal data online that is provided by the Department of Health Care Services (DHCS). These data include populations that receive Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) treatment. Standard data are analyzed each year to evaluate the quality of county programs and those reports can be found at [www.CalEQRO.com](http://www.CalEQRO.com). Additionally, Mental Health Services Act (MHSA) data are found in the ‘MHSA Transparency Tool’ presented on the Mental Health Services Oversight and Accountability Commission (MHSOAC) website.<sup>7</sup>

The Planning Council would like to examine some county-level data that are not readily available online and for which there is no other public source. Please answer these questions using information for fiscal year (FY) 2021-2022 or the most recent fiscal year for which you have data. Not all counties will have readily available data for some of the questions asked below. In that case, please enter N/A for ‘data not available.’ We acknowledge and appreciate the necessary time and effort provided by local boards and their behavioral health departments to collect and discuss these data.

#### **Adult Residential Care**

There is little public data available about who is residing in licensed facilities listed on the website of the Community Care Licensing Division<sup>8</sup> at the CA Department of Social Services. This lack of data makes it difficult to know how many of the licensed Adult Residential Facilities (ARFs) operate with services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. In 2020, legislation was signed that requires collection of data from licensed operators about how many residents have SMI and whether these facilities have services to support client recovery or transition to other housing. The response rate from facility operators does not provide an accurate picture for our work.

The Planning Council wants to understand what types of data are currently available at the county level regarding ARFs and Institutions for Mental Diseases (IMDs)<sup>9</sup> available to serve individuals with SMI, and how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs. ‘Bed day’ is

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<sup>7</sup> [www.mhsoac.ca.gov](http://www.mhsoac.ca.gov), see MHSA Transparency Tool, under ‘Data and Reports’

<sup>8</sup> Link to Licensed Care directory at California Department of Social Services.  
<https://www.cclid.dss.ca.gov/carefacilitysearch/>

<sup>9</sup> Institution for Mental Diseases (IMD) List: <https://www.dhcs.ca.gov/services/MH/Pages/IMD-List.aspx>



defined as an occupancy or treatment slot for one person for one day. One major difference is that IMDs offer mental health treatment services in a psychiatric hospital or certain types of skilled nursing home facilities. In contrast, a non-psychiatric facility such as an ARF is a residential facility that may provide social support services like case management but not psychiatric treatment.

*The following is a text summary of the survey questions for Part I of the 2022 Data Notebook. Please note that the questions are presented here in a different format than the finalized SurveyMonkey online survey. Refer to the PDF preview of the SurveyMonkey survey to see a more accurate presentation of the items.*

**Questions:**

- 1) Please identify your County / Local Board or Commission.**
- 2) For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Care Facility (ARF), during the last fiscal year? (Text response)**
- 3) What is the total number of ARF bed-days paid for these individuals, during the last fiscal year? (Text response)**
- 4) Unmet needs: how many individuals served by your county behavioral health department need this type of housing but currently are not living in an ARF? (Text response)**
- 5) Does your county have any 'Institutions for Mental Disease' (IMD)?**
  - a. No
  - b. Yes. If Yes, how many IMDs? (Text response)
- 6) For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during the last fiscal year?**  
In-county: (Text response)      Out-of-county: (Text response)
- 7) What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during the same time period? (Text response)**

## **Homelessness: Programs and Services in California Counties**

The Planning Council has a long history of advocacy for individuals with SMI who are homeless, or who are at-risk of becoming homeless. California's recent natural disasters and public health emergency have exacerbated the affordable housing crisis and homelessness. Federal funding was provided to states that could be used for temporary housing for individuals living on the streets as a method to stop the spread of the COVID-19 virus. Additional policy changes were made to mitigate the rate of evictions for persons who became unemployed as a result of the public health crisis.

Studies indicate that only one in three individuals who are homeless also have serious mental illness and/or a substance use disorder. The Planning Council does not endorse the idea that homelessness is caused by mental illness, nor that the public BH system is responsible to fix homelessness, financially or otherwise. However, we do know that recovery happens best when an individual has a safe, stable place to live.

The issue of homelessness is very complex and involves multiple systems and layers of interaction. Therefore, the Council will continue to track and report on the programs and supports offered by counties to assist homeless individuals who have SMI and/or SUD. Causes and contributory factors are complex, and thus our solutions will need to address numerous multidimensional and multi-systemic challenges.

Every year, the states, counties, and many cities perform a "Point-in-Time" count<sup>10</sup> of the homeless individuals in their counties, usually on a specific date in January. Such data are key to state and federal policy and funding decisions. The pandemic disrupted both the methods and the regular schedule for the count in 2021, during which there was no data collected for California's unsheltered population due to Covid-19 protocols. Those preliminary data were taken down subsequently for further review before re-posting. Therefore, the "percent increase" column for this table compares the 2022 totals with the totals for 2020, for which there was complete data.

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<sup>10</sup> Link to data for yearly Point-in-Time Count:  
[https://files.hudexchange.info/reports/published/CoC\\_PopSub\\_NatTerrDC\\_2022.pdf](https://files.hudexchange.info/reports/published/CoC_PopSub_NatTerrDC_2022.pdf)

**Table 3: State of California Estimates of Homeless Individuals Point in Time<sup>11</sup> Count 2022**

<b>Summary of Homeless individuals</b>	<b>SHELTERED</b>	<b>UNSHELTERED</b>	<b><u>TOTAL</u> <u>2022</u></b>	<b><u>Percent</u> <u>Increase</u> <u>over 2022</u></b>
<b>Persons in households without children</b>	34,545	110,888	145,433	7.7%
<b>Persons in households with children</b>	21,253	4,285	25,538	-0.9%
<b>Unaccompanied homeless youth</b>	2,828	6,762	9,590	-21.2%
<b>Veterans</b>	3,003	7,392	10,395	-8.8%
<b>Chronically homeless individuals</b>	15,773	45,132	60,905	17.6%
<b><u>Total (2020)</u> Homeless Persons in CA</b>	56,030	115,491	171,521	6.2%
<b><u>Total (2020)</u> Homeless Persons, USA</b>	348,630	233,832	582,462	.3%

<sup>11</sup> PIT Count = yearly January Point-in-Time Count of Homeless Individuals, conducted according to the guidance of the U.S. Department of Housing and Urban Development ([www.HUD.gov](http://www.HUD.gov)). Sheltered persons include those who were in homeless shelters and various types of transitional or emergency housing.

**Questions, continued:**

- 8) **During fiscal year 2021-2022, what new programs were implemented, or existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness? (Mark all that apply.)**
- a. Emergency Shelter
  - b. Temporary Housing
  - c. Transitional Housing
  - d. Housing/Motel Vouchers
  - e. Supportive Housing
  - f. Safe Parking Lots
  - g. Rapid Re-Housing
  - h. Adult Residential Care Patch/Subsidy
  - i. Other (*Please specify*)

**Child Welfare Services: Foster Children in Certain Types of Congregate Care**

In California, about 60,000 children under the age of 18 are in foster care. They were removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determined that these children could not live safely with their caregiver(s). Most children are placed with a family who receive foster children, but a small number of the children need a higher level of care and are placed in a setting with more sophisticated services.

California is striving to move away from facilities formerly known as long-term group homes, and prefers to place all youth in family settings, if possible. Regulations have revised the treatment facilities for children whose needs cannot be met safely in a family setting. The new facility type is called a Short-Term Residential Treatment Program (STRTP). STRTPs are designed to provide short-term placement that includes intensive behavioral health services.

All of California's counties are working toward closing long-term group homes and are establishing licensed STRTPs. This transition will take time and it is important for your board to talk with your county director about what is happening in your county for children in foster care who are not yet able to be placed in a family setting, or who are in a family setting and experience a crisis that requires short-term intensive treatment.

Some counties do not yet have STRTPs and may place children/youth in another county or even out-of-state. Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

**Examples of the foster care CDSS data for Q4, 2020, in CA:**

- Total foster youth and children: 53,180
- Total placed in an STRTP: 2,444 (or 4.6% of foster youth)
- Total STRTP placed out-of-county: 1174 (or 2.2% of foster youth)
- Total STRTP placed out-of-state: 66 (or 0.12 % of foster youth)

**Questions (continued):**

**9) Do you think your county is doing enough to serve the foster children and youth in group care?**

- a. Yes
- b. No. If No, what is your recommendation? Please list or describe briefly.  
(*Text response*)

**10) Has your county received any children needing “group home” level of care from another county?**

- a. No
- b. Yes. If Yes, how many? (*Text response*)

**11) Has your county placed any children needing “group home” level of care into another county?**

- a. No
- b. Yes. If Yes, how many? (*Text response*)

## **CBHPC 2023 Data Notebook – Part II:**

### **Stakeholder Engagement in the Public Mental Health System**

#### **Context and Background**

The topic selected for the 2023 Data Notebook is “stakeholder engagement.” Stakeholder engagement refers to the active involvement of individuals or groups with a vested interest in the mental health system. These stakeholders include consumers of mental health services, their families, mental health professionals, government agencies, community organizations, advocacy groups, and policymakers. Engaging these stakeholders fosters a participatory approach, giving voice to diverse perspectives and enabling collective decision-making. Stakeholder engagement is integral to the implementation of the Mental Health Services Act (MHSA) in California. By involving a wide range of voices, the MHSA can develop and deliver programs and services that are responsive to community needs, ultimately improving mental health outcomes and well-being in California.

Stakeholder engagement offers numerous benefits in the context of mental health. Firstly, it enhances service delivery by allowing the mental health system to address the specific needs and preferences of individuals with mental health conditions. Through collaborative decision-making, services can be designed to be more accessible, culturally sensitive, and person-centered, ultimately leading to improved outcomes for those seeking support.

Secondly, stakeholder engagement empowers the community by providing opportunities for active participation and involvement in the development of mental health policies and programs. By valuing the perspectives of diverse stakeholders, the system becomes more responsive to the concerns, priorities, and aspirations of the community it serves. This active involvement fosters a sense of ownership and empowerment among community members, enabling them to contribute to shaping the mental health services available to them.

Thirdly, it plays a crucial role in ensuring accountability within the mental health system. By involving stakeholders, a system of checks and balances is created, promoting transparency and holding the system accountable for its actions and outcomes. This involvement helps to guarantee that resources are allocated effectively and efficiently, maximizing their impact and addressing any potential issues or discrepancies that may arise.

Overall, stakeholder engagement in mental health has far-reaching benefits. It leads to improved service delivery that is tailored to individual needs, empowers the community

by involving them in decision-making processes, and ensures accountability and transparency within the mental health system. By actively engaging stakeholders, mental health organizations can create a more inclusive and effective system that ultimately improves the well-being of individuals experiencing mental health conditions.

### **Challenges and Barriers**

The effective engagement of stakeholders in the California public mental health system faces several barriers and challenges. One of the primary challenges is ensuring diverse representation among stakeholders. Overcoming language barriers, cultural differences, and limited outreach resources is crucial to capture a wide range of perspectives. Inadequate funding and staffing also pose significant challenges, hindering the capacity to hold regular meetings, conduct outreach efforts, and provide necessary support to stakeholders.

Some other potential barriers include:

- Stigma and discrimination surrounding mental health create additional obstacles to stakeholder engagement. Addressing stigma requires targeted educational campaigns, anti-stigma initiatives, and the creation of safe spaces that foster open dialogue and inclusivity.
- Power imbalances among stakeholders can also impede effective engagement. Achieving equitable representation and providing mechanisms to address power differentials are essential to foster an inclusive and democratic stakeholder engagement process.
- The complexity and fragmentation of the California public mental health system further present challenges. Effective communication strategies, standardized protocols, and clear channels of collaboration are necessary to engage stakeholders from different sectors and align their efforts.
- Limited accessibility poses another barrier to meaningful stakeholder engagement. Proactive measures such as providing accommodations, utilizing virtual platforms for remote participation, and ensuring inclusive physical spaces are essential to address accessibility barriers.
- Stakeholder engagement processes can be time-consuming and may lead to engagement fatigue over time. Balancing the need for sustained engagement with stakeholders' limited time and competing priorities requires clear goals, efficient processes, and recognition of stakeholders' contributions to maintain their interest and involvement.

Overcoming these barriers and challenges necessitates a comprehensive approach. By addressing these challenges, the California public mental health system can cultivate inclusive, responsive, and impactful mental health policies and programs.

### **Key Stakeholders**

In the public mental health system, various stakeholders play vital roles in shaping policies, programs, and services. The California Code of Regulations provides the following definition of “stakeholders” within the public mental health system:

#### **Cal. Code Regs. Tit. 9, § 3200.270 - Stakeholders**

"Stakeholders" means individuals or entities with an interest in mental health services in the State of California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness/ and/or serious emotional disturbance and/or their families.

Additionally, California Welfare and Institutions Code provides a list of stakeholders for the Community Program Planning (CPP) Process:

#### **California Code, Welfare and Institutions Code - WIC § 5848 (a)**

Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans' organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations.

Using these sources, we can identify key stakeholder groups for engagement. Here is a more detailed list of these key stakeholders:

**Adults and Seniors with severe mental illness (SMI):** This group represents individuals who are directly impacted by mental health conditions. Their perspectives and experiences are essential in understanding the unique challenges they face and in



developing services that meet their specific needs. Engaging adults and seniors with SMI ensures their voices are heard and helps tailor interventions to improve their overall well-being and recovery.

**Families of children, adults, and seniors with SMI:** Family members are crucial stakeholders as they provide support, care, and advocacy for their loved ones with mental illness. Their insights offer a valuable perspective on the challenges faced by individuals with SMI and the impact on the family unit. Involving families in decision-making processes helps ensure that services are holistic, family-centered, and responsive to the needs of both the individual and their support network.

**Providers of Mental Health and/or Related Services:** Mental health professionals, including psychiatrists, psychologists, counselors, and social workers, are instrumental in delivering quality care and support. Their expertise and frontline experience provide valuable input on service gaps, best practices, and areas for improvement within the mental health system. Engaging with mental health providers ensures that policies and programs are evidence-based, align with professional standards, and promote quality outcomes.

**Law Enforcement Agencies:** Law enforcement agencies often come into contact with individuals experiencing mental health crises. Their involvement in stakeholder engagement facilitates collaboration between mental health services and law enforcement, aiming to improve crisis intervention and diversion programs. This partnership can enhance community safety, reduce unnecessary arrests and incarcerations, and facilitate appropriate referrals to mental health services.

**Educators and/or Representatives of Education:** Educators play a significant role in identifying and supporting students with mental health needs. Their involvement as stakeholders contributes to the development of early intervention strategies, mental health promotion programs, and the implementation of appropriate supports within educational settings. Collaborating with educators helps create a nurturing environment that supports the academic, social, and emotional well-being of students.

**Social Services Agencies:** Social services agencies, such as those involved in housing, employment, and welfare, intersect with the mental health system. Their participation in stakeholder engagement ensures coordination and integration of services, addressing the complex needs of individuals with mental health conditions holistically. Collaboration with social services agencies supports efforts to provide stable housing, employment opportunities, and social support networks to promote recovery and community integration.

**Veterans:** Veterans, particularly those who have served in combat or experienced traumatic events, often face mental health challenges such as post-traumatic stress

disorder (PTSD) and depression. Engaging veterans as stakeholders enables the mental health system to address their unique needs and develop specialized programs tailored to their experiences. This collaboration ensures that mental health services for veterans are comprehensive, accessible, and culturally sensitive.

**Representatives from Veterans Organizations:** Representatives from veterans' organizations, such as advocacy groups or support networks, provide a platform for veterans' voices and perspectives to be heard. Their involvement in stakeholder engagement fosters collaboration and helps shape policies, programs, and services that meet the specific needs of veterans.

**Providers of Alcohol and Drug Services:** Substance use disorders frequently co-occur with mental health conditions, requiring integrated care approaches. Engaging providers of alcohol and drug services as stakeholders promotes collaboration between mental health and addiction treatment providers. This collaboration ensures a comprehensive approach to addressing the complex needs of individuals with co-occurring disorders, facilitating recovery and reducing barriers to treatment.

**Health Care Organizations:** Health care organizations, including hospitals, clinics, and primary care providers, are essential stakeholders in the mental health system. Collaboration with these organizations helps integrate mental health care into primary care settings, reduce stigma, and improve access to services. Involving health care organizations enhances the coordination of care and strengthens the overall continuum of mental health support.

**Other important Interests:** The mental health system involves numerous other stakeholders, such as policymakers, researchers, community leaders, advocacy groups, and philanthropic organizations. Each brings unique perspectives, expertise, and resources to the table. Their involvement in stakeholder engagement ensures that policies and programs are informed by evidence, responsive to community needs, and adequately resourced.

By engaging and involving these diverse stakeholders, the public mental health system can benefit from a comprehensive range of insights, expertise, and perspectives. This collaborative approach leads to more effective, inclusive, and person-centered mental health services that better serve the needs of individuals, families, and communities.

### **Best Practices for Stakeholder Engagement**

There are many resources available regarding promising and best practices for stakeholder engagement. Some commonly identified guiding principles and best practices are:

1. **Inclusive Approach:** Ensure that the stakeholder engagement process is inclusive and representative of diverse perspectives. Include individuals with lived experience, family members, behavioral health service providers, advocacy groups, community organizations, and policymakers. Embrace diversity and strive for equity in representation.
2. **Early and Ongoing Engagement:** Engage stakeholders early in the decision-making process and maintain ongoing communication throughout the planning, implementation, and evaluation stages. Provide opportunities for input, collaboration, and feedback at various stages to ensure meaningful participation.
3. **Purposeful Communication:** Foster open and transparent communication with stakeholders. Provide clear information about goals, processes, and timelines. Use plain language and avoid jargon to ensure that all stakeholders can easily understand and contribute to the conversation. Likewise, practice active listening when stakeholders are speaking. Rather than assuming what they mean, ask follow-up questions to ensure that their input is understood.
4. **Collaboration and Co-creation:** Foster a collaborative environment that encourages stakeholders to actively participate in decision-making. Co-create solutions by involving stakeholders in the design and implementation of programs, policies, and services. Value their expertise and insights.
5. **Training and Education:** Provide stakeholders with relevant training and education to enhance their understanding of behavioral health issues, policies, and practices. Equip them with the knowledge necessary to contribute effectively and make informed decisions.
6. **Flexibility and Adaptability:** Recognize that stakeholders may have different levels of expertise, resources, and availability. Provide flexibility in engagement methods to accommodate diverse needs, such as offering virtual options, providing written materials, and conducting surveys or focus groups.
7. **Data-Informed Decision Making:** Use data and evidence to inform discussions and decision-making processes. Share relevant data with stakeholders to foster informed dialogue and facilitate collaborative problem-solving.
8. **Empowerment and Shared Leadership:** Empower stakeholders to actively contribute and take ownership of the process. Promote shared leadership by involving stakeholders in the development of agendas, facilitating meetings, and encouraging their participation in decision-making.
9. **Recognition and Appreciation:** Recognize and appreciate the contributions of stakeholders. Acknowledge their time, effort, and expertise. Provide opportunities for public recognition, such as featuring success stories or highlighting stakeholder involvement in reports and presentations.

10. **Evaluation and Continuous Improvement:** Regularly evaluate the effectiveness of stakeholder engagement efforts and seek feedback from participants. Use this feedback to refine engagement strategies and improve future processes.

These are just some of the many suggested best practices and guiding principles for quality stakeholder engagement. By incorporating these and other best practices, behavioral health systems can effectively engage stakeholders, leverage their expertise, and create more responsive, person-centered, and equitable services and policies.

### **MHSA Community Program Planning Process**

One of the major ways that the MHSA includes stakeholder engagement is the MHSA Community Program Planning (CPP) Process. This state-mandated participatory process is a collaborative approach used in California to develop and refine mental health programs funded by the MHSA. Counties use the CPP process in the development of Three-Year Program and Expenditure Plans and updates. Counties work alongside stakeholders to analyze current community mental health needs, issues resulting from any lack of community services, and current system capacity, as well as evaluate priorities and strategies to meet the needs of the community.

California Codes and Regulations dictate that the MHSA CPP process should be:

- Based in community collaboration (CCR, 9 CA §3320 and 3200.060).
- Culturally competent (CCR, 9 CA §3320 and 3200.100).
- Client and family driven (CCR, 9 CA §3320, 3200.050 and 3200.120).
- Wellness, recovery and resilience-focused (CA WIC § 5813.5(d)).
- Focused on providing an integrated service experience for clients and their families (CCR, 9 CA §3320 and 3200.190).

MHSA CPP Processes must include the following regarding stakeholder participants:

- **Stakeholders** (as previously defined/discussed based on WIC, § 5848a).
- **Underserved populations.** Representatives from unserved and/or underserved populations and family members of unserved/underserved populations (CCR, 9 CA § 3300).
- **Diversity.** Participants that “reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity” (CCR, 9 CA § 3300).

Additionally, the CPP process should, at a minimum include the following things:

- Staffing for positions and/or units to facilitate the CPP process.

- Training for stakeholders and county staff.
- Outreach to consumers with SMI and their family members to ensure the opportunity to participate.
- A local review process that includes a 30-day public comment period prior to submitting the Three-Year Program and Expenditure Plans or Annual Updates.

The MHSA currently allows counties to use **up to 5% of their total Community Services and Support (CSS) funds** to facilitate a robust planning process. This includes using funding to accommodate stakeholder participation in the CPP process. All counties are required to use the CPP process and document the Three-Year Program and Expenditure Plans and Annual Updates. This includes descriptions of the methods used to collect stakeholder input, documentation that a public hearing was held, summary and analysis and a description of changes made based on community input.

**The local MH/BH boards and commissions** have the following responsibilities in this process:

- Review and approve the procedures used to ensure stakeholder involvement in all stages of the planning process.
- Review the adopted plan or update and make recommendations.
- Conduct MHSA public hearings at the close of the 30-day public comment periods.

Overall, the MHSA Community Program Planning Process fosters a participatory and community-driven approach to mental health program development. By engaging stakeholders and leveraging their expertise and insights, the CPP Process aims to create programs that are responsive, culturally sensitive, and tailored to the unique needs of the community. This collaborative effort ultimately leads to the implementation of effective and impactful mental health services in California communities.

While the MHSA CPP process is an important (and legally required) example of stakeholder engagement, the principles and practices of stakeholder engagement can be applied to many different programs and processes. This includes but is not limited to mental/behavioral health board/commission meetings, EQRO focus groups, and SAMHSA funded programs.

## **Resources**

The following resources all pertain to stakeholder engagement in mental health, including the CPP process. We encourage counties to utilize these resources to learn more about responsive and effective engagement practices.

- [CALBHBC: MHSA CPP One-Pager](#)
- [CALBHBC: Community Engagement PowerPoint](#)
- [MHSAAC: CPP Processes - Report of Other Public Community Planning Processes](#)
- [MHSAAC: Promising CPP Practices](#)
- [SAMHSA: Community Engagement – An Essential Component of an Effective and Equitable Substance Use Prevention Program](#)

## **Part II: Data Notebook Questions**

Please respond by means of the Survey Monkey link provided with this Data Notebook.

**12. For each of the following categories, please choose the option from the dropdown menu that best describes how often your county organizes stakeholder engagement meetings or events.**

- **Dropdown menu options:**
  - Less than once a year
  - Annually (once a year)
  - Every 6 months
  - Quarterly (four times a year)
  - Monthly
  - More than once a month
- **Categories:**
  - MHSA Community Planning Process (CPP)
  - MHSA 3-year plan updates
  - EQRO focus groups
  - SAMHSA-funded programs
  - Mental/Behavioral Health Board/Commission Meetings
  - County Behavioral Health co-sponsoring/partnering with other departments or agencies
  - Other (please specify):

**13. Estimate the number of people who participated in your stakeholder processes in fiscal year 2021/2022. (Numerical response)**

**14. Approximately what percentage of stakeholder engagement events or efforts in your county were in-person only, virtual only, a combination of both in-person and virtual, or written communications (please answer with a whole number for each, such that the total of the four amounts to 100)**

- In-person only:
- Virtual only:
- Combination of both in-person and virtual:
- Written communications (such as online surveys or email questionnaires):

**15. Which of the following languages did your county use to conduct stakeholder meetings or outreach during fiscal year 2021/2022, with or without the use of interpreters? (Check all that apply)**

- Arabic
- Armenian
- Cambodian
- Chinese
- English
- Farsi
- Hindi
- Hmong
- Japanese
- Korean
- Laotian
- Mien
- Punjabi
- Russian
- Spanish
- Tagalog
- Thai
- American Sign Language (ASL)
- Other languages (please specify)

**This list of languages reflects the threshold and concentration languages for all counties as of July 2021 from the following DHCS document: [Threshold and Concentration Languages \(ca.gov\)](#)**

**16. Which of the following stakeholder groups have you collected and implemented input from within the last year? (Check all that apply)**

- Adults with severe mental illness (SMI)
- Older adults / Seniors with SMI
- Families of children, adults and seniors with SMI
- Individuals with developmental disabilities and/or their representatives
- Providers of mental health and/or related services
- Representatives of managed care plans
- Law enforcement agencies

- Educators and/or representatives of education
- Social services agencies
- Veterans
- Representative from veterans' organizations
- Providers of alcohol and drug services
- Health care organizations
- Hearing impaired individuals
- LGBTQ+ individuals
- Youth
- Other important interests (please specify)
- Specific racial/Ethnic groups (please specify)

**17. Please describe how stakeholder input is communicated to the behavioral health director, the mental/behavioral health board/commission, and any other agencies or groups for informing policy. (Text response)**

**18. Please describe how your county implements collected stakeholder input to actively inform policy and programs. Include how the county decides what ideas to implement or actions to take. (Text response)**

**19. Does your county have a Community Program Planning (CPP) plan in place?**

- Yes (If yes, describe how you directly involve stakeholders in the development and implementation of this plan)
- No

**20. Is your county supporting the CPP process in any of the following ways? (Please select all that apply)**

- a) Reimbursement of travel costs for stakeholders participating in in-person meetings or events.
- b) Providing refreshments or food for stakeholder participants
- c) Dedicated staff assistance to facilitate stakeholder meetings and events.
- d) Providing information and training for stakeholders on MHSa programs, regulations, and procedures.
- e) Holding meetings in physically/geographically accessible locations around the county.
- f) Utilizing language interpreting services.
- g) Holding meetings at times convenient to community stakeholders' schedules.
- h) Providing technical assistance for stakeholders participating in webinars or teleconferences.
- i) Other (please specify)
- j) None of the above



**21. Does your county provide training for staff on cultural awareness, community outreach, and stakeholder engagement? If yes, how? If no, why not?**

- Yes (with comment)
- No (with comment)

**22. Which of the following barriers does your county face regarding achieving meaningful and impactful engagement of stakeholders (specifically, mental health consumers and family members)? (Check all that apply)**

- a. General difficulty with reaching stakeholders.
- b. Difficulty conducting community outreach to racial/ethnic communities or other specific communities of interest.
- c. Difficulty reaching stakeholders with disabilities.
- d. Lack of funding or resources for stakeholder engagement efforts.
- e. Shortage of properly trained staff to support and facilitate stakeholder engagement.
- f. Difficulty adapting to virtual meetings/communications.
- g. Difficulty providing accommodations to stakeholders.
- h. Difficulty incorporating stakeholder input in the early stages of programming.
- i. Lack of “buy-in” from decision makers when it comes to implementing stakeholder input.
- j. Other (please specify)

**23. Are your behavioral health board/commission members involved in your county’s stakeholder engagement and/or CPP processes? If yes, describe how.**

- a. Yes (with text comment)
- b. No

*Note: California WIC 5892 allocates Mental Health Services Funds for county mental health programs to pay for the expenses of mental health board members to perform their duties, and to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process. This includes 5% of total CSS funds to support a robust CPP process with community stakeholders.*

**24. Has the COVID-19 pandemic increased or decreased the level of stakeholder engagement and input in your county?**

- a. Increased
- b. Decreased
- c. No change

**25. Is there a fear or perception in your county that spending time, money, or other resources on stakeholder engagement conflicts with the need to provide direct services? (Yes/No)**

- 26. What is one change or improvement regarding stakeholder engagement that your county would like to make within the next fiscal year? (Written response)**
- 27. Do you have any other thoughts or comments regarding stakeholder engagement in your county or statewide? (Written response)**

### **Post-Survey Questionnaire**

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Behavioral Health Planning Council. Questions below ask about operations of mental health boards, and behavioral health boards or commissions, etc.

- 28. What process was used to complete this Data Notebook? (Please select all that apply)**
- a. MH board reviewed WIC 5604.2 regarding the reporting roles of mental health boards and commissions.
  - b. MH board completed majority of the Data Notebook.
  - c. Data Notebook placed on agenda and discussed at board meeting.
  - d. MH board work group or temporary ad hoc committee worked on it.
  - e. MH board partnered with county staff or director.
  - f. MH board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.
  - g. Other (please specify)
- 29. Does your board have designated staff to support your activities?**
- a. Yes (if yes, please provide their job classification)
  - b. No
- 30. Please provide contact information for this staff member or board liaison.**
- 31. Please provide contact information for your board's presiding officer (chair, etc.)**
- 32. Do you have any feedback or recommendations to improve the Data Notebook for next year?**

## Senate Bill 326: Analysis and Report for the Santa Cruz County Mental Health Advisory Board and NAMI Santa Cruz County Board of Directors

Assessing the (Potential) Impact and Implications of the Highly Controversial Bill (Companion to AB 531) – And its Possible Far-Reaching Effects on the Santa Cruz County Behavioral Health System (and Local Partner Organizations)



### MHSA Under Threat

The Mental Health Services Act (MHSA) – also known as Proposition 63 – was passed with great fanfare and state-wide excitement by California voters in 2004. The bill – overwhelmingly supported by residents throughout the Golden State – imposed a then-significant 1% tax on California’s growing millionaire population (those with personal income over \$1 million) to fund the provision of behavioral health services. At least 95% of MHSA revenues – the vast majority of funds – is handed over to counties (and their respected mental health systems) directly - to fund the delivery of a wide array of specialized services for individuals living with or at risk of developing a mental illness. Almost immediately, the highly-anticipated MHSA began to pay dividends for county mental health plans – who began to receive (highly influential, largely unexpected, and regular) monetary support to support (and arguably improve) the landscape of behavioral health services within their municipalities. Roughly one-third of (all) the county mental health infrastructure throughout the state of California is fueled and/or directly supported by the MHSA – which contributes over \$3.8 billion annually.

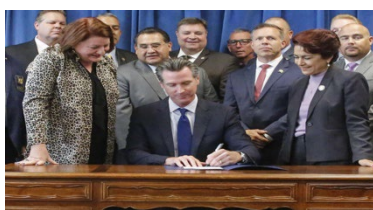
Most who have worked directly within the behavioral health space/field in the (almost) two-decades since California voters overwhelmingly greenlighted Proposition 63 (the MHSA), herald the bill as a “system-shifting-success.” But at the same time, 19 years later, others (including a large lot of Capitol Hill) are vociferously calling the MHSA “antiquated, ineffective, and behind the times.” The fight is real. And so are the implications. Existing law authorizes the State Legislature to add (any needed) provisions to clarify and modify procedures of the Mental Health Services Act by a majority vote. Governor Gavin Newsom understands this - and is actively using his

extensive political capital to mount a cold and calculated charge at the MHSA, local behavioral health programs, and the discretion and flexibility that California's county mental health plans have had to effectively deliver them. In many respects, Newsome wants to completely reshape and reinvent the wheel of the MHSA – significantly altering the way that California spends its “millionaire's tax.” The Governor's controversial new legislative proposal - which he says will effectively “modernize California's behavioral health system” - will be presented to voters on March 5, 2024. If passed by a majority vote, Newsom's bill (SB 326 Eggman) would immediately recast and officially rename the Mental Health Services Act (MHSA) – shaking the foundation of its almost-two-decade legacy - as the “Behavioral Health Services Act (BHSA).”

The Mental Health Services Act established (rather) broad categories for how California counties can spend their annual windfalls (cash infusions) – and *most importantly* the percentage of funds which must be spent on certain areas and activities. Three components of the MHSA focus on direct clinical services (Community Services and Supports, Prevention and Early Intervention, and Innovative Programs) and three components focus on Infrastructure (Capital Facilities, Information technology, and Workforce Education). If it passes in the statewide March 2024 primary election, Governor Gavin Newsom's Behavioral Health Services Act would drastically change the funding categories of the MHSA – requiring county mental health plans to allocate (much) more funding towards housing interventions (a huge theme), Full Service Partnerships (FSPs) and treatment of substance use disorders (SUDS) - all while reducing individual municipalities' overall discretion. Rather notably, the BHSA would eliminate the long-standing and influential “Innovative Program” category in favor of the administration of programs providing a broad array of housing interventions. Some behavioral health insiders/experts forecast an imminent clash between established mental health programs and other (BHSA adverts) who offer homeless services (a buzz word)– each “side” is reliant on the same (limited) MHSA/BHSA funding to sustain their operations.

Those on the current (MHSA) side of things contest that the state has already gone “all in” on homelessness – having spent more than \$20 billion on housing and homelessness since 2018. Newsom and those in the BHSA camp, who plan on diverting nearly one third of the state's Mental Health Services Act money to help address homelessness contend that homelessness is one of the most high-profile challenges plaguing California – increasing 32% in the past four years. At the end of the day, there's a distinct possibility that, after heated battles and fisticuffs, the re-vamped MHSA (BHSA) could very well result in county mental health plans (throughout the state of California) having to spend less, cut back on, or even entirely eliminate some of their current (and provenly effective) programs - and other long-functioning mental health offerings/services established within their communities. We'll examine “why” in this report - and examine the implications that SB 326 Eggman could have here in Santa Cruz County- for our extremely important and impactful local County Mental Health Plan and its associated community based and partner organizations.

### **An Examination of SB 326 (Eggman) – “The Behavioral Health Services Act” - Gavin Newsome's Proposal to “Modernize California's Behavioral Health System.”**



Modernizing California's mental health system sounds like a rather romantic notion on the surface – heck, the original Mental Health Services Act legislation (2004) hasn't had a severe poke (or largescale shake up) in almost 2 decades. But, before we all get aboard Gavin Newsom's bullet train policy and deem the upcoming MHSA revamp 100% necessary, we need to closely examine the specifics and get into the nitty gritty of the bill: what are the potential gains of the far-reaching piece of legislation, and what could be the potential losses (or changes) for individual county mental health systems.

In a dramatic move, SB 326 (Eggman) would radically alter the distribution of funding – completely doing away with some key, and arguably foundational, funding vehicles and modalities prominently featured in the current MHSA funding paradigm/program. One of the first major things that the new (newly named) Behavioral Health Services Act would do is open up direct funding sources to serve those with (all manner and states of) substance

use disorders (SUD). A small, but impactful percentage (5%) of BHSA funding will go directly to population-based mental health and SUD programs. But, a much larger piece of the proverbial pie will almost undoubtedly be necessary to serve this new, pressing, and at-risk population (often living with co-occurring disorders). Over \$1 billion (30% annually) of total BHSA dollars would be dedicated to housing interventions – and 50% of that amount would be used to serve those who are chronically homeless (with a focus on encampments). 35% of BHSA dollars would be specifically earmarked for what are known as **Full Service Partnerships (FSPs)** - Newsom’s immediately impactful Behavioral Health Services Act would devote 30% of the “millionaire’s tax” to “behavioral health services and supports” – including workforce education and training, capital facilities and technological needs, innovative behavioral health pilots and programs, services under the adult, child, and older adult systems of care, and early intervention programs (at least 50% of total spending in the category).

As noted previously, SB 326 (Eggman) and the Behavioral Health Services Act would completely do away with any and all county “innovation programs” – a mainstay and staple in the (current) MHSA days. Instead, Newsom’s legislation requires the establishment of a county-administered program to provide housing interventions for persons who are chronically homeless, or who are experiencing or at risk of homelessness. Gavin Newsome has high hopes that voters will validate his proposal (SB 326 Eggman) *in conjunction with a complimentary \$4.68 billion bond measure* to significantly replenish California’s psychiatric treatment beds. The bond measure – the Behavioral Health Infrastructure {Bond} Act – *must pass* in order for the amendments to the Mental Health Services Act (SB 326 Eggman) to pass concurrently in the March 5, 2024 statewide primary election. Just an FYI: AB 531 (Irwin) the Behavioral Health Infrastructure Bond Act of 2023 authorizes \$4.68 in general obligation bonds to finance grants for the acquisition and construction and rehabilitation of unlocked, voluntary, and community-based treatment settings and residential care settings. Of the \$4.68 billion, up to \$865 will be used to construct and rehabilitate housing for veterans and other experiencing, or at risk of homelessness (and are living with a mental health challenge). At least that’s the ultimate proposed goal.

### **The Allocation and Funding Categories of MHSA Revenues Under *Current Californian Law***

When Californian voters approved the groundbreaking Mental Health Services Act in 2004 – which exacted a 1 percent tax on (all) residents earning more than \$1 million dollars to fund the provision of the state’s mental health services – broad categories were established to dictate how counties could spend the influx of cash (and the fixed percentage of funds that needed be spent on specific kinds of activities). At least 95% - the vast majority – of MHSA funds were initially allocated to support a wide (and in some cases revolutionary) array of services for men and women living with or at risk of a mental illness. Here are the existing MHSA funding categories and their respective (set in stone) allocations:

#### **(Total of \$2.1 Billion Annually)**

**Prevention and Early Intervention:** \$369 Million - 19%

Outreach to Older Adults (Seniors) – Suicide Prevention – School-based Services

**Innovation Programs:** \$91 Million - 5%

Technology Integration – Holistic Care

**Community Services and Supports:** \$1.626 Billion - 76%

Outpatient Treatment – Crisis Intervention – Full-Service Partnerships – Wellness Centers – Capital Facilities – Housing Services – Workforce and Training

You’ll immediately notice that the vast majority (76%) of current (county) Mental Health Services Act funding must be allocated and directly spent on providing various “Community Services and Supports” (CSS). This wide, expansive – and quite foundational - spending category actively supports a wide range of direct service provisions delivered by county mental health plans (including outpatient treatments). Current state regulations require counties to use a full 50% of all Community Services and Supports funds to establish and fuel Full-Service Partnerships (FSP’s). FSP’s (an emerging and contested buzz word and soon-to-be central issue for both sides of

the status quo vs. BHSAs debate) provide much-needed mental health and wrap-around services – like employment and housing support, case management, and clinical care – for individuals deemed to have “the greatest mental health needs.” In addition to direct funding for Community Services and Supports, counties can devote 5% of their MHSA haul to “Innovation Programs” – with which they can tinker around, experiment, and try brand new and novel approaches to preventing and treating mental illness in their communities. As noted above, counties must devote 19% of their total MHSA funding to Prevention and Early Intervention (PEI) activities – specifically aimed at preventing mental illnesses before they become crippling and/or severe.

In the subsequent sections, better picture will emerge of exactly how Governor Newsom’s new legislation (SB 326 Eggman) could change and disrupt the current (and arguably effective) MHSA paradigm and existing behavioral health services – requiring counties to allocate significantly more MHSA/BHSA funding towards providing housing interventions and funding local Full Service Partnerships. All while potentially reducing overall county (mental health plan) spending discretion and available funds to support a number of their currently financed (and effective) programs. For example, the newly (eventually) passed Behavioral Health Services Act would completely eliminate (delete all of the provisions relating to) the highly-praised Innovative Program category – instead requiring county mental health plans to establish and directly administer a program providing housing interventions.

### **The Big Shift: Imminent Changes in the Funding Categories and County Allocation of MHSA Funds Under Gavin Newsom’s Controversial Proposal (SB 326 Eggman) – Known as the “The Behavioral Health Services Act”**

If given the greenlight by California voters at the March 5, 2024 primary election SB 326 (Eggman) – also widely known as the governor’s Behavioral Health Modernization proposal– would unilaterally and almost instantaneously influence and effect the way counties (statewide) allocate funds to support local services devoted to individuals living with or at risk of developing a mental illness within their communities. Some laud Newsom’s proposed legislation – an expansion to include treatment of substance use disorders - as “progress and modernization,” and others contend that SB 326 is a step (back) in the completely wrong direction. The (newly established) BHSAs would still allocate 92% of total funds directly to California counties (and their respective mental health plans) - but the focus of funding allocations would shift towards providing additional funds for housing interventions and the support of Full-Service Partnerships (including Substance Use Disorder and Assertive Community Treatments).

In conjunction with the Behavioral Health Infrastructure {bond} Act. – which must *concurrently* pass in the March primary in order for the Governor’s proposed sweeping amendments to the MHSA to take effect – SB 326 (Eggman) zeroes in on the housing crisis that is (and has been) actively plaguing communities across the state. Some critics contend that the diversion of (strict and categorized) behavioral health dollars to combat housing insecurity and outright homelessness isn’t the (current) right, equitable and prudent strategy. But, under the Governor’s proposal a full 30% of MHSA/BHSA county funding would be used for housing or infrastructure funding to formulate new housing and the provision of housing itself. Housing and the unhoused are huge themes throughout the burgeoning piece of legislation. *One of the key areas of foci* for SB 326 and its companion \$4.68 Billion Bond Act that need to be “OK’d” by California voters in March 2024. The Governor’s proposal would require that 50% of MHSA/BHSA funds in the important “Housing Intervention category” (30% of total funds) be directed for the provision of housing interventions for individuals experiencing chronic homelessness. And all of the housing services provided by Full-Service Partnership participants/organizations (another buzz word) would also be counted under this influential category.



With “housing” and housing interventions the obvious victors (and foci) in Governor Gavin Newsom’s sweeping dismantlement of the Mental Health Services Act – in favor of his own Behavioral Health Services Act and accompanying Bond measure – some county mental health plans (and key players within the California behavioral health space) have vocalized their concern regarding a possible reduction in the flexibility in the dispersion of



MHSA funds within their (long-established) communities. Some studies have shown that based on current expenditures, individual counties would be forced/required to increase spending on Full-Service Partnerships by around \$121 million and spending on “housing” by \$493 million in the coming years (if SB 326 Eggman is pushed forward in March 2024). Let’s take a quick look at – and brief breakdown of – the key allocation of MHSA funds and specific categories existing within SB 326 (Eggman) – California Governor Gavin Newsom’s Behavioral Health Services Act:

**Housing Interventions: 30%**

Family Housing for Children and Youth – Rental and Operating Subsidies – 50% for Chronically Homeless Individuals

**Behavioral Health Services and Supports: 30%**

Adult, Older Adult, and Youth Services. – Capital Facilities – Deposits to Prudent Reserves – Early Interventions (Majority Must be Spent on Early Interventions)

**Population-Based Mental Health and Substance Use Disorder Prevention: 5%**

Suicide and/or Overdose Prevention – Population-wide Reduction in Mental Health Disorders (Cannot Include the Provision of Services to Individuals)

**Full-Service Partnerships: 35%**

Substance-Use Disorder Treatment – Assertive Community Treatment – Employment Services

The first thing that you’ll notice when comparing and contrasting the funding/spending categories inherent to the existing Mental Health Services Act and the Governor’s proposed Behavioral Health Services Act is the complete elimination/dismantlement of “Community Services and Supports (CSS).” This powerful and foundational MHSA funding avenue/stream – encompassing everything from outpatient treatment and crisis intervention to wellness centers and housing services – has long-fueled a monumental 76% of total behavioral health programming in counties (mental health plans) throughout the State of California. Gavin Newsom’s legislation and sweeping transformation will undoubtedly cut into the funding discretion that counties have long enjoyed – to innovate, target local populations, and exact positive systemic change. The funding category that gives county mental health plans the most freedom and overall flexibility – Behavioral Health Services and Supports (BHSS) – is miniscule compared to existing policy (Community Services and Supports). Under Newsome’s proposal, only 30% of total MHSA county funding would go towards supports and services for adults, older adults, and children, early intervention programs (majority), workforce education/training, capital facilities and technological needs, and innovative behavioral health projects.



Trying to figure out exactly how the exact percentages work out and line-up when comparing the highly disparate MHSA and BHSA funding structures – “this money goes to this category and this money goes to this category ... and these categories combine and create this spending category” – can be a rather confusing undertaking. In many areas and respects, the BHSA and MHSA don’t totally jive or completely line up. But the total (potential) change exacted by Newsome’s system-shaping proposal is massive. Under the Governor’s proposal, 30% of total MHSA funds allocated California counties must be used on housing intervention programs/undertakings for the

provision of housing – or any kind of infrastructure funding to create brand new housing. And 50% of all (these) funds dedicated to this (brand new and controversial) funding category must be used to create/facilitate housing interventions for those who are chronically homeless. Newsom’s proposal would decree that all counties spend a substantial 35% of total funding on “Full -Service Partnerships” – including a brand-new focus on substance use disorders and assertive community treatment.

**Exact Dollar Amount (a total of \$2.1 Billion in MHSA funds) That Will be Allocated to Each (New) Category Under Governor Gavin Newsome’s Proposed SB 326:**

**\$730 Million:** Devoted to **Full-Service Partnerships** (Services for those enrolled in a partnership – including housing interventions)

**\$626 Million:** Devoted to **Housing Interventions and Supports** (50% on services for the chronically homeless)

**\$626 Million:** Devoted to **Behavioral Health Services and Supports** (wellness centers, crisis intervention, stigma and discrimination reduction, outpatient treatment, school-based services, outreach, older adult and youth-centric services, capital financing, technology improvements, workforce development and education)

When you begin to (carefully) compare and contrast current expenditures to those dictated by Newsom’s SB 326 proposal you’ll find that counties across the state of California will have to significantly increase spending in two key areas: housing (the chief focus and foundation of the new proposed legislation) and Full Service Partnerships (FSP’s). To achieve funding targets, housing interventions are estimated to draw around \$493 million from county coffers. And Full-Service Partnerships an additional \$121 million.

To fund these dramatic expansions and developments under the advent of SB 326, counties would need to scramble to reduce or redirect their expenditures on programs/offering that fall under the Behavioral Health Services and Supports funding category limit. This turns out to be a pretty big deal – effecting the way that counties support their current (and largely effective) behavioral health programs and partners and expand their community-based offerings in the future. Currently, under the Mental Health Services Act, expenditures that would be eligible under the (new or possibly forthcoming) BHSS category make up around 60% of total MHSA dollars/expenditures. Newsom’s SB 326 caps the (at least now) broad category at 30% - meaning expenditures would have to be slashed dramatically – from close to \$1.3 billion to \$621 million.

At the end of the day, after all careful analysis, it seems as if the proposed revamped MHSA (known as the BHSA in the future) would dramatically shift the focus of funding to early intervention programs, Full-Service Partnerships, and (most importantly) housing. The change would undoubtedly affect – and perhaps eliminate - the currently available programming provided by counties, partner organizations, and community-based organizations under the currently functioning MHSA – including prevention and outreach services, crisis response, and outpatient services.



When the Mental Health Services Act levied a 1% tax on personal income above \$1 million to mend California’s fractured behavioral health system, the funds represented nearly a third of all dollars spent in the field. Currently, the majority of money goes directly to counties to use as they see fit. There’s much-appreciated *flexibility* and adaptability endemic to the present system. The proposed (funding) categories introduced by Newsom and his administrative constituents could hatchet away at the flexibility long afforded to individual counties- to deliver precise and tailor-made behavioral health services within their communities. By establishing the “Behavioral Health Services and Supports” (BHSS) as a sort of “super category” – with only 30% of total spending allocated towards *all of it* – Governor Newsom would effectively eliminate a huge chunk of the MHSA funding that could/can accommodate flexible program expenditures. Brand new BHSS policies (under SB 326) would decree that counties spend precious funds on things like early interventions that would cut into funding available for other (proven or innovative) county initiatives.

The fact that the majority of Behavioral Health Services and Supports (BHSS) funds must be spent on “early intervention programs” will surely loom large going into the future – putting a stranglehold and establishing a choke point on currently existing expenditures – including outpatient treatment services, prevention services, outreach, and crisis response. All programs existing within the current (MHSA) “Community Services and Supports” structure – representing 76% or \$1.626 billion in annual MHSA expenditures – will be totally split up and separated; classified under new Housing Interventions, BHSS, and FSP categories. Where specific (currently operating MHSA behavioral health) programs will fall within the new BHSS framework is still being



discussed/debated - but it's assumed that all Prevention and Early Intervention (PEI) programs would fall under the BHSS category, and innovation programs under Housing Interventions and BHSS. But the exact percentages and monetary allocations are still being worked out - and largely up in the air at this point. Many who've combed through the legislation and crunched the numbers believe that there's a sizable chance that some/many PEI and CSS programs that fit within the newly established BHSS category could experience sizable reductions in MHSA funding.

For many California counties, the MHSA was (and has always been) a total godsend. Almost overnight, it gifted (county) mental health plans a hugely appreciated degree of flexibility and discretion in how they could deliver over \$2.1 billion annually to fund, fix, and dramatically improve their arsenal of locally offered behavioral health services. For years, counties have operated with relative freedom and confidence – operating a superfluity of Innovation, Community Supports and Services (CSS), and Prevention and Early Intervention (PEI) mental health programs to meet local needs with relative impunity. The flexibility, freedom, and autonomy offered and guaranteed by the MHSA – and its almost two decades of transformative policy – will most likely be a thing of the past (a happy and cherished memory) if Governor Gavin Newsom's sweeping SB 326 proposal actually passes in the March 2024 primary - and manifests as the system-changing, system-shaking (or system breaking?) legislation that many say that it could be.

### **The Behavioral Health Infrastructure Bond Act: The Companion (Or the Crux?) of SB 326?**

In addition to dutifully pushing SB 326 through the legislative process, California Governor Gavin Newsom is backing – and urging the State's voters to approve – a massive \$6.38 bond measure on the March 2024 primary ballot. The Bond – known collectively as the Behavioral Health Infrastructure Bond Act – would fund an impressive 10,000 new mental health treatment beds. Here's the key: The bond measure *must pass* in order for the amendments to the Mental Health Services Act (SB 326 Eggman) to (also) pass concurrently in the March 5, 2024 primary election. AB 531 (Irwin) the Behavioral Health Infrastructure Bond Act of 2023 authorizes \$4.68 in general obligation bonds to finance grants for the acquisition and construction and rehabilitation of unlocked, voluntary, and community-based treatment settings and residential care settings. Of the \$6.38 billion, up to \$865 will be used to construct and rehabilitate housing for veterans and other experiencing, or at risk of homelessness (and are living with a mental health challenge). At least that's the ultimate proposed goal. The debate surrounding the AB 531 Bond Act has gotten hot recently, and some mental health advocates harbor concerns that the housing mandate and SB 326 could result in a sizable (\$700 million +) loss to existing county mental health plans and their existing services.



### **Pushing Back: Opponents of SB 326 and AB 531 (\$4.68 Billion Bond Act) Make Their Voices Heard**

Not everyone is (or was) happy with Gavin Newsom's proposed largescale dismantling of the almost-two-decades-old Mental Health Services Act. Many service providers, mental health advocates, and analysts have voiced serious gripes about SB 326 (and its sister AB 531 Bond Act). When California's Governor announced his plans to battle the state's escalating homeless crisis using MHSA dollars during his January 2024 State of the State tour, scores of groups rose in active opposition - voicing concerns that the new and sweeping housing mandates could jeopardize (some, or many) existing behavioral health programs. Many established mental health providers (and peer groups) rose together to collectively battle against the Governor and his Sacramento constituents (fellow legislators) – criticizing them for neither providing a complete justification for their proposed far-reaching changes (in SB 326), nor extensively analyzing how these changes may negatively impact currently delivered/offered services in their communities. Recently, it seems like the Governor is starting to be willing to listen – and in some cases willing to completely acquiesce – to growing, collective, organized, and unified pressure.

### **Responding to His Constituents – Gavin Newsome's Recent Amendments to SB 326**

Governor Gavin Newsom's dramatic unveiling of SB 326 - his sweeping and transformational set of reforms to the existing Mental Health Services Act – probably didn't go as smoothly as he planned. Newsome desperately tried to

spin a universally positive narrative - that the vast majority of California county mental health plans (and their respective partners and community-based organizations) were 100% behind his legislation. Well, no. Even though Newsome proudly highlighted a flashy collection of glowing accolades and atta-boys from influential leaders in the State's behavioral health and substance use disorder spheres of influence, serious -and swelling - opposition to his system-shifting policies quickly emerged. As voices in protest (and outrage in many cases) grew louder – and more impassioned- statewide, Newsom and his colleague and SB 326 compatriot Senator Eggman bowed to mounting pressure – and responded with a series of important and far-reaching amendments to the (their) bill.



Prior to the recently-announced amendments to SB 326, many of the State's (children's) mental health advocates were up in arms – argued that the Governor was effectively pitting the California's children and homeless residents against each other – forcing them to compete for the same services (and basic funding streams). The (current) MHSA has long-focused on the areas of prevention and children's services – areas where the State of California has long-underinvested. Those involved in adolescent (and TAY) mental health contended that Newsom's original (pre-amended) BHSA legislation would siphon funds away from (currently offered) prevention

and early intervention services for youth, and actually/ultimately worsen California's mental health crisis. Current MHSA policy requires a portion of its funds to be spent on children and youth – 51% of early intervention and prevention dollars are required to be spent on those 0-25 years old. Newsom's original proposed changes to the MHSA effectively eliminated any and all requirements that money be spent on children and transition age youth – and opened up the possibility for counties to spend *zero dollars on children's mental health*. If the original proposed changes (and bill text) to the MHSA were enacted in their entirety, the State's children and TAY population could have experienced a reduction in annual behavioral health services and supports of over \$700 million.

If enacted in its original form, SB 326's complete lack of funding for and focus on children's/youth/adolescent behavioral health (services) could have had a dramatic, immediate and possibly catastrophic effect for county mental health plans (and the State's mentally ill youth.) As frustrations and tensions mounted, and conversations between the Governor's office and up-in-arms (children's) mental health advocates became increasingly heated Newsom and Eggman caved – approving a series of amendments to their prized legislation. Most importantly, the amendments include a mandate that 51% of money set aside for prevention programs to directly toward youth and children under the age of 26. The newly amended language in SB 326 Eggman is/was the result of weeks of stakeholder meetings, input, and impassioned back-and-forth – and is already garnering an overwhelmingly positive response among children's groups, counties, and families throughout California. “We really, really want to thank the administration for being so willing to work with us on these amendments,” says Lishaun Francis, director at youth-advocacy group Children Now. “We were really excited to see a number of things - primarily the set for kids in the prevention and early intervention bucket.”

### **SB 326 Criticisms Continue to Persist Throughout California**

If approved by voters in the March 2024 primary election, SB 326 together with companion and sister AB 531 (Behavioral Health Infrastructure Bond Act) could result in sweeping, once-in-a generation policy changes. Some critics call SB 326 and AB 531 “rushed” – a far cry from the original 2004 Mental Health Services Act (MHSA) legislation that was born from public hearings and multi-year discourse from stakeholders and probably most importantly, mental health consumers, throughout the state of California. Gavin Newsome's complete 233-page overhaul of the MHSA is criticized as being overly complicated – rushed - and drafted behind closed doors without the same degree of stakeholder, consumer, and broad community feedback.

It's not uncommon to hear the word “rushed” – or even “rash” – when discussing the Behavioral Health Services Act (SB 326) and its constant companion legislation AB 531. Critics argue that putting both system-shifting pieces on the March 2024 legislature is unnecessarily swift for such a massive reform, and that this go around, consumers

and educated stakeholders will have less than 6 months to totally discuss, digest, and provide necessary feedback on the ballot measure. Critics argue that the stakeholder process and direct consumer involvement so intrinsic – and vital- to the original 2004 MHSA legislation has not been evident in the current legislation.

Input from consumers – those partaking in behavioral health and substance use disorder treatments/services – and directly impacted populations were key to the development of original MHSA policy. But SB 326 may allow counties (mental health plans) to implement changes to their MHSA/BHSA plans without the currently required stakeholder process. Consumers living with a (serious or mild) mental illness offer unique and often vital perspectives regarding systemic issues and injustices that abound. Senate Bill 326 will increase membership on the Mental Health Services Act Oversight and Accountability Commission from 16 to 20 people but cap the number of voting consumers at 2.

### **Current State of Legislation: SB 326 and AB 531 – What’s Next?**

Gavin Newsome’s groundbreaking and quite controversial legislative package meant to modernize and transform California’s behavioral health system passed a significant hurdle in late August 2023. After a close examination and a not-so-dramatic debate, the State Assembly Health Committee voted – in an overwhelmingly decisive 11-0 manner – to pass SB 326 (authored by Senator Susan Eggman).. The vote by the Assembly Health Committee may have seemed assumed, blasé, or uneventful to some closely following the journey of Newsome/Eggman’s proposed modifications to the MHSA (part of the Governor’s two-bill legislative package), but it did mark the very first vote on SB 326 by any (important) governmental party.

Gavin Newsom’s two bill package – SB 326 and companion \$6.38 billion bond measure AB 531 – moved onto the next phase (California Legislature) ... inching one step closer to a sure-to-controversial placement on the ballot at the 2024 March primary election. Both bills have been designed to work concurrently (and must be passed together) – with the ultimate goal of completely transforming the design of and monetary allocations devoted to California’s mental health and substance use disorder services system in the years to come. Bond measure AB 531 – which would allocate \$4.68 billion to establish new supportive housing and community-based treatment settings – continued its tortuous journey through the State legislature in the Senate Appropriations Committee. And SB 326 – already dissected in this report – ventured on to the Assembly Housing and Community Development Committee.

Just last week - on September 14, 2023- California’s/Newsom’s sweeping mental health transformation initiatives overwhelmingly passed the California Legislature – giving the State’s voters an opportunity to enact the Governor’s proposed sure-to-be impactful health and homelessness measures in March of 2024. The California Legislature approved the two-companion bills – cornerstone pieces of Newsom’s multi-year homelessness and behavioral health agenda – to reform and modernize current MHSA policies and provide funding to build new behavioral health beds and housing for the State’s residents (and at-risk populations). The bills – Assembly Bill 531 and Senate Bill 326 (Eggman) – will dedicate billions of dollars to new behavioral health housing, provide funding key to California’s behavioral infrastructure and workforce, and create new accountability and transparency policies.

The highly anticipated final votes came after months of back-and-forth with stakeholders across the state – including veteran organizations, mental health consumer groups and families with “lived experience,” school administrators, businesses/organizations, first responders, and local (county) behavioral health plans. Newsom’s planned policies were tweaked and amended multiple times to bring more groups/parties on board – supporting his sure-to-be system shaking/shifting bills.

The (proposed) \$6.38 general obligation bond to build 10,000 new treatment beds and supporting housing units – Assembly Bill 531 (Irwin) – represents the single largest expansion in California’s mental health treatment and residential settings in the State’s history. If passed by voters in the March 2024 primary election, SB 531 would create brand new (dedicated) housing for homeless individuals living with behavioral health challenges – with a portion of funds directed towards serving America’s veteran population (a \$1 billion allocation for housing).



What's next regarding sister-bills SB 326 (Eggman) and AB 531 (Irwin)? Governor Newsom has until October 14<sup>th</sup>, 2023 to take action on the legislation. Once signed by Newsom – which is pretty such a done deal at this point – his sweeping modernization of the MHSA and the state's behavioral health services systems and accompanying (huge) bond measure will head to the ballot – for final approval by Californian voters. Both bills are tightly linked and dependent upon each other and will appear jointly and quite prominently – as a single measure - on the March 2024 ballot as **“Proposition 1.”**

Upon the penultimate go-ahead of SB 326 (Eggman) and AB 531 (Irwin) by the State's Legislature, bill-author and Senate Health Committee Chair Susan Eggman sounded relieved and seemed to (finally be) at peace. More than a solid year of constant (and intense) policy-drafting, bill amendments, and heated constituent and stakeholder engagement finally paid dividends:

“I am so grateful for the support of my Senate and Assembly colleagues in approving SB 326 and AB 531 and for the leadership and effort Governor Newsom has demonstrated on reforming our behavioral health care system. Together these bills provide a critically needed overhaul to the landmark Mental Health Services Act and infuse desperately needed resources into our behavioral health care continuum. The Governor made a commitment to get this done this year and today the Governor and the Legislature delivered on that commitment. We have a behavioral health crisis playing out on our streets. With this package, Californians now will have the chance to voice their support for a new direction with a vote for safer communities and a more coherent, functional and humane approach to community-based behavioral health care.” – Eggman

### **The Curious (And Slightly Controversial) Enigma That is CA State Senator, Susan Eggman**

Currently regarded (and lauded) as one of the most knowledgeable and impactful California legislators on behavioral health issues, Susan Eggman will (finally) be termed out of the State Senate this year after nearly 12 years of service. Zeroing in on the possible (eventual) end to her long and slightly unorthodox career as a politician, Eggman has been a whirlwind of activity the past few years. Most notably (recently) passionately pushing for her (and Governor Newsome's) complete overhaul of the landmark Mental Health Services Act (MHSA) – the so called “millionaire's tax” passed by voters as Proposition 63 in 2004 – through SB 326. Is the recently focused-upon and newsworthy Eggman making up for lost time, and ending her political tenure with a carefully calculated flourish of activity? It's definitely worth considering (and examining) her most recent- and highly noteworthy – undertakings in the behavioral health realm (SB 326 included).



An influential (especially recently) Democratic State Senator hailing from Stockton, CA, Susan Talamantes Eggman is on a mission to *get things done*. Maybe it's the fact that her waning days in the State legislature – 12 years, first in the Assembly, and now in the Senate – are about to end, that has added fuel to her fire: recently introducing a series of influential (and controversial) legislative pieces/bills that could dramatically shift and transform the landscape of California's behavioral system - for decades to come (after the eventual end of her political career). Eggman, 62, has stated that when her days - working side by side with the Governor and other State legislators- as an active politician finally end that she will return to teaching Social Work at California State University, Sacramento - and dabble in mental health advocacy. Born in the Castro Valley, where her family owned an apiary (bee keeping business) Susan Eggman's interest in behavioral health issues coalesced while working at a local psychiatric facility during her senior year of high school. Among other things, Eggman is known to be a “community activist,” and the first Latina and the first Lesbian to be elected to the Stockton City Council (2006). She was teaching at Sacramento State in 2012 when she secured a seat on the California State Assembly – where she served for 8 years – and then was easily elected to the Senate in 2020. Senate Bill 326 – the Behavioral Health and

Modernization Act – is one of Eggman’s most highlighted and arguably impactful measures to date ... but in the recent years, the Democratic State Senator has been introducing and fiercely backing other instrumental pieces of behavioral health legislation as well.

Her (and Newsome’s) modifications to the MHSA and “millionaire’s tax” of 2004 faced major hurdles in the waning days of legislative session, and vocal opposition (and outright condemnation) from stakeholders (mostly consumer groups) and counties concerned about funding allocations and losing vital (long-established) services. And the Behavioral Health Bond Act – co-authored by Eggman – central to Governor Newsome’s efforts to reform California’s behavioral health system and combat the State’s homelessness epidemic will be combined as a single measure - “Proposition 1” - on the March 2024 primary ballot. Her most-recent sister-measures passed just in time: California’s State Legislature adjourned on September 14<sup>th</sup>, and the bills were pushed through September 14<sup>th</sup>.

During the past few years, Senator Eggman has introduced a series of bills to attack and attempt to significantly modify the restrictions enacted by the 50-years-old Lanterman-Petris Short Act (LPS). Some have zigged and zagged through the State Legislature and been signed by the Governor. This year, Eggman successfully attempted to expand the rather-restrictive LPS definition of “grave disability” – which she and many behavioral health advocates have long said prevents meaningful and impactful interventions and treatments. Senate Bill 43 – one of Eggman’s most-recent and proudest accomplishments – expands the “grave disability” standard to include substance abuse... which in many cases accompanies and often times exacerbates types of severe mental illness. And results in an inability to care or provide for oneself. SB 43 is a foundational part of Eggman’s overall mission to fix or alter the behavioral health system in California and has emerged as a key piece in her portfolio of legislative initiatives – achieving gradual but growing bipartisan support. While Governor Gavin Newsome hasn’t announced his official position on SB 43, the initiative is expected to pass and be signed by the politician. The specifics of SB 43 were hotly contested in the Capital, and debates over the timeline for implementation of the new standards continued well into the chaotic final weeks of the legislative session. Ultimately, in a flurry of last-minute amendments, counties (and respective mental health plans) were allowed to adopt the expanded LPS standards “optionally” in 2004 but *must* adopt them by Jan. 1, 2026.



Three years ago, Susan Eggman championed a then-major/influential bill aimed at strengthening the almost-two-decades-old “Laura’s Law” – also known as Assisted Outpatient Treatment (AOT). While working in a behavioral health clinic in 2001 - 19-year-old Nevada college student Laura Wilcox was shot and killed by a symptomatic mentally ill patient whose family’s pleas to treat and intervene were completely ignored by the site’s officials. The eventual policy/bill known collectively as “Laura’s Law” emerged as one of the few legal avenues for family members attempting to help or treat mentally ill relatives. Today, most states – including California – have Assisted Outpatient Treatment programs that provide treatment to severely mentally ill persons (generally voluntarily). And most are overseen by civil, rather than criminal courts to intervene before someone ends up in prison or jail as a direct result of an untreated mental illness. When the original “Laura’s Law” was passed by California legislature in 2002, counties throughout the State could “opt out” – with no public hearings. Eggman’s 2020 behavioral health legislation required all counties who “opt out” to conduct hearings – which generated a vortex of contentious local public debate/hearings/arguments that led to a widespread adopting of Assisted Outpatient Treatments throughout California.

Partly resting on the foundation of Laura’s Law, the “CARE Act” (Community Assistance, Recovery, and Empowerment Act) is Eggman’s most-recent behavioral health initiative to permeate the State of California. Passed just last year, with the strong and steady backing of Governor Gavin Newsom, the CARE Act established statewide – unlike Laura’s Law – with severe (financial) sanctions for counties that fail(ed) to create programs. As a centerpiece to Newsom’s (and Eggman’s) administrative focus on mental health reform (and increased funding), the CARE Act rolled out in eight California counties, and will be featured statewide in 2024. The CARE Act requires that all counties create a brand-new system of civil courts to oversee intervention, housing, and treatment for the



State’s residents “cycling through hospital emergency rooms. In jails or prisons ill-equipped to assist them, or on the streets.” The soon-to-be-decreed CARE Act hasn’t been met without a fair share of negativity and backlash from localities throughout the State – many of whom argue that local funding of CARE Court – intrinsic to the CARE Act – could directly impact local Mental Health Services Act (MHSA) dollars: estimated at \$120 million dollars for eight (currently operating) counties and \$290 million for the rest of Californian counties (during the next year).

**A Quick Note on the Possible Impact on (County Mental Health Plan) Medi-Cal Certified Peer Support Specialists**

Passed to wide fanfare and enthusiasm in 2021, the Medi-Cal Peer Support Specialist Certification Program Act established evidenced-based, recovery-focused Peer Support Specialist Services in county mental health plans across the State of California. Many parties closely analyzing SB 326 (Eggman) agree/project that Peer Support Specialist services – across the continuum of care – could be drastically reduced by the passage of the bill. Currently, Medi-Cal certified Peer Support Specialists strictly operate within the Medi-Cal Specialty Mental Health Services and Drug Medi-Cal service (area) administered by individual County Behavioral Health Agencies (plans). Almost 100% of Medi-Cal certified Peer Support Specialists can perform zero work outside of County managed behavioral health programs. Advocacy group “Cal Voices” anticipates that in the first year alone, SB 326 (Eggman) will cut the current level of MHSA funding for Community Supports and Services (CSS) – the main funding source for Peer Support Specialist Services – in half. Today, most Medi-Cal Peer Support Specialists are employed within crisis mobilization teams, outreach and engagement, and outpatient services. By shifting funds away from currently effective behavioral health services and treatments towards housing and other interventions, there may be a significantly reduced need/demand for Medi-Cal Peer Support Specialist services in the behavioral health outpatient system/realm of care. This may influence the hiring and growth of Peer Support Specialists across California – just as formal certification and full employ is finally being implemented statewide.



**Direct Impact on Santa Cruz County (County Mental Health Plan and Partner Organizations)**



SB 326 – Gavin Newsom’s much heralded bill to ‘revolutionize’ the State’s behavioral health (and substance use and homeless services) system will do away with the current – and rather broad- “Community Services and Supports” funding category – redirecting and/or eliminating \$1.626 Billion (76% of total MHSA funds) of funding to County mental health plans. Most of the funding will be re-categorized, but some will most-undoubtedly get lost in the shuffle. According to Santa Cruz County’s “MHSA Community

Services and Supports Information Sheet” (directly published by the Santa Cruz County behavioral health department) here is what CSS entails, and may be on the proverbial chopping block:

**Community Services and Supports: \$1.626 Billion - 76%**

Outpatient Treatment – Crisis Intervention – Full-Service Partnerships – Wellness Centers – Capital Facilities – Housing Services – Workforce and Training

**What is the purpose of the Community Services and Supports (CSS) Component?**

To provide services and supports for children and youth who have been diagnosed with or may have serious emotional disorders, and adults and older adults who have been diagnosed with or may have serious and persistent mental issues.

**What are the allowable expenditures for the Community Services and Supports (CSS) Component?:**

This component allows funds to be used for mental health services, personnel, operating expenditures and program management. Services must address all age groups. Programs funded by the MHSA must be voluntary in nature. The majority of funds under CSS must be used for Full-Service Partnerships.

### **What are the service categories under CSS?**

There are three types of services:

**Full-Service Partnerships (FSP):** The foundation of Full-Service Partnerships is doing ‘whatever it takes’ to help individuals on their path to recovery and wellness. There is a low staff to client ratio, a 24/7 crisis availability, and a team approach that is a partnership between mental health staff and clients. FSP’s assist with housing, employment, and education, in addition to providing mental health services.

**General System Development:** Funds to help improve programs and services to address mental illness or emotional disturbance, including reducing ethnic disparities, mental health treatment, rehabilitation services including supportive housing and supportive employment, and personal service coordination and case management.

**Outreach and Engagement:** This funding is established to reach underserved populations, including outreach to persons with brief or crisis-oriented contact, and as an approach to reduce ethnic disparities.



### **Completely Gone? Santa Cruz County’s “Innovative Programs” MHA Funding Stream (5% Total MHA Funds)**

Current MHA legislation awards Californian counties over \$91 million annually to fund “Innovative Programs” within their communities. SB 326 (Eggman) does away with the funding category/avenue entirely – eliminating 5% of (current) MHA funding. According to the widely available Santa Cruz County MHA Information sheet, here is how MHA Innovative Programs are defined and classified:

#### **What is an Innovative Program?**

An innovative program is defined as one that contributes to learning rather than a primary focus on providing a service. Innovative programs are available for a range of approaches including, but not limited to:

- Introduction of a new mental health practice.
- Substantial change of an existing mental health practice, including significant adaptation for a new setting or community.
- New application to the mental health system of a promising community approach or an approach that has been successful in non-mental health contexts or settings.

As noted in the Santa Cruz County MHA Information sheet:

Proposed Innovative projects that have previously demonstrated their effectiveness in a mental health setting and that do not add to the learning process or move the mental health system towards a development or new practice/approach may be eligible for funding under other MHA components. However, an Innovative Project may include a Prevention and Early Intervention (PEI) strategy if it were distinct from the PEI requirements, such as targeted to a group not listed as a “priority population.”

#### **The Funds for This Component Must be Used for One of the Following Purposes:**

- To increase access to underserved groups.
- To increase the quality of services, including better outcomes
- To promote interagency collaboration
- To increase access to services.

(All innovative projects must be designed for voluntary participation. Innovative projects are largely considered to be pilot or demonstration projects and are subject to time limitations to assess and evaluate their efficacy)



### **Prevention and Early Intervention Services in Santa Cruz County: Reorganized by SB 326**

Senate Bill 326 (Eggman) also does away with the current Prevention and Early Intervention direct MHA funding stream for Californian counties. Currently, county mental health plans receive \$369 million annually (19% MHA funds) for Prevention and Early Intervention services. Here, according to the “Santa Cruz County MHA Prevention

and Early Intervention Information Sheet” is what is at risk – of being restructured, altered, or completely eliminated – in the category here, locally.

What is the purpose of the Prevention and Early Intervention (PEI) component?

The intent is to prevent mental illness from becoming severe and disabling. The PEI plan must include at least one of the following programs: Prevention, Early Intervention, Outreach for Increasing Recognition of Early Signs of Mental Illness, Stigma and Discrimination Reduction, and Access to Linkage to Treatment Programs or Timely Access to Services for Underserved Populations. The PEI component may include one or more Suicide Prevention Programs. If programs are combined, the County must estimate the percentage of funds dedicated to each program.

**Definition of Programs:**

**Prevention:** A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. Examples of risk factors include adverse childhood experiences, experience of severe trauma, ongoing stress, poverty, family conflict or domestic violence, having a previous mental illness, a previous suicide attempt, or having a family member with a severe mental illness.

**Early Intervention:** Treatment or other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence.

**Outreach for Increasing Recognition of Early Signs of Mental Illness:** A process of engaging, encouraging, educating, and/training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness. Potential responders include, but are not limited to families, employers, primary healthcare providers, law enforcement, and school personnel. Outreach may include reaching out to individuals with signs and symptoms of a mental illness so they can recognize and respond to their own symptoms

**Access to Linkage and Treatment:** A set of related activities to connect children, adults, and seniors living with severe mental illness, as early as in the onset of these conditions as practicable to medically necessary care and treatment, including, but not limited to care provided by county mental health programs. Examples include screening, assessment, referral, telephone help lines, and mobile response.

**Stigma and Discrimination Reduction:** Activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services, and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.

As published in the “Santa Cruz County MHSA Prevention and Early Intervention Information Sheet,” the following strategies and core foci are to be used in each of the County’s (currently MHSA-approved, established, and operating) PEI programs:

**Access and Linkage:** Connecting people with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment, including but not limited to care provided by county mental health programs.

**Timely Access to Mental Health Services for Underserved Populations (Individuals and Families):** Increase the extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of mental illness receives appropriate services as early in the onset as possible, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, and cost of services.

**Stigma and Discrimination Reduction:** Promoting, designing and implementing programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination relating to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcome, and positive.



It's worth noting that one of the current and core MHSA PEI funding components dictates that presently, a full **51% of PEI budgets** must be dedicated to individuals 25 years and younger. Community programs that actively serve caregivers, parents, and family members with the goal of addressing MHSA outcomes for youth and children at risk of or with early onset of mental illness can be counted as meeting this requirement.



### The (Potential) Impact Senate Bill 326 (Eggman) Could Have on NAMI Santa Cruz County



With its complete elimination of the currently and healthily funded MHSA Prevention and Early Intervention (PEI) category, Senate Bill 326 (Eggman) would restructure or potentially eliminate funding for some existing programs in Santa Cruz County. Currently, NAMI Santa Cruz County has a long-standing project/partnership with the County of Santa Cruz under the (maybe?-soon-to-be-eliminated) MHSA PEI category – an effort falling specifically under PEI's "stigma and discrimination reduction" efforts. NAMI Santa Cruz County's official program name is: Stigma and Discrimination Reduction Agency: NAMI-SCC. Under the current MHSA structure, NAMI SCC is doing everything right – proven to conduct a wide range of activities to "reduce negative feelings, attitudes, beliefs, perceptions, and stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services – and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of their families." Under the current MHSA PEI category, NAMI SCC is checking all of the boxes. Under Newsom and Eggman's new proposed BHSAs modifications however, NAMI's position and stature within Santa Cruz County's mental health plan becomes far less clear/certain though.

The Mental Health Services Act established rather broad – at least broad by today's standards- categories for how counties across the State of California could spend their share of 2004 millionaire's tax. And the percentage of their annual cash windfalls that could be spent on certain behavioral health areas and projects. Three components – Innovative Programs, Prevention and Early Intervention, and Community Services and Supports – were key pieces of the clinical services funded by the important piece of legislation. If it passes the statewide March 2024 primary election, Governor Gavin Newsom's Behavioral Health Services Act would drastically change the funding categories of the MHSA – effectively eliminating the currently operating (and effective) Prevention and Early Intervention category – and require California county mental health plans to allocate (much more) millions (even billions) of (current) funding towards housing interventions and associated initiatives. By zeroing in on homelessness and the unhoused – an issue Newsom and his camp have already spent more than \$20 billion to manage (since 2018) – there's a good chance that the Governor may force counties (like Santa Cruz) to spend less, or completely eliminate some of their current (and arguably 100% effective) programs. And sever ties with long-functioning and specialized behavioral health services and programs within their communities.

Right now – and at least for a few years – NAMI Santa Cruz County is sitting pretty and riding high with its current County (PEI – Stigma and Discrimination Reduction) partnership. But in a couple of years, when (or if) the MHSA and the PEI category are completely wiped off the map, where will the organization be (in terms of partnering with the Santa Cruz County mental health plan?). In the first year alone, Gavin Newsom and Susan Eggman's system shaking legislation – SB 326 – will reduce the current MHSA funding category "Community Supports and Services" by approximately \$700 million – shifting currently allocated behavioral health services funds to housing interventions. This could, and probably will, create a huge deficit in the CSS programming budget (with a complete annihilation of the PEI budget) while also expanding the BHSAs target population to include those dealing with substance use disorders (a hallmark of SB 326).





Any and All Suggestions, Questions, Comments, Edits, and/or Clarifications Are Welcome - and can be sent directly to [hugh@namiscc.org](mailto:hugh@namiscc.org)

Thank you.

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Addressing: **Mental Health Advisory Board** September 21, 2023

Concerning: **My expulsion (dismissal) from Mental Health Client Action Network (MHCAN)**

In the month of April, I was expelled for one year by a majority (unanimous) vote by the staff at MHCAN. The reason for the dismissal was that I was taking NOTES. They said it was in violation of HIPAA.

Prior to my dismissal I had many complaints against the staff, volunteers, and other clients.

I also told Sarah Leonard I would like to get my peer support certificate to become a staff member. I could help MHCAN to improve and to make things better.

Sarah found this statement as harassment and offensive, seeing me as a problem.

- A) Staff Meetings: When I first became a client at MHCAN there were staff meetings where the clients were invited. Clients are no longer invited. This is very important to everyone who is a regular client. Meeting allows the clients to know how things are run and how decisions are made by the staff. And what the rules are.
- B) Kitchen: The kitchen is a vital resource for everyone including the staff. The kitchen was closed for several reasons; The staff and clients not being able to keep it clean, Violence (fights) in the kitchen, Rat infestation.
- C) Video Project: This project that I was asked to participate in, I did not. This project ended and is supposed to start back up. It has not. From friends and clients- this was great financially for clients who participated.
- D) Shadow Speaking: This is a peer support program. When I first attended MHCAN my main reason was the kitchen. It took a while to learn about this program. At first I just sat in and listened. Later I realized what it really is. This became my main reason for attending MHCAN. It showed me a new goal that I did not see or know about: Peer support certificate. This program helped me financially, psychologically and much more. Shadow speaking ended, was supposed to start back up in June. It has not.

- E) Funding: MHCAN has lost funding causing closure of projects and programs and lay off of staff.
- F) Security Guards: There are guards who do not want to be assigned to MHCAN due to Drugs, alcohol, violence. I was told of one incident of two men having sex in the men's room.
- G) Video cameras: I had many complaints against staff, volunteers and clients. They did not see it so they don't know what happened. I told them to look on the video cameras. They (Sarah) said it doesn't work. They're working on it. Cameras have never worked since I have been there, over a year. I don't know when the cameras last worked or if they ever worked.
- H) Volunteers: Many people complain about the volunteers. Looks like they get clients (friends) who need some money for the day and say they are volunteers so they can get paid- make them feel useful. (A form of peer support). Problem is they have no training, no skills in peer support. They have no Peer Support Certificate. Volunteers end up as tools (instruments) to harass other clients the staff doesn't like.
- I) Neighbors: The neighbors are the biggest threat to MHCAN, staff and clients. The neighbors have the influence (power) the power to close MHCAN. The neighbors complaints: violence, yelling and screaming, profanity, littering, trashing the area, vandalism, alcohol and drugs. This covers most of it.
- J) Experience from other clients: Other clients who have been expelled. There are other clients who have the same experience and more. Getting expelled is devastating. The loss of all the resources, programs and projects. Not being able to see your friends. Most people do not want to talk about this out of fear and retribution.

# Out of the Darkness Walk: Sept. 30



By Jondi Gumz

For Farah Galvez, the “Out of the Darkness” Walk on Sept. 30 at Skypark to prevent suicide is very personal.

She lost her 24-year-old son, Trevor Theissen, in May 2022.

“He was a big part of the community,” she said.

Trevor graduated from Scotts Valley High School in 2016.

He was into art. He was a giving person. He was an advocate who brought scootering to the skate park.

Before he spoke up, scooters were not allowed. He addressed the City Council, which helped change the rules.

Farah talks about the trifecta of suicide. Her son had a broken heart, a physical ailment (kidney stone) and severe depression.

“All of that came into play, and we lost him,” she said. “He had a wonderful job. He was happy. That was the most heart-breaking part.”

So Farah, who has a younger son, Wesley, a senior at Scotts Valley High, is dealing with grief and creating something positive from what happened.

“I wanted to make sure his life was not in vain,” she said. “Hopefully we can give hope — save families from going through this.”

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## Goal: 250 Walkers

She found the American Foundation for Suicide Prevention — whose chief medical officer Dr. Christine Moutier spoke in Santa Cruz in March.

Finding that organization led to Farah

volunteering to put together the first-ever in Santa Cruz County “Out of the Darkness” walk, which is designed to raise funds and awareness.

Her goals are 250 walkers and \$25,000.

She’s about halfway there, she said from a fundraiser at Woodstock Pizza, and she needs volunteers.

“I have a great committee of parents, their kids knew Trevor,” she said.

The walk in Scotts Valley is one of 22 in California and 410 in the nation.

Check-in time at Skypark is at 9:30 a.m.

Walking starts at 10:30 a.m. on a 1.8-mile route that goes to Mount Hermon Road and Bean Creek Road before looping back to Skypark.

And there is an ADA route, accessible to people using wheelchairs.

People can sign up in advance or show up and register on the day of the walk.

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## Normalizing

Farah hopes this will start normalizing the conversation about mental health.

“How are you feeling today?”

“What’s the pain level? 1-10, how do you feel?”

She’s learned that pain is a factor in suicide.

When someone thinks, I just want the pain to stop, “we need to decrease access to pills, decrease access to guns, and increase access to connectivity. Mental health, we need to talk about it, create a space where they have hope.”

She added, “Just because you’re not bleeding doesn’t mean you’re not hurting.”

She can imagine Trevor telling her, “Just keep going. If you can help somebody with what I went through... I feel him and I pray a lot. I’ll see him again. I know that.” ■

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Register for the walk Sept. 30 at <https://tinyurl.com/out-of-darkness-walk-sept30> or email Farah at [AFSPStaCruzCtyWalk@gmail.com](mailto:AFSPStaCruzCtyWalk@gmail.com)

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Cover Photo: Farah Galvez and her son Trevor Theissen



Photo Credit: Jondi Gumz

Poplar Pennycoke, Lacy Rebiskie, Tamara Juracz, and Ryder Brancatelli create hope rocks at the suicide prevention walk booth Aug. 20 at Scotts Valley Art, Wine & Beer Festival.