Health, Housing & Community Services
Mental Health Commission

To: Mental Health Commissioners
From: Jamie Works-Wright, Commission Secretary
Date: February 16, 2023

Documents Pertaining to 2/28/23 Agenda items:

Agenda Item	Description	Page
2. a	Approval of the February 23, 2023 Meeting Agenda	1
2. b	Approval of the January 28, 2022 Meeting Minutes	4
9.	Mental Health Manager Report – Jeff Buell	
	a. Manager Report b. Caseload Statics January	7 11
Email Correspondence	**Memo:** Health and Safety Protocols for In-Person Commission Meetings **Attachment:** Health and Safety Protocols for Commissions Feb 2023 (002).pdf **Attachment:** Covid-symptoms-English commissions (002).pdf **Memo:** Important Notes: Remote Requirements & Allowances (Suggested Agenda Text) for local Boards/Commissions **Memo:** [Shared Post] The Bitter Cycle of Schizophrenia **Attachment:** Bitter cycle of schizophrenia **Memo:** Children and Youth Behavioral Health Initiative (CYBHI) Grant Funding Available **Attachment:** DHCS-CYBHI-EBP-CDEP-Round-2-Request-for-Applications.pdf **Attachment:** DHCS-CYBHI-EBP-CDEP-Grant-Strategy-Overview-December-2022.pdf **Memo:** Mental Health Advisory Board Retreat (February 4, 2023) **Attachment:** MHAB 2023 Retreat Binder.pdf **Memo:** Election Info for MHC Officers - begin serving March 23, 2023 at in-person meeting **Memo:** MHC Feb Agenda topics and deadlines **Memo:** Retreat Agenda, Saturday, January 28, 2023, 10 am - 2 pm **Memo:** BCC Legislation - 911 Needs Assessment and Crisis Capacity Assessment for Alameda County	18 20 22 23 26 27 32 35 60 82 84 148 150 151 157

	Attachment: 911 Needs Assessment and Crisis Capacity Assessment for Alameda County	159

Health, Housing & Community Service Department
Mental Health Commission

Berkeley/ Albany Mental Health Commission

Regular Meeting
Thursday, February 23, 2023

Time: 7:00 p.m. - 9:00 p.m. **Zoom meeting** https://us06web.zoom.us/j/85337202554

Public Advisory: Pursuant to Government Code Section 54953(e) and the state declared emergency, this meeting of the City Council will be conducted exclusively through teleconference and Zoom videoconference. The COVID-19 state of emergency continues to directly impact the ability of the members to meet safely in person and presents imminent risks to the health of attendees. Therefore, no physical meeting location will be available.

To access the meeting remotely: Join from a PC, Mac, and IPad, IPhone or Android device: Please use the URL: https://us06web.zoom.us/j/85337202554

. If you do not wish for your name to appear on the screen, then use the drop-down menu and click on “rename” to rename yourself to be anonymous. To request to speak, use the “raise hand” icon by rolling over the bottom of the screen.

To Join by phone: Dial 1-669-900-9128 and enter the meeting ID 853 3720 2554. If you wish to comment during the public comment portion of the agenda, Press *9 and wait to be recognized by the Chair.

Please be mindful that the teleconference will be recorded, and all other rules of procedure and decorum will apply for Council meetings conducted by teleconference or videoconference.

All agenda items are for discussion and possible action

Public Comment Policy: *Members of the public may speak on any items on the Agenda and items not on the Agenda during the initial Public Comment period. Members of the public may also comment on any item listed on the agenda as the item is taken up. Members of the public may not speak more than once on any given item. The Chair may limit public comment to 3 minutes or less.*

AGENDA

7:00pm

1. **Roll Call**
2. **Preliminary Matters**
    a. Action Item: Approval of the February 23, 2023 agenda
    b. Public Comment (non-agenda items)
    c. Action Item: Approval of the January 28, 2023 minutes

Health, Housing & Community Service Department
Mental Health Commission

3. **Bridge to SCU and SCU Update – Dr. Lisa Warhuus, Director Health, Housing & Community Services**

4. **M.H. First - Community First Presentation on Current Community-Based alternative non-police first responder program in Oakland and Sacramento**

5. **Elections for Chair - beginning March 2023**

6. **Elections for Vice Chair – beginning March 2023**

7. **Discussion about current MHC meeting date & time and take action**

8. **Subcommittee Reports**

    a. **Diversion Subcommittee – Mary-Lee Kimber Smith**
    b. **Youth Subcommittee – Monica Jones**
    c. **Membership Subcommittee**
    d. **Site Visit Subcommittee – discussion to renew**
    e. **Evaluation Subcommittee**
    f. **Crisis Stabilization Subcommittee**

9. **Mental Health Manager's Report and Caseload Statistics – Jeff Buell**
    a. **MHC Manager Report**
    b. **Caseload Statistic January 2023**

10. **Update: law enforcement arrests regarding people with dementia - Ned Opton**

11. **Update: Access to 988 for Berkeley people – Ned Opton**

12. **Closing**

Communications to Berkeley boards, commissions or committees are public record and will become part of the City's electronic records, which are accessible through the City's website. **Please note: Email addresses, names, addresses, and other contact information are not required, but if included in any communication to a City board, commission or committee, will become part of the public record.** If you do not want your e-mail address or any other contact information to be made public, you may deliver communications via U.S. Postal Service or in person to the secretary of the relevant board, commission or committee. If you do not want your contact information included in the public record, please do not include that information in your communication. Please contact the secretary to the relevant board, commission or committee for further information. The Health, Housing and Community Services Department does not take a position as to the content.

Health, Housing & Community Service Department
Mental Health Commission

Contact person: Jamie Works-Wright, Mental Health Commission Secretary (510) 981-7721 or Jworks-wright@cityofberkeley.info

Communication Access Information: This meeting is being held in a wheelchair accessible location. To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the Disability Services specialist at 981-6418 (V) or 981-6347 (TDD) at least three business days before the meeting date. ***Please refrain from wearing scented products to this meeting. Attendees at trainings are reminded that other attendees may be sensitive to various scents, whether natural or manufactured, in products and materials. Please help the City respect these needs.*** *Thank you.*

SB 343 Disclaimer

Any writings or documents provided to a majority of the Commission regarding any item on this agenda will be made available for public inspection in the SB 343 Communications Binder located at the Adult Clinic at 2640 MLK Jr. Way, Berkeley, CA 9470

Department of Health,
Housing & Community Services
Mental Health Commission

Berkeley/Albany Mental Health Commission
Drafted Minutes

10:00 am
Zoom Webinar

Regular Meeting
January 28, 2023

Members of the Public Present: Andrea Zeppa, Rosina Keren, Myra Tahir
Staff Present: Jamie Works-Wright

1) **Call to Order at 10:07am**
   Commissioners Present: Judy Appel, Margaret Fine, Monica Jones, Edward Opton, Andrea Prichett, Mary Lee Kimber-Smith, Glenn Turner **Absent:** Tommy Escarcega, Terry Taplin

2) **Preliminary Matters**
   a) **Approval of the January 28, 2023 agenda**
   M/S/C (Jones, Appel) Motion to put the Youth Subcommittee, session 3 from session 1 and it will move the Diversion Plan and Division services up.
   PASSED
   Ayes: Appel, Fine, Jones, Prichett, Kimber-Smith, Turner **Noes:** None; **Abstentions:** Opton; **Absent:** Escarcega, Taplin

   b) **Public Comment-** No Public Comments

   c) **Approval of the October 27, 2022 Minutes**
   M/S/C (Fine, Jones) Motion to adopt the minutes
   PASSED
   Ayes: Appel, Fine, Jones, Opton, Kimber-Smith, Turner **Noes:** None; **Abstentions:** Prichett; **Absent:** Escarcega, Taplin

3. **Work Plan Goal 2023 – Session 1 Discussion – 40 minutes:**
   Developing and Implementing an Overarching Diversion Plan for People Living with Serious Mental Illness and Substance Use Issues and Disorders—Reducing Enforcement and Increasing Services - Mary-Lee Kimber Smith, Andrea Pritchett, Ned Opton, Glenn Turner
   M/S/C (Kimber-Smith, Fine) Motion to pass the resolution to send to the city council within 2 weeks.
   PASSED

Ayes: Appel, Fine, Jones, Opton, Prichett, Kimber-Smith, Turner **Noes:** None; **Abstentions:** None; **Absent:** Escarcega, Taplin

4. **Work Plan Goal 2023 – Session 2 – 40 minutes:**
   Evaluating the Division of Mental Health and public mental health and substance use services and developing the relationship with the Division Manager – Andrea Pritchett, Ned Opton
   M/S/C (Prichett, Kimber-Smith) Motion to create an Evaluation Subcommittee and use the description from slides to create a plan for evaluation for needs and performance.
   PASSED
   Ayes: Appel, Fine, Jones, Opton, Prichett, Kimber-Smith, Turner **Noes:** None; **Abstentions:** None; **Absent:** Escarcega, Taplin

5. **Work Plan Goal 2023 – Session 3 – 40 Minutes:**
   Mapping Out How to Engage Youth by Welcoming Them as Stakeholders in their Mental Health Advocacy –Monica Jones, Judy Appel, Mary-Lee Kimber Smith and presenter Rosina Keren
   -No Motion Made

6. **Work Plan Goal 2023 – Session 4 – 40 minutes:**
   Building a Diverse Membership, including People with Lived Experience from Diverse Demographic and Identity Groups – Glenn Turner, Margaret Fine
   M/S/C (Fine, Turner) Motion to establish a Membership Subcommittee with Margaret Fine and Glenn Turner.
   PASSED
   Ayes: Appel, Fine, Jones, Opton, Prichett, Kimber-Smith, Turner **Noes:** None; **Abstentions:** None; **Absent:** Escarcega, Taplin

7. **Overview of Commissioners' Manual, Brown Act, Roberts' Rules – 15 minutes**
   -No motion made

8. Developing Annual Report 2022 – Session 5 – 30 minutes (to create subcommittee), Reviewing workplan 2022 and Alameda County Advisory Board Annual Report 2022
   M/S/C (Fine, Turner) Motion that the writing of the Annual Report will be tasked by the Evaluation Subcommittee.
   PASSED
   Ayes: Appel, Prichett, Kimber-Smith, Turner **Noes:** Fine; **Abstentions:** Jones, Opton; **Absent:** Escarcega, Taplin
   M/S/C (Fine, Turner) Motion to appoint Judy Appel, Andrea Prichett and Glenn Turner to the Evaluation Subcommittee.
   PASSED
   Ayes: Appel, Jones, Opton, Prichett, Turner **Noes:** None; **Abstentions:** Fine; **Absent:** Escarcega, Kimber-Smith, Taplin

*1:55pm Motion to extend meeting for 15 minutes
M/S/C (Fine, Opton)
PASSED

Ayes: Appel, Fine, Jones, Opton, Kimber-Smith, Turner **Noes:** None; **Abstentions:** Prichett (comment); **Absent:** Escarcega, Taplin

9. **Adjournment – 2:08 PM**
   M/S/C (Fine, Kimber-Smith) Motion to end the meeting
   PASSED
   Ayes: Appel, Fine, Jones, Opton, Kimber-Smith, Turner **Noes:** None; **Abstentions:** None; **Absent:** Escarcega, Prichett, Taplin

Minutes submitted by: _____
Jamie Works-Wright, Commission Secretary

Health Housing and
Community Services Department
Mental Health Division

MEMORANDUM

To: Mental Health Commission
From: Jeffrey Buell, Mental Health Division Manager
Date: 2/14/2023
Subject: Mental Health Manager Report

Mental Health Services Report

Please find the attached report on Mental Health Services for January 2023.

Information Requested by MHC

The MHC Co-Chairs have posed the following questions, and responses are provided for each:

1) How does the Division of Mental Health coordinate with the police related to 5150s? During the April 2022 presentation before the Mental Health Commission, the police indicated that they have approximately 90 5150s per month.
    a. There are multiple ways that the Mental Health Division may coordinate with law enforcement for 5150 evaluations. One common scenario may be when a call for service is made to 911-Dispatch, and a determination is made either by the dispatcher or by the 1st responders on scene that a 5150 evaluation may be appropriate. Dispatch will know whether the MCT unit is available and will dispatch them to the call if available or requested by 1st responders. When MCT is on the scene, law enforcement is tasked with maintaining safety of the environment and operational decisions are left to the mental health unit, which may result in a 5150 evaluation and/or transport, a referral to a CSU, linkage to community resources, crisis counseling, etc. Another common scenario occurs when a 5150 evaluation is needed at a site where there is already a trained, licensed Berkeley Mental Health staff person (Mental Health Clinic, High School Health Center, Clinician on a home visit, etc). The clinician may assess and determine that law enforcement is or is not necessary to maintain safety or appropriate service, and may contact 911-Dispatch to arrange for 5150 transportation after they have determined that an involuntary detention is necessary. With regards to 5150 evaluations performed by MCT every

2180 Milvia Street, 2nd Floor, Berkeley, CA 94704 Tel: 510. 981.5100 TDD: 510.981.6903 Fax: 510. 981.5450
E-mail: housing@ci.berkeley.ca.us - http://www.cityofberkeley.info/housing/

month, the number fluctuates depending on the availability of staffing. In the past five years, monthly averages typically range between 15-50 evaluations per month, where 50 evaluations per month is typical for a fully staffed MCT in Berkeley.

2) How does the Division of Mental Health collaborate with police specifically for people who frequently interact with the police related serious mental illness and substance use issues?
    a. Any scenario that involves safety could involve law enforcement personnel, including but not limited to crisis calls, treatment services in the community or clinic setting, or even phone/telehealth calls. Serious mental illness and substance use issues must be considered, and safety is of course a primary concern. Staff will attempt to de-escalate a situation verbally whenever possible. If a resident or client indicates or demonstrates unsafe behavior, staff would use their clinical judgement as to whether or not the introduction of law enforcement to the situation will provide for more or less safety. The staff contacting emergency dispatch should describe the scenario and the help that is needed when they determine that law enforcement is necessary. In an ideal scenario, the staff are able to brief the dispatched police officers when they arrive at a scene and consult/plan for the next best steps to keep everyone safe and supported. The least restrictive interventions required are the goal of any supportive intervention, and especially when safety is involved. Whenever possible, we prefer the mental health staff to take the lead in such interventions, whether it be clinic or Mobile Crisis staff, to provide for as many diversion opportunities as possible. Mental Health staff will continue to follow up with clients after the intervention, seeking to bridge care and treatment as best as possible. For residents who are not engaged in long term treatment, we do have a Transitional Outreach Team that can seek to follow up and link amenable residents to longer term services after the crisis contact. 911-Dispatch is currently the link needed to facilitate 5150 ambulance transport for Alameda County residents.

3) How does the Division of Mental Health use crisis stabilization services such as Amber House and Cherry Hill for detox and withdrawal management (or other services) to support clients? How frequently does the Division use these services for referring clients?
    a. Crisis and Treatment teams use CSU and SUD services are standard intervention resources offered to clients served by Berkeley Mental Health. The resources are referred to clients on an as needed bases to provide support, depending on the need and the choice of the clients. Clients maintain their rights to self-determination and ability to opt in to services (unless they are involuntarily detained for further 5150 evaluation at a receiving facility). It is difficult to determine Division usage/referral of these services, as there is not a direct mechanism in place to track when these specific services are discussed, offered, referred, or accepted.

4) What are the processes, protocols, procedures for the Division of Mental Health to assist people with serious mental illness and/or substance use issues and disorders that reside in encampments during abatement evictions?
    a. The homeless and encampment outreach function that was previously held by Berkeley Mental Health was transferred to the City Manager's office under the auspices of Neighborhood Services. Since BMH no longer has an official outreach capacity or staffing, there is limited ability to work with members of an encampment unless they have already opted in to mental health treatment services. In cases where residents have opted in to treatment services already, their treatment teams will continue to provide referrals, clinical case management, linkages to partner agencies, and general resources to support their mental illness and/or SUD needs, even in the face of encampment abatement evictions. It's been our experience that Neighborhood Services staff (which includes former BMH HOTT staff) will provide engagement and outreach opportunities to these locations in order to connect residents with services, and extra services tend to be provided before any abatement actions are taken.

5) Who are the key providers that the Division of Mental Health has partnerships for services, referrals, and linkages in Berkeley and Alameda County? Please kindly further describe how the Division uses the continuum of care for clients who may need resources only available in the county.
    a. There are many providers with whom the Mental Health Division partner for services, referrals, and linkages. These include but are not limited to partners such as Alameda County Behavioral Health Care Services, Alameda County ACCESS, Alameda County Healthcare for the Homeless, BACS, Bonita House, Dorothy Day House, Amber House, Berkeley Drop-in Center, Berkeley Food and Housing, Women's Daytime Drop-in Center, Pacific Center for Human Growth, Lifelong Medical, Homeless Action Center, Berkeley Free Clinic, East Bay Community Law Center, UC Berkeley, City of Berkeley HHCS Divisions (Aging, Environmental Health, Office of the Director, Public Health), and others. When any person is seeking mental health services, our intake or crisis teams will gather as much information as possible about the resident's situation and needs. This may include discussion with the person, review of the records they want to release, or support from collateral resources like family. The staff will review the available options according to the person's current eligibility, and if amenable, the staff will link them to the desired resources. If those resources are only available through the County, then the staff can offer to help with a warm hand-off if desired. Some services, such as mild-moderate mental health, are provided only by the county, and must go through the County's ACCESS program. City staff can help the person contact and go through their intake process to assist their connection.

6) What is the current update on implementation and training of the Community Health Records for the Division of Mental Health staff? Are you currently able to run utilization reports?
    a. Staff are currently going through the self-paced online training for the Community Health Records for which they have 30 days to complete. Staff will then receive post training support sessions to walk through how to use the tool in their-day to-day work. We are not able to run utilization reports yet.

Mental Health Division Updates

The Mental Health Division has several areas of updates at this time:

A) The Division is going through a structural reorganization of several of its teams to right-size the workload and better offer support for future expansion. In broad strokes, two new programs will be created to align and synergize the treatment services being provided to the public: the FSP Services Program will align the two adult full-service partnership teams, and High School Mental Health Program will oversee and broaden the offerings available to the current High School Health Center.
B) The Mental Health Division has had 6 (of the 22 in its gas-powered fleet) vehicles disabled by catalytic converter thieves in the span of two weeks. Due to the worldwide supply chain issues, sourcing parts alone to repair these vehicles will take up to 6 months. Other jurisdictions, like San Francisco, have also had similar decimation of their municipal fleets. We've made it an emergency priority to find protected parking spaces where the remaining fleet can be secured, which has resulted in a significant proportion of staff hour being reapportioned to moving vehicles between various secured parking sites and the mental health clinic.
C) The Division's engagement with the Community Health Record is at its 30-day training phase. After IT connects all staff with the online training, it will be completed within 30 days. Technical assistance will be available to staff as they integrate the use of the Community Health Record into their everyday use and work with client care.
D) Results Based Accountability: The final RBA dashboards have been completed by RDA. Initial baseline data has been gathered and RDA is in process of gathering and plugging data in to move the project forward. The Division is taking next steps to hire a permanent Mental Health Division staff person to continue gathering and posting this data into the dashboard system going forward. These data will continue to be collected and utilized for purposes of decision making and services adjustments.

Berkeley Mental Health Caseload Statistics for January 2023

Adult Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Previous 12 Months	Fiscal Year 2023 (July '22-June '23) Demographics as of January 2023
Adult, Older Adult and TAY Full Service Partnership (AFSP) (Highest level outpatient clinical case management and treatment)	1-10 for clinical staff.	4.5 Clinicians, 1 Clinical Supervisor	62	$8,555	Clients: 59 API: 1 Black or African-American: 32 Hispanic or Latino: 1 White: 25 American Indian: 0 Other/Unknown: 0 Male: 32 Female: 25 Missing Gender ID: 1 Prefer Not to Answer Gen ID: 1 Multiple Gender ID: 0 Heterosexual: 46 Missing Sex Orient: 5 Bisexual: 2 Prefer Not to Answer Sex Orient: 3 Multiple Sex Orient: 2 Gay: 1 Lesbian: 0
Adult FSP Psychiatry (January Stats)	1-100	.5 FTE	48		
AFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)				$2,037,600	
Homeless Full-Service Partnership (HFSP) (Highest level outpatient clinical case management and treatment)	1-8 for clinical staff	3.5 Clinicians, 0 Clinical Supervisor	36	$7,052	Clients: 38 API: 2 Black or African-American: 22 Hispanic or Latino: 1 Other/Unknown: 0 White: 13 Male: 26 Female: 10 Missing Gender ID: 2 Prefer No to Answer: 0

					Multiple Gender Identities: 0 Heterosexual: 29 Missing Sex Orient: 4 Bisexual: 4 Gay: 1 Multiple Sex Orient: 0 Prefer Not to Answer: 0 Lesbian: 0
HFPS Psychiatry (January Stats)	1-100	.0 FTE	22		
HFSP FY22 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			TBD		
Comprehensive Community Treatment (CCT) **(High level outpatient clinical case management and treatment)**	1-20	5 Clinicians 1 Team Lead 1 Clinical Supervisor	154	$2,648	Clients: 167 American Indian: 3 API: 16 Black or African-American: 66 Hispanic or Latino: 5 Other/Unknown: 3 White: 74 Male: 84 Female: 78 Multiple Gender Identities: 2 Missing Gender ID: 1 Non-Conforming Gender ID: 1 Queer: 1 Prefer Not to Answer Gender ID: 0 Female to Male: 0 Other Gender ID: 0 Queer Gender ID: 0 Heterosexual Sex Orient: 130 Missing Sexual Orient: 18 Bisexual Sex Orient: 4 Lesbian Sex Orient: 5 Gay Sex Orient: 4 Prefer Not to Answer Sex Orient: 2 Multiple Sexual Orient: 1 Queer Sexual Orient: 2 Other Sexual Orient: 1

Berkeley Mental Health Caseload Statistics for January 2023

CCT Psychiatry (January Stats)	1-200	0.75 FTE	122		
CCT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$2,617,010		
Focus on Independence Team (FIT) (Lower level of care, only for individuals previously on FSP or CCT)	1-20 Team Lead, 1-50 Post Masters Clinical 1-30 Non-Degreed Clinical	1 Licensed Clinician 1 CHW Sp./ Non-Degreed Clinical, 0 Clinical Supervisor	88	$1,291	Clients: 90 API: 7 Black or African American: 33 Hispanic or Latino: 4 Other/Unknown: 0 White: 46 Male: 52 Female: 36 Intersex: 1 Missing Gender ID: 1 Other Gender ID: 0 Heterosexual: 78 Missing Sexual Orient: 7 Prefer Not to Answer Sexual Orient: 3 Gay: 1 Multiple Sexual Orient: 1 Questioning: 0
FIT Psychiatry (January Stats)	1-200	.25	81		
FIT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$900,451		

Family, Youth and Children's Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Last 12 months	Fiscal Year 2023 (July '22-June '23) Demographics as of January 2023
Children's Full-Service Partnership (CFSP)	1-8	1 Senior Behavioral Health Clinician, 1 Clinician	9	$5,942	Clients: 10 American Indian: 0 API: 0 Black or African-American: 4 Hispanic or Latino: 6 Other/Unknown: 0 White: 0 Female: 4 Male: 4 Missing Gender ID: 2 Non-Conforming Gender ID: 0 Heterosexual: 6 Missing Sexual Orient: 4 Gay: 0 Other Sexual Orient: 0 Questioning Sexual Orient: 0
CFSP Psychiatry (January Stats)	1-100	0	1		
CFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$489,235		
Early and Periodic Screening, Diagnostic and Treatment Prevention (EPSDT) /Educationally Related Mental Health Services (ERMHS)	1-20	1.5 Clinicians, 1 Clinical Supervisor	44	$2,189	Clients: 56 American Indian: 6 API: 3 Black or African-American: 20 Hispanic or Latino: 12 Other/Unknown: 1 White: 14 Female: 22 Male: 20 Missing Gender ID: 9 Multiple Gender ID: 4 Non-Conforming Gender ID: 1 Female to Male: 0 Other Gender ID: 0 Heterosexual: 23

					Missing Sexual Orient: 23 Gay: 4 Multiple Sexual Orient: 3 Bisexual: 2 Prefer Not to Answer: 1 Other Sexual Orient: 0 Queer Sexual Orient: 0 Questioning Sexual Orient: 0
ERMHS/EPSDT Psychiatry (January Stats)	1-100	0	10		
EPSDT/ERMHS FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$1,062,409		
High School Health Center and Berkeley Technological Academy (HSHC)	1-6 Clinician (majority of time spent on crisis counseling)	3.5 Clinicians, 1 Clinical Supervisor	Drop-in: 22 Externally referred: 33 Ongoing tx:55 Groups: 7 Offered/ 7 Conducted		N/A
HSHC FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$396,106		

Crisis and ACCESS Services	Staff Ratio	Clinical Staff Positions Filled	Total # of Clients/Incidents	MCT Incidents Detail	Calendar Year 2022 (Jan '22- Dec '22) Demographics – From Mobile Crisis Incident Log (through January 2023)
Mobile Crisis (MCT)	N/A	2 Clinicians filled at this time	• 90 - Incidents • 17- 5150 Evals • 5 - 5150 Evals leading to involuntary transport	• 66 - Incidents: Location - Phone • 22 - Incidents: Location - Field • 1 - Incidents: Location - Home	Clients: 66 API: 2 Black or African-American: 11 White: 24 Hispanic or Latino: 1 Other/Unknown: 28 Female: 26 Male: 35 Transgender: 0 Unknown: 5
MCT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$771,623		
Transitional Outreach Team (TOT)	N/A	.5 Licensed Clinician, (TOT and CAT have been recently merged)	• 12 – Incident(s)	N/A	Clients: 6 API: 0 Black or African-American: 1 White: 4 Hispanic or Latino: 0 Other/Unknown: 1 Female: 4 Male: 1 Transgender: 0 Unknown: 1
TOT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$272,323		
Community Assessment Team (CAT)	N/A	3 Non-Licensed Clinicians, .5 Licensed Clinician, 0 Clinical Supervisor	• 109 - Incidents	N/A	Clients: 68 API: 1 Black or African-American: 10 White: 18 Hispanic or Latino: 2 Other/Unknown: 37 Female: 27 Male: 31 Transgender: 1 Unknown: 9

CAT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)	$735,075

Not reflected in above chart is Early Childhood Consultation, Wellness and Recovery Programming, or Family Support.
In demographics, other/unknown is used both when a client indicates that they are multi-racial and when demographic info is not known.

*Average System Costs come from Yellowfin, and per ACBH include all costs to mental health programs, sub-acute residential programs, hospitals, and jail mental health costs.

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, February 15, 2023 9:33 AM
To: Works-Wright, Jamie
Subject: FW: Health and Safety Protocols for In-Person Commission Meetings
Attachments: Health and Safety Protocols for Commissions Feb 2023.pdf; covid-symptoms-english commissions.pdf; Voluntary Sign-In Sheet.docx; Do not move chairs.docx; Masks encouraged.docx

Hello Commissioners,

Please see the information attached and below about in place commission meetings. We have not secured a location at this time but I am still waiting to hear back from parks.

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Numainville, Mark L.
Sent: Tuesday, February 14, 2023 5:03 PM
To: Aguilar, Hansel <HAguilar@cityofberkeley.info>; Allen, Shallon L. <SLAllen@cityofberkeley.info>; Amnah, Hilary <HAmnah@cityofberkeley.info>; Beasley, Melanie E. <MEBeasley@cityofberkeley.info>; Bellow, LaTanya <LBellow@cityofberkeley.info>; Bondi, James <JBondi@cityofberkeley.info>; Brozyna, Andrew <ABrozyna@cityofberkeley.info>; Bryant, Ginsi <GBryant@cityofberkeley.info>; Budnick, Noah <NBudnick@cityofberkeley.info>; Burns, Anne M <ABurns@cityofberkeley.info>; Campos, Guillermo <GCampos@cityofberkeley.info>; Cash, Anna <ACash@cityofberkeley.info>; Castrillon, Richard <rcastrillon@cityofberkeley.info>; Chin, Khin <KChin@cityofberkeley.info>; Cole, Shamika S. <SSCole@cityofberkeley.info>; Covello, Zoe <ZCovello@cityofberkeley.info>; Crane, Fatema <FCrane@cityofberkeley.info>; Dougherty, Desiree <ddougherty@cityofberkeley.info>; Enke, Joe <jenke@cityofberkeley.info>; Ernst, Margot <MErnst@cityofberkeley.info>; Franklin, Eve <EFranklin@cityofberkeley.info>; Garcia, Claudia <CGarcia@cityofberkeley.info>; Garvey, Brian <BGarvey@cityofberkeley.info>; Graham, Felicia <FGraham@cityofberkeley.info>; Harvey, Samuel <SHarvey@cityofberkeley.info>; Heath, Julia <JHeath@cityofberkeley.info>; Hernandez-Gonzalez, Karen <KHernandez-Gonzalez@cityofberkeley.info>; Hollander, Eleanor <EHollander@cityofberkeley.info>; Jacobs, Joshua <JJacobs@cityofberkeley.info>; James, Ashley <AJames@cityofberkeley.info>; Javandel, Farid

<FJavandel@cityofberkeley.info>; Katz, Mary-Claire <MKatz@cityofberkeley.info>; Kouyoumdjian, Aram <AKouyoumdjian@cityofberkeley.info>; Lopes, Bernadette <Blopes@cityofberkeley.info>; Lovvorn, Jennifer <JLovvorn@cityofberkeley.info>; Mariscal, Cecelia <CMariscal@cityofberkeley.info>; Martinez, Maritza <MMartinez@cityofberkeley.info>; May, Keith <KMay@cityofberkeley.info>; Mayer, Tess <tmayer@cityofberkeley.info>; Miller, Roger <RMiller@cityofberkeley.info>; Milliken, Rebecca <RMilliken@cityofberkeley.info>; Moore, Sarah M. <SMoore@cityofberkeley.info>; Murillo, Jose <JMurillo@cityofberkeley.info>; Obermeit, Heidi <hobermeit@cityofberkeley.info>; Oehler, Joshua <JOehler@cityofberkeley.info>; Pearson, Alene <apearson@cityofberkeley.info>; Radu, Peter <pradu@cityofberkeley.info>; Riemer, Allison <ARiemer@cityofberkeley.info>; Romain, Billi <BRomain@cityofberkeley.info>; Slaughter, Kieron <kslaughter@cityofberkeley.info>; Taleporos, Zoe <ZTaleporos@cityofberkeley.info>; Terrones, Roberto <RTerrones@cityofberkeley.info>; Uberti, Mike <MUberti@cityofberkeley.info>; Updegrave, Samantha <SUpdegrave@cityofberkeley.info>; Vance-Dozier, Okeya <OVance-Dozier@cityofberkeley.info>; Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>; Wu, Grace <GWu@cityofberkeley.info>
Subject: Health and Safety Protocols for In-Person Commission Meetings

Internal

Commission Secretaries,

Attached are the health and safety protocols for in-person meetings of City commissions. These protocols were developed in coordination with the Public Health Officer, the City Attorney's Office, and the City Manager's Office. They are not subject to modification by the commission.

Please share these protocols with your commissioners prior to your March in-person meeting.

In addition, please see the guidance below for secretaries. Sample signage is attached.

Room Set Up and Signage Recommendations for Commission Secretaries

Room Entry
- Hand Sanitizer at entry point
- Extra masks for the public
- VOLUNTARY sign-in sheet

Signs
- If You Are Feeling Sick…
- Masks Encouraged
- Room Capacity
- Please Do Not Move Chairs

Resources for Masking Information
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Get-the-Most-out-of-Masking.aspx
https://www.cdph.ca.gov/Programs/OPA/Pages/Communications-Toolkits/Mask-Up.aspx

Mark Numainville, City Clerk
City of Berkeley
2180 Milvia Street, 1st Floor
Berkeley, CA 94704
(510) 981-6909 direct
mnumainville@cityofberkeley.info

Health and Safety Protocols for In-Person Meetings of Berkeley Boards and Commissions
February 2023

The policy below applies to in-person meetings of Berkeley Boards and Commissioners held in accordance with the Government Code (Brown Act) after the end of the State-declared emergency on February 28, 2023.

I. Vaccination Status

All attendees are encouraged to be fully up to date on their vaccinations, including any boosters for which they are eligible.

II. Health Status Precautions

For members of the public who are feeling sick, including but not limited to cough, shortness of breath or difficulty breathing, fever or chills, muscle or body aches, vomiting or diarrhea, or new loss of taste or smell, it is recommended that they do not attend the meeting in-person as a public health precaution. In these cases, the public may submit comments in writing in lieu of attending in-person.

If an in-person attendee has been in close contact, as defined below, with a person who has tested positive for COVID-19 in the past five days, they are advised to wear a well-fitting mask (N95s, KN95s, KF94s are best), test for COVID-19 3-5 days from last exposure, and consider submitting comments in writing in lieu of attending in-person.

Close contact is defined as someone sharing the same indoor airspace, e.g., home, clinic waiting room, airplane, etc., for a cumulative total of 15 minutes or more over a 24-hour period within 2 days before symptoms of the infected person appear (or before a positive test for asymptomatic individuals); or having contact with COVID-19 droplets (e.g., being coughed on while not wearing recommended personal protective equipment).

A voluntary sign-in sheet will be available at the meeting entry for in-person attendees. This will assist with contact tracing in case of COVID-19 contact resulting from the meeting.

Members of City Commissions are encouraged to take a rapid COVID-19 test on the day of the meeting.

III. Face Coverings/Mask

Face coverings or masks that cover both the nose and mouth are encouraged for all commissioners, staff, and attendees at an in-person City Commission meeting. Face coverings will be provided by the City and available for attendees to use at the meeting. Members of Commissions, city staff, and the public are encouraged to wear a mask at all times, except when speaking publicly from the dais or at the public comment podium, although masking is encouraged even when speaking.

Health and Safety Protocols for In-Person Meetings of Berkeley Boards and Commissions
February 2023

IV. Physical Distancing

Currently, there are no physical distancing requirements in place by the State of California or the Local Health Officer for an indoor event similar to a Commission meeting.

Audience seating capacity will be at regular allowable levels per the Fire Code. Capacity limits will be posted at the meeting location. However, all attendees are requested to be respectful of the personal space of other attendees. An area of the public seating area will be designated as “distanced seating” to accommodate persons that need to distance for personal health reasons.

Distancing will be implemented for the dais as space allows.

V. Protocols for Teleconference Participation by Commissioners

Upon the repeal of the state-declared emergency, all standard Brown Act requirements will be in effect for Commissioners participating remotely due to an approved ADA accommodation. For Commissioners participating remotely, the agenda must be posted at the remote location, the remote location must be accessible to the public, and the public must be able to participate and give public comment from the remote location.

- A Commissioner at a remote location will follow the same health and safety protocols as in-person meetings.
- A Commissioner at a remote location may impose reasonable capacity limits at their location.

VI. Hand Washing/Sanitizing

Hand sanitizing stations are available at the meeting locations. The bathrooms have soap and water for handwashing.

VII. Air Flow/Circulation/Sanitizing

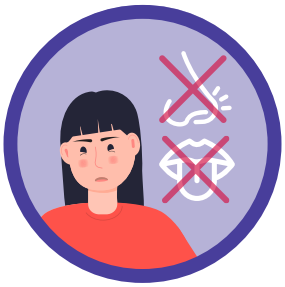
Air filtration devices are used at all meeting locations. Window ventilation may be used if weather conditions allow.

CHECK COVID-19 SYMPTOMS

Cough

Fever or Chills

Lost of taste or smell



Congestion

Body aches

Shortness of breath

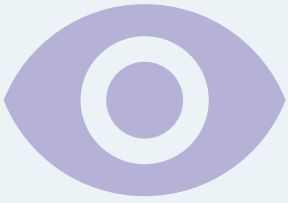
Sore throat

Vomiting or Diarrhea

HAVE SYMPTOMS? IT IS RECOMMENDED THAT YOU

1) Stay Home

2) Monitor Symptoms



3) Get tested

SYMPTOMS CAN APPEAR 2-14 DAYS FROM EXPOSURE

CITY OF BERKELEY

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Tuesday, February 14, 2023 2:37 PM
To: Works-Wright, Jamie
Subject: FW: Important Notes: Remote Requirements & Allowances (Suggested Agenda Text) for local Boards/Commissions

Please see the information below about remote and in person meetings

Thank you for your time.

Jamie Works-Wright
Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
2640 MLK Jr. Way
Berkeley, CA 94704
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: CAL BHBC <cal@calbhbc.com>
Sent: Tuesday, February 14, 2023 1:48 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Important Notes: Remote Requirements & Allowances (Suggested Agenda Text) for local Boards/Commissions

Since Brown Act public emergency allowances related to COVID-19 end in California on February 28th, teleconferencing allowances (related to posting members' physical locations on agendas) also end.

Please note the following requirements and allowances.

I. Teleconference Requirements (when there are no public emergency or other allowances)

1. Agendas must be posted at all teleconference physical locations
2. Each teleconference location must be listed on the meeting notice and agenda
3. Each teleconference location must be accessible to the public, allowing for public comment.
4. Quorum within county: At least a quorum of the members must participate from locations within the county (or jurisdiction)
5. Votes by Roll Call: All votes must be by roll call

6. Allowances have additional requirements (see below)

II. Allowances related to "Just Cause" or "Member Emergency"

Suggested Agenda & Agenda Addendum Text:

At the beginning of the agenda:
[Name of Board/Commission] may take action at the beginning of the meeting regarding requests for "Just Cause" or "Emergency" allowances provided that related Brown Act guidelines are met. (Guidelines are listed on the last page of this agenda.)

At the end of the agenda:
Brown Act "Just Cause" or "Member Emergency" Allowance Guidelines:

Requirements: A local board/commission member may participate remotely without posting their physical location on the agenda if all of the following requirements are met:

1. Quorum at Physical Location - At least a quorum of the members of the board/commission participate in person from a singular physical location clearly identified in the agenda.
2. Public Access - (Both Remote and In-Person) The public may access the meeting through:

    - A two-way audiovisual platform or
    - A two-way telephonic service and a live webcasting of the meeting
    - In-Person Public Access to the physical location.

Circumstances: One of the following circumstances applies:

1. "**Just Cause**" - The member notifies the legislative body at the earliest opportunity possible, including at the start of a regular meeting, of their need to participate remotely for just cause, including a general description of the circumstances relating to their need to appear remotely at the given meeting. The provisions of this clause shall not be used by any member of the legislative body for more than two meetings per calendar year. **or**
2. "**Emergency Circumstances**" - The member requests to participate in the meeting remotely due to emergency circumstances and the board/commission takes action to approve the request. The board/commission shall request a general description of the circumstances relating to the member's need to appear remotely at the given meeting. A general description of an item generally need not exceed 20 words and shall not require the member to disclose any medical diagnosis or disability, or any personal medical information.

Procedures:

1. Member Request - A member shall make a request to participate remotely at a meeting pursuant to this clause as soon as possible. The member shall make a separate request for each meeting in which they seek to participate remotely.
2. Board/Commission Response - The board/commission may take action on a request to participate remotely at the earliest opportunity. If the request does not allow sufficient time to place proposed action on such a request on the posted agenda for the meeting for which the request is made, the legislative body may take action at the beginning of the meeting.
3. Disclosure - The member shall publicly disclose at the meeting before any action is taken, whether any other individuals 18 years of age or older are present in the room at the remote location with the member, and the general nature of the member's relationship with any such individuals.
4. BOTH Audio & Visual Participation - The member shall participate through both audio and visual technology.

5. Limits to Remote Participation - The provisions of this subdivision [of the Brown Act] shall not serve as a means for any member of a legislative body to participate in meetings of the legislative body solely by teleconference from a remote location for a period of more than three consecutive months or 20 percent of the regular meetings for the local agency within a calendar year, or more than two meetings if the legislative body regularly meets fewer than 10 times per calendar year.

DEFINITIONS:

"**Emergency circumstances**": A physical or family medical emergency that prevents a member from attending in person.

"**Just cause**" means any of the following:

1.
2.
3. A childcare or caregiving need of a child, parent, grandparent, grandchild, sibling, spouse, or domestic
4. partner that requires them to participate remotely.
5.
6.
7.
8. A contagious illness that prevents a member from attending in person.
9.
10.
11.
12. A need related to a physical or mental disability.
13.
14.
15.
16. Travel while on official business of the legislative body or another state or local agency.
17.

.

For additional information, see pages 4+ of the Brown Act Guide: calbhbc.org/brown-act

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Tuesday, February 14, 2023 12:38 PM
To: Works-Wright, Jamie
Subject: FW: [Shared Post] The Bitter Cycle of Schizophrenia

Internal

Hello Commissioner

Please see the message below and the article

Thank you for your time.

Jamie Works-Wright
Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
2640 MLK Jr. Way
Berkeley, CA 94704
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: Edward Opton <eopton1@gmail.com>
Sent: Monday, February 13, 2023 8:54 AM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: [Shared Post] The Bitter Cycle of Schizophrenia

https://www.independent.com/2021/05/22/the-bitter-cycle-of-schizophrenia/

2.13.23

Can we distribute above article to MHC?

Ned

The Bitter Cycle of Schizophrenia

Meds, No Meds; Housing, No Housing; Homeless, Arrested

Credit: WikiCommons

By **Deborah McCoy**

Sat May 22, 2021 | 8:37am

The worst part of schizophrenia is the cyclic events that interrupt my daughter's life. In turn, those events interrupt my life. It's like going to a movie and watching it repeatedly. Here's the plot: no beds available for the dually diagnosed. Go to short-term locked unit. Get on meds, different regime each time, calm the voices in her head, better able to concentrate, put out on the street, no follow-up care, and written prescription she needs to fill to take meds. Not taking meds, is homeless, starts drinking, smoking meth and

pot, behavior gets her noticed, police get called, resists arrest, goes to jail. She takes meds while in jail, is restored to sanity, serves her sentence (refuses probation), out to the streets with an appointment 2-3 weeks later, written prescription, doesn't fill it. Smoking meth and pot, drinking alcohol. Usually returns to jail within 3-6 months.

The End

The credits roll:

State of California under Governor Ronald Reagan and all the remaining states under President Ronald Reagan: responsible for closing mental health hospitals releasing thousands, then millions of very sick individuals into the street, incapable of working, or maintaining a household, instantly becoming homeless.

City of Santa Barbara: always making homeless move along, even when they are sleeping. Message: we don't want you here — even though she's been here since 1994 at age 3, attended school, graduated from San Marcos, and considers it home.

County and city officials: pulling their hair out in frustration, but writes new grants to help homeless and uses $$ to support admin activities to study issues, when the ultimate solution for homelessness is housing.

NIMBYs: shoot down every low-income housing project proposed by City Housing Authority. Giving someone a home is the ONLY cure for homelessness.

City Housing Authority: pulling out their hair, for same reasons as above.

City Council: wants a final solution, but $$ is a problem. Yawn!

County of Santa Barbara: released her from conservatorship, knowing her history repeats itself, catching her in the revolving door: streets, hospital or jail, back to the streets without coordination or follow up. BeWell invested many thousands of dollars on her for five years of care in an IMD (institution for mental disease). Their investment was at least a break from drug use while her brain finished its development. Without follow up or a source of enforcement about taking meds, she won't take them because her anosognosia always pushes her to believe she is well. With my tutelage, since I am a nurse, she was taught from an early age that "you don't need medication unless you're sick," which only reinforces what her anosognosia informs her about her decision to go medication free.

Her parents, whose educations as a nurse and criminal defense attorney failed them. When their daughter had a severe psychotic break at 17, it was recommended she be hospitalized, but we said no. We didn't understand we would lose control of her healthcare at 18, the onset of psychosis often occurs during late adolescence, and the longer her psychosis went untreated the less chance of recovery. We gave in to our fears she'd be labeled, decreasing her insurability, and no chances for med school or

her career goal to be a neonatologist. But only now do we understand what a watershed moment that was and how large of a loss that opportunity for a possible cure it was.

February 5, 2021

Recently I spent a day with my daughter after she was released from jail. In our discussions, I asked her about being back on meds. Here are the highlights of what she said:

“Why should I take meds? First, I’m not sick so I shouldn’t have to take their poisons (anosognosia). Each time I go see a doctor, each has their favorite drugs, so I’ve tried them all and they don’t work except to give me side effects. Some of them make me gain tons of weight, pee blood, and they don’t work. I don’t see the same doc, because they’re always leaving BeWell, and I have to start all over. I’ve had every diagnosis in the DSM IV because they do their own assessments and come up with different opinions. Psychiatry is a bunch of hocus-pocus, and I don’t want to be their guinea pig anymore.

“Nothing in my life has a chance of changing until I have my own place. Every day I work to get food after my money runs out, and figure out where to sleep so I don’t get awakened by some cop who says, ‘Move along!’ Sometimes I’m so sleep deprived, I can hardly stay awake, or walk somewhere to get food. How would the cops and city and county officials like being awakened every night 3-4 times a night? They say they care, but what have they done for me? Nothing, especially since they stopped feeding people, and prevent others from feeding people. They just pass rules about illegal camping. Just where am I supposed to go? Give me a home and I’ll stay there! This city is where I grew up, and I don’t want to go anywhere else. I don’t know anywhere else!

“Going to jail is a pain, but at least they feed me (it is so disgusting!). It is dry and warm and I can shower, sleep in a bed. They won’t let me use my ATM card to put money on my books to get canteen to get other foods. (That should be a crime right there!) We’re locked up and have to eat what they serve. We are at the mercy of the guards, some who are intentionally and unnecessarily mean. There’s no way to complain about how they treat us, no complaint forms available. If someone complains, the guards are even meaner than before. And they throw out complaints when someone does fill out a form.

“They steal my belongings and money when I’m there (jail). Or they just left it all where I was when they arrested me. So there goes my ID, my ATM card, and whatever money I had. When I get out, I can’t access my bank account to get a new ATM card because I don’t have an ID. And I can’t get an ID because I don’t have $25 to pay for it. And because I don’t have my birth certificate, DMV won’t give me an ID. And the bank and DMV want an address to mail them to me! What am I supposed to say then? They won’t send it to general delivery at the post office, either, fearing they’ll get stolen. And I can’t get a PO box because I have no ID and no money. Once when I was in jail, they closed my P0 Box for lack of payment, even though I had money in my account to pay it. If I try to make a complaint about getting my stuff back after I get out of jail, who is going to be

believed — me or some cop? How can I prove how much money I have, or that they stole my stuff like when they stole my Coach shoes and my UGG boots? I just hate cops!

“Each time I go to a sober-living house, they are mad if I can’t sleep and stay up, or make noise. The rules are different every day, depending on which staff you’re talking to. Addicts trying to fix addicts — what a joke!

“When I meet new mental health ‘professionals’ I get treated like I’m an idiot or a child who needs a mother. I have a mother, thank you! This most recent visit included a guy who talked down to me. I may be bat-shit crazy, but I’m not STUPID!”

February 19, 2021

She’s in jail again. This time, she tried stealing a car — a felony. She still has the charges from her CVS adventure — another felony — when she was brandishing a knife at police who shot her four times with beanbags back in spring of 2020 — yea, it made the news, and the *Independent*. Photos on Channel 3 News’ coverage depict an officer, back to the camera, holding her backpack. (She still doesn’t have her backpack back from SBPD, and claims it contains $800. She says that money won’t be there when she gets it back! I tend to believe her because she doesn’t lie about things like that and addicts keep track of their supply and monies to obtain more.)

Her third charge is possession of meth and paraphernalia. I’m told she could go to prison with this trio! Yea, that’ll help (sarcasm dripping) making her more mentally ill, more institutionalized, loss of more autonomy eventually robbing her of any chance to live independently in our community.

I know, however, how deadly that CVS event might have been. It was as little as 10 years ago, Santa Barbara police shot and killed a schizophrenic young man, wielding a table knife on the Westside. He was across the street from the officers, yet they felt their lives were mortally threatened. Like hell, but it was a justifiable shoot. I bet his family doesn’t think so. Thanks to the greater S.B. community, who rose up in protest, the use of fatal force is more judiciously utilized.

Like my daughter, he probably was paranoid, believing someone, real or imagined, was intent on harming him. Like my daughter, he was a patient at ADMHS (Alcohol, Drug, and Mental Health Services) and he went off his meds, getting no follow up.

Once I saw a knife in my daughter’s backpack. In response to my questions, my daughter said, “Mom, it’s not the safest place to be by yourself, homeless on the streets, especially for a woman. I carry a knife for my own protection. It’s why so many people who live in the streets have dogs.”

I’ll be in court during her appearance in front of the same judge who originally sent her to Patton State Forensic Hospital in 2014. After a six-month stay, she was the daughter

I remembered, the one I raised. The one who could make me laugh wholeheartedly, loved family fully and unselfishly, was very logical in her thinking while apologetic about worrying me, always concerned about others. I pray for a repeat outcome this time.

How does this affect me? My sense of humor turns very dark, and sarcasm is the theme of thoughts and words. I try to not think about it, but that's usually only possible when I am at work or asleep. I don't work 24/7, nor do I want to. I sleep more than usual. As I write this, my mouth is dry, my eyes filled with not-yet-shed tears, my shoulders and neck are killing me where I stash all my stress, my fears for her are a ball heavy in the bottom of my stomach, but I'm hungry and nauseous. My heart is broken while feeling rubbed raw like road rash. That's ironic because we've been here at this intersection so many times since she was 17. These ensuing years, repeated cycles of the revolving door, have caused my heart a deepening abrasion that is as deep as any 3rd degree burn. She'll be 30 this September.

You'd think I would have better coping skills by now, just through practice, but how does any parent ever forget about their suffering, cancerous child? I almost wish she had cancer instead of schizophrenia. I could talk about it more freely. Cancer research goes on daily, often with life-changing results and cures. Social norms surround cancer fundraising, walks for a cure, and supportive services for families.

None of these are around schizophrenia for affected individuals and families. When I mention she lives with mental illness, I often get weird looks which seem to ask me what I did wrong as her parent?

"Please, Lord, help us!" I pray every moment of my days.

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Friday, February 10, 2023 9:17 AM
To: Works-Wright, Jamie
Subject: FW: Children and Youth Behavioral Health Initiative (CYBHI) Grant Funding Available
Attachments: DHCS-CYBHI-EBP-CDEP-Round-2-Request-for-Applications.pdf; DHCS-CYBHI-EBP-CDEP-Grant-Strategy-Overview-December-2022.pdf

Hello Commissioners,

Please see the information below from Edward Opton

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Edward Opton <eopton1@gmail.com>
Sent: Thursday, February 9, 2023 9:10 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Fwd: Children and Youth Behavioral Health Initiative (CYBHI) Grant Funding Available

Jamie,

I'd appreciate it if you would forward to the Mental Health Commission, and to others who may be interested, the text that follows, concerning CYBHI, the Children and Youth Behavioral Health Initiative, as an item for discussion at the February MHC meeting or at the March meeting if it is already too late to add an item for the February meeting.

At the meeting, I will propose that the MHC establish a Grants and Innovations Subcommittee to communicate with City of Berkeley behavioral health management concerning potential MHC participation at the planning stage for grants and other program innovation efforts. I'll suggest that the MHC schedule 15 minutes to discuss and vote on establishing such a subcommittee.

Edward Opton

---------- Forwarded message ---------
From: **DHCS CYBHI** <CYBHI@dhcs.ca.gov>
Date: Thu, Feb 9, 2023 at 5:02 PM
Subject: Children and Youth Behavioral Health Initiative (CYBHI) Grant Funding Available
To:

Children and Youth Behavioral Health Initiative (CYBHI) Grant Funding Available

On February 9, 2023 as part of the Children and Youth Behavioral Health Initiative (CYBHI), the Department of Health Care Services (DHCS) released a Request for Application (RFA) seeking proposals for the second round of grant funding totaling $100 million to scale evidence-based practices and community-defined evidence practices (EBPs and CDEPs, respectively) across the state. For the second round of EBP/CDEP grant funding, DHCS seeks proposals from various individuals, organizations, and agencies to scale trauma-informed programs and practices.

Interested parties are encouraged to apply for funding using this application form by **April 10, 2023, at 5:00 p.m.**

Background:

With input from stakeholders, DHCS will expand a limited number of EBPs and CDEPs throughout the state that are based on robust evidence for effectiveness, impact on racial equity, and sustainability. By scaling EBPs and CDEPs statewide, DHCS aims to improve access to critical behavioral health interventions, including those focused on prevention, early intervention, and resiliency/recovery, for children and youth, specifically those from Black, Indigenous, and people of color (BIPOC) and lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) communities.

Children and Youth Behavioral Health Initiative (CYBHI)

Office of Strategic Partnerships

California Department of Health Care Services

Children and Youth Behavioral Health Initiative
California Department of Health Care Services

Evidence-Based Practices and Community-Defined Evidence Practices Grant Program

Round Two: Trauma-Informed Programs and Practices

Request for Applications

Release date: February 9, 2023

Application deadline: April 10, 2023

Round Two: Trauma-Informed Programs and Practices

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Part 1: Overview

1.1 Introduction to the Grant Opportunity

Authorized as part of the 2021 Budget Act, the Children and Youth Behavioral Health Initiative (CYBHI) is a multi-year, multi-department package of investments that reimagines the systems that support behavioral health (BH) and wellness for all California's children, youth, and their families. Efforts focus on promoting social and emotional well-being, preventing BH challenges, and providing equitable, appropriate, timely, and accessible services for emerging and existing BH needs for children and youth ages 0-25. The $4.7 billion investment of state General Funds for CYBHI will improve access to, and the quality of, BH services for all children and youth in California, regardless of payer.

As a component of CYBHI, the Department of Health Care Services (DHCS) will scale throughout the state specified evidence-based practices (EBPs) and community-defined evidence practices (CDEPs) that are based on robust evidence for effectiveness, impact on racial equity, and long-term sustainability. By scaling EBPs and CDEPs throughout the state, DHCS aims to improve access to critical BH interventions, including those focused on prevention, early intervention and resiliency/recovery, for children and youth, with a specific focus on children and youth from Black and Indigenous People of Color (BIPOC) and LGBTQIA+ communities.

During Fiscal Year (FY) 2022-2023, through six competitive grant funding rounds, DHCS intends to award grants, totaling approximately $429 million, in the following focus areas[1]. Applicants may apply to one or more of the below grant rounds:

- Round 1: Parent/caregiver support programs and practices (December 2022);
- Round 2: Trauma-informed programs and practices (February 2023);
- Round 3: Early childhood wraparound services (March 2023);
- Round 4: Youth-driven programs (April 2023);
- Round 5: Early intervention programs and practices (April 2023); and,
- Round 6: Community-defined programs and practices (approximate timeline for release: June 2023).

[1] DHCS received input from stakeholders regarding the selection of practices and will make final decisions in conjunction with RFA releases for each round. Specific EBPs/CDEPs included in each round, and eligible for funding awards to scale practices, will be announced in the associated RFA.

1.2 Equity-Driven Approach

Reducing health disparities and promoting health equity is a central component of the overall grant strategy. With input from stakeholders, DHCS identified the following populations of focus for this grant initiative:

- Populations of focus identified by the California Reducing Disparities Project[2] (i.e., African Americans, Asians and Pacific Islanders, Latinos, LGBTQIA+, Native Americans).
- Specific populations or segments defined by characteristics other than race, ethnicity and sexual orientation that are experiencing disparities in BH needs (i.e., justice-involved individuals, tribal nations, families engaged with the foster care or justice system, individuals with disabilities, families experiencing homelessness, individuals in rural regions, refugees, the socio-economically disadvantaged).

Equity-driven outcomes for populations of focus are a key aspect for grant awards and data reporting for grant recipients. In selecting the theme for each round and specific EBPs/CDEPs, DHCS and its stakeholders were guided by DHCS's guiding principles to achieving equity in BH, the bold goals included in its Comprehensive Quality Strategy, and Medi-Cal's Strategy to Support Health and Opportunity for Children and Families.

DHCS selected EBPs/CDEPs that:

- *Maximized impact and reduced disparities* for all children and youth with an emphasis on programs/practices that focus on marginalized communities;
- *Incorporated youth and family voices* to ensure that the selected programs/practices resonated with a diverse audience;
- *Focused on the upstream continuum of care* to reduce the risk of significant BH concerns in the future;
- *Affirmed the right to access help* and provide access to high-quality, appropriate care for all children and youth;
- *Destigmatized community support* to enable every community to recognize the signs of BH concerns and be willing to support those with BH concerns without stigma; and,
- *Have a data driven-approach* to expand the use of evidence-based BH services.

DHCS will prioritize grants to organizations that demonstrate the ability to scale and sustain engagement with populations of focus (e.g., underserved racial and ethnic

[2] California Reducing Health Disparities Project, June 2022

groups, underserved geographies, underserved income-levels, LGBTQIA+ people, etc.) to increase health equity for California youth.

1.3 Purpose

This Request for Application (RFA) details the grant parameters and requirements for Round Two: Trauma-informed programs and practices. Based on input from Think Tank[3] and Workgroup[4] discussions, as well as that from DHCS OSP leadership, Round Two will aim to scale trauma-informed care available to children, youth, parents, and caregivers in California. Trauma-informed care addresses how trauma may impact an individual's life and response to BH services, focusing on realizing the prevalence of trauma; recognizing how trauma affects an individual; and responding by putting knowledge into practice.[5]

DHCS will contract with eligible recipients to support training, capacity building, implementation, and expansion of trauma-informed BH services across various settings (e.g., clinic, community-based organizations, primary care, schools), as applicable. Broadly, these funds are intended to expand and create culturally relevant and responsive services for children and youth to prevent and mitigate BH concerns and promote well-being for children and to support trauma-informed approaches for parents, caregivers and other individuals that work closely with children.

Specifically, this grant funding round aims to:

- Increase early intervention so children and youth with or at high risk for BH conditions can access services before conditions escalate and require higher level care.
- Support the resilience of children and youth by mitigating the adverse effects of Adverse Childhood Experiences (ACEs). Adverse effects may include, but are not limited to, brain development, emotional health and BH conditions, among other, conditions.
- Build knowledge of trauma-informed support and communication for parents, caregivers and individuals close to children and youth.
- Increase the capacity of child-serving service systems (e.g., child welfare, juvenile justice system) to deliver trauma-informed practices.
- Cultivate safe and stable learning environments that model trauma-informed approaches to working with children.

[3] Think Tanks Overview and Members

[4] Workgroup Member List

[5] Trauma-Informed Care in Behavioral Health Services

- Improve grief support for children and youth with trauma (e.g., death of a parent or loved one, COVID-related, home or community violence).
- Improve the availability and sustainability of services for pregnant and parenting people, caregivers, and children/youth.
- Reduce health disparities by improving equitable access to services for parents, caregivers, and children in California that are culturally and linguistically responsive to the needs of the populations of focus.

DHCS will award grants, **totaling $100 million**, to scale trauma-informed care throughout California to support wellness and build resilience of children, youth, and those individuals who are close with children (e.g., parents, caregivers, teachers, justice-affiliated providers). For Round Two, the following EBPs and/or CDEPs will be scaled through competitive grant awards:

a. Attachment and Biobehavioral Catch-Up[6];
b. Child Parent Psychotherapy[7];
c. Cognitive Behavioral Interventions for Trauma in Schools[8];
d. Dialectical Behavior Therapy[9];
e. Family Centered Treatment[10];
f. Functional Family therapy[11]
g. Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems[12];
h. Trauma-Focused Cognitive Behavioral Therapy[13];
i. Multisystemic Therapy[14];

[6] Attachment and Biobehavioral Catch-Up

[7] Child Parent Psychotherapy

[8] Cognitive Behavioral Interventions for Trauma in Schools

[9] Dialectical Behavior Therapy

[10] Family Centered Treatment

[11] Functional Family Therapy

[12] Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems

[13] Trauma-Focused Cognitive Behavioral Therapy

[14] Multisystemic Therapy

j. Crossover Youth Practice Model[15];

k. Other practices for specified populations of focus (e.g., Family Acceptance Project[16])

DHCS recognizes that the short-listed evidence-based practices may not have been developed or normalized on populations of focus and that additional EBPs and CDEPs practices may be relevant to this grant round. As such, additional practices and programs relating to Trauma-Informed Care may be considered eligible for grant funding with the submission of supplementary material demonstrating how the program or practice aligns with the objectives of this RFA. Practices and programs that are appropriate and/or can be adapted for focus populations (see "Populations of Focus" below) will be prioritized.

1.4 Authorizing and Applicable Law

California Welfare and Institution (W&I) Code sections 5961 and 5961.5.

1.5 Timeline

Below is the tentative time schedule for this RFA. If DHCS finds a need to alter the timelines listed herein, either an addendum or a correction notice will be issued announcing the alternate timelines. Applications will be accepted electronically beginning **February 9, 2023**. The application and attachments, along with instructions for submission of the online application, can be found on the DHCS CYBHI EBP/CDEP Grants webpage. If the Applicant is unable to email the application, please contact DHCS at CYBHI@dhcs.ca.gov with the preferred delivery method. DHCS will not consider late application packages.

The deadline for applications will be **April 10, 2023, at 5:00 p.m. PT**. It is the applicant's responsibility to ensure that the submitted application is accurate and complete. Reviewers may request additional clarifying information from the applicant.

Application Milestones	Dates
RFA release and application open	February 9, 2023 at 5:00 p.m. PT
Deadline for submission of questions from potential respondents	February 22, 2023 at 5:00 p.m. PT

[15] Crossover Youth Practice Model

[16] Family Acceptance Project

DHCS to post responses to select questions	March 8, 2023 at 5:00 p.m. PT
Application due date	April 10, 2023 at 5:00 p.m. PT
Award announcements	On or before June 30, 2023 at 5:00 p.m. PT

1.6 Third-Party Grant Administrator (TPA)

DHCS will contract with a third-party administrator (TPA) to conduct grant management activities, including but not limited to the following:

- Contracting with individuals and entities awarded grants;
- Distribution of grant funding;
- Oversight and monitoring of grantees;
- Data collection and reporting on specified performance metrics;
- Provision of technical assistance and training to grantees; and,
- Other activities defined by DHCS.

1.7 Grant Application and Award Tracks

Eligible applicants may apply for grant funding in one of three grant tracks:

1) Training - The training track is designed for *individuals* seeking access to manualized training and/or certification in a shortlisted EBP and CDEP (or related adaptation).
2) Implementation – This track is designed for *organizations* seeking grant funding for one of the following activities:
    a. Start-up – The start-up track is designed for organizations that are seeking start-up funds to newly implement an EBP and CDEP (or related adaptation).
    b. Operational expansion – The operational expansion track is designed for organizations looking to:
        i. Expand provision of short-listed EBP and CDEP (or related adaptation) that they currently provide, or
        ii. Scale delivery of a short-listed EBP and CDEP (or adaptation) by training or credentialing more providers.
3) Integrated – This track is designed for organizations seeking grant funding for more than one track listed above (i.e., Implementation and Training)

Eligible recipients can submit an application specific to a single track, or an integrated proposal that includes activities on multiple tracks. Eligible recipients may also apply for more than one EBP and/or CDEP by submitting separate applications for each program.

As part of the training track, there is no limit to the number of individuals working for a single organization that can apply for grant funding. However, if the organization is also applying for an implementation grant that includes training for the same individuals, DHCS will not consider separate awards. For individual applicants who are employed by an organization, DHCS recommends submitting documentation that the individual and organization have not separately applied for the same purpose.

For the implementation track, eligible recipients may work together to submit a joint application for a proposal that spans multiple organizations. Note: in these cases, one organization may act as the "primary lead" and submit the application on behalf of the collective; however, the application must indicate if there are subrecipients that are party to the grant application. It must also delineate the roles and responsibilities of each party. Primary leads must also submit an emailed addendum to CYBHI@dhcs.ca.gov providing the secondary entity(s) information. In the emailed addendum, please identify the name and address of the secondary applicant, as well as the funding amount requested for that grant application.

Grant awards will be calculated based on multiple factors, including but not limited to: number of total applications received, number of applications received by track and practice model type, and, number of total individuals expected to be impacted (i.e., served) by grant applicant as a result of the grant award. Priority will be given to applicants serving communities with higher demonstrated need (e.g., mental health professional shortage areas, socio-economically disadvantaged communities, communities with populations of focus) or those which propose to reduce disparities between racial/ethnic/marginalized groups in the community.

1.8 Grant Award Period

All grant awards will be for a maximum period of two years. Upon award, DHCS, or its designee, will finalize contract terms with the grantees.

1.9 Maximum Grant Award Amounts

The maximum award amount will vary by track as shown in the table below. The amounts listed are "up to" maximum amounts to cover the entire two-year grant award period (i.e., the amounts below are total amounts and not annual amounts). Applicants applying for multiple tracks as part of an integrated proposal may submit a budget proposal up to the combined maximum award amount for the tracks they are applying for; however, activities related to each track will still be limited by the track' maximum award amounts (e.g., an integrated start-up ($750,000) and training ($10,000) proposal would have a maximum award size of $760,000). **NOTE:**

ACTUAL GRANT AWARDS WILL VARY AND NOT ALL APPLICANTS WILL RECEIVE THE MAXIMUM AWARD. Applicants must justify requested amounts as part of the application process. Supplemental documentation may be required to support the request.

ESTIMATED MAXIMUM OF GRANT AMOUNTS BY TRACK		
Training Track	Implementation Track (Start-Up)	Implementation Track (Operational Expansion)
$10,000	$750,000	$400,000

As outlined in Section 3.2 “Application Components,” all applicants will be required to submit a budget proposal for how grant funds will be spent. Applicants are welcome to propose a budget that they feel suits their proposed approach; however, as part of the budget proposal, applicants are expected to provide a detailed justification for each line item in their proposed budget. This justification could include, but is not limited to, why the element is necessary for the proposed approach and how the cost estimation was calculated.

Not all applicants will receive an award within the range outlined above. DHCS reserves the right to make final determinations about award size, including whether to award a grant covering only a partial amount of the applicant’s proposed expenses.

Part 2: Grant Requirements

2.1 Eligible Service Settings

Grantees may deliver services in various settings including, but not limited to: homes, schools, clinics, and community-based settings.

2.2 Eligible Grant Recipients

Entities eligible to receive grants as a part of this RFA, Round Two Trauma-Informed Programs and Practices grants, include but are not limited to:

a. Community-based organizations that provide services to children, youth, and/or families;

b. Provider clinics (e.g., primary care, community mental health, BH);

c. County or city governments (e.g., county BH departments, public health);

d. Early learning and care providers (e.g., childcare and preschool settings);

e. Family resource centers;

f. Statewide and local agencies (e.g., First 5 associations);

g. Faith-based organizations;

h. Regional centers;

i. Local Education Agencies (County Offices of Education, school districts), public K–12 school sites, charter schools;

j. Institutions of higher education (e.g., California Community Colleges, California State University, University of California);

k. Tribal entities (i.e., any Indian Tribe, tribal organization, Indian-controlled organization serving Indians, Native Hawaiian organization, or Alaska Native entity);

l. Health plans;

m. Hospitals and hospital systems; and,

n. Others, as applicable.

Note: DHCS will take the practice model into consideration when determining whether a particular organization delivers services in a setting that is consistent with the model. For example, some practice models require services to be delivered in a clinical practice setting.

Additional requirements will be specified in the contract between the grantee and the TPA or DHCS. Examples of additional requirements for eligible entities include, but are not limited to, the following:

- Must be located and conduct grant activities in the State of California;
- Have state or federal recognition as a formal organization or entity, such as a Federal Employer Identification Number (EIN) or California Tax ID; and,
- Must not be debarred or suspended by either the State of California or the Federal Government.

Please note that applications are limited to a single program or practice. Applicants may apply for funding for more than one program or practice by submitting separate applications for each program or practice

2.3 Eligible Expenditures

Eligible expenditures must be necessary, reasonable, and allocatable to the activities proposed in the application. This may include:

a. Equipment and capital improvements (e.g., modifications to physical space to support practices and programs);

b. Manual access for practices and programs;

c. Planning costs;

d. Specialized training (e.g., disability training, cultural competence, anti-racism);

e. Staffing (e.g., benefits, contractors);

f. Supplies (e.g., printing, toys);

g. Technology (e.g., computers, virtual care platform, electronic medical record);

h. Technical assistance;

i. Training costs;

j. Travel; and,

k. Other (applicants must define).

For eligible applicants (e.g., CBOs, county BH departments) who participate in Medi-Cal, and are already reimbursed for EBPs / CDEPs, these awards aim to support training, capacity building, implementation, and expansion of trauma-informed BH services across various settings (in contrast to other awards which are designed to fund the direct provision of services).

2.4 Ineligible Expenditures

Ineligible expenditures for all tracks may include but are not limited to:

a. Fundraising;

b. Taxes; and,

c. Debts, late payment fees, contingency funds.

2.5 Grant Monitoring and Participation in Training and Technical Assistance

All grant recipients are required to participate in mandatory grant monitoring and technical assistance activities conducted by DHCS, or its designee (i.e., the TPA). DHCS expects grantees to:

- Deliver trauma-informed care EBPs and CDEPs with fidelity to the specified model while using a culturally relevant and responsive approach to implementation with populations of focus.
- Seek additional training in trauma-informed care, as needed and appropriate, to build or strengthen competencies for serving populations of focus.
- Collect data and report, via periodic written progress reports to DHCS and/or its designee, standardized client-demographic data and outcome-specific data.
- Adhere to reporting and evaluation requirements as defined by DHCS, including informed consent, data collection and submission, and participation in evaluation activities.
- Achieve and maintain the specific benchmarks (e.g. referral rates, initial assessment, providers trained) for the grant within specified timeframes.
- Attend and participate in regular (e.g., weekly, biweekly, monthly) monitoring meetings and check-in calls with a TPA and/or DHCS.
- Participate in required collaborative learning sessions (e.g., monthly learning collaborative sessions) to ensure adherence to manualized instructions and/or best practices.
- Based on input from Think Tank[17] and Workgroup[18] discussion, as well as DHCS OSP leadership, develop an implementation plan to support trauma-informed care, which includes:
    a. Establishing a system for early identification, screening, referral, and/or provision of treatment for children and families.

[17] Think Tanks Overview and Members

[18] Workgroup Member List

b. Developing a protocol for managing risk (e.g., mandated reports, as required for certain individuals under the Federal Child Abuse Prevention and Treatment Act (CAPTA) for known or suspected instances of child abuse and neglect[19]) and escalating concerns before disclosing to parents/caregivers and third parties (e.g., police, child-protective services).

c. Identifying barriers to trauma-informed services within the community and with solutions to address identified barriers.

2.6 Data Reporting Requirements

As a condition of funding, all grantees are required to share standardized data, in a manner and form determined by DHCS.[20] As a part of the award, grantees must agree to report data and outcomes for a period of 1-2 years post award, as applicable based on award type.

Based on input from Think Tank[21] and Workgroup[22] discussion, as well as DHCS OSP leadership, below are examples of the type of data that will be required to be reported under each funding track:

- Training status of BH professionals (e.g., number of certifications, proof of certification/training completion).
- Client demographic information (e.g., age, sex, sexual orientation and gender identity, race/ethnicity).
- Service utilization data (e.g., number of clients enrolled, service location, average length of service, program completion rates).
- Child outcomes (e.g., stressful life events, adverse childhood experiences, internalizing and externalizing symptoms, social and academic functioning, child-caregiver relationship) as appropriate.
- Adult self-report outcomes (e.g., caregiver stress, teacher-child relationship), as appropriate.
- Number of mandated reports submitted, as required for certain individuals under the Federal Child Abuse Prevention and Treatment Act (CAPTA) for known or suspected instances of child abuse and neglect[23]

[19] Mandatory Reporters of Child Abuse and Neglect

[20] W&I Code Section 5961.5(f)

[21] Think Tanks Overview and Members

[22] Workgroup Member List

[23] Mandatory Reporters of Child Abuse and Neglect

Part 3: Application Components and Evaluation Criteria

3.1 Application and Submission Format

Applicants who have a demonstrated track record of serving populations of focus but do not have the organizational capacity to complete a written grant application may request that portions of this grant application be completed in an alternative format (e.g., video submission).

All grant applicants are expected to complete their application via https://www.surveymonkey.com.

To request an alternative application, please contact DHCS at CYBHI@dhcs.ca.gov by March 8, 2023 at 5:00 p.m. PT. As part of your request, please include a justification for the request and an explanation of how granting the request will further DHCS' goals of promoting diversity, equity and inclusion. DHCS will make reasonable efforts to grant these requests. Please note that most alternative applications will still be required to submit a SurveyMonkey application April 10, 2023 at 5:00 p.m. PT, though it may be possible to address certain questions with an alternative format submission (e.g., video submission, virtual interview).

3.2 Application Components

a. Application Overview

i. Applicant/entity legal name

a) If individual – please include license information

b) If organization – please identify name and credential of Chief Executive Officer/President or other legal designee **(Max 100 words)**

c) If sub-organization that is party to the grant – please identify name and credential of Chief Executive Officer/President or other legal designee **(Max 100 words)**

ii. Contact information- please provide an email you would like us to contact you at

iii. Entity description – please provide a detailed narrative overview of entity's mission, service profile, years in operation, experience with providing trauma-informed care, etc. **(Max 500 words)**

iv. Individual/entity's service location(s) – please include physical address(es) where services are provided to clients

a) County of service

b) Primary zip code of service

v. Individual/entity type (select from list, if other, please describe)

vi. Affiliation- If applicable, please identify if the individual/entity is affiliated/under contract with a health plan (commercial or Medi-Cal), a county BH department, or a clinic (primary care or BH) to deliver BH services. If yes, select:

a) Affiliated entity;

b) Type of affiliation; and

c) County of service.

vii. Focus area- Select the EBP(s) that are the focus of your grant application. If your grant application focuses on a CDEP or an adaptation of an EBP, select “CDEP/EBP adaptation” and provide the name of the CDEP/EBP adaptation.

viii. Grant tracks- Select the grant track(s) to which applicant is applying

ix. Requested total funding amount(s)

a) Requested total amount in Training Track

b) Requested total amount in Implementation Track

b. Populations of Focus

i. Describe the individual/entity’s existing client population **(Max 250 words)**

ii. Describe the populations of focus, including projected population size and description of populations (e.g., race, ethnicity, federally recognized tribe, language, sex, gender identity, sexual orientation, age, socioeconomic status) to be served, if awarded a grant. **(Max 250 words)**

iii. Describe the individual/entity’s strategy for conducting outreach and engagement to reach the populations of focus. Please provide at least one example of a time when you successfully engaged the population of focus in a manner that resulted in increased access to services. **(Max 500 words)**

iv. Describe the individual/entity’s strategy for ensuring staff are appropriately trained and services are culturally relevant and responsive. **(Max 500 words)**

c. Proposed Approach

i. **For Training Track only applications** – Describe the individual's timeline for completing required training activities. Please also describe the goals, strategy, and associated milestones in your plan to scale the selected EBP/CDEP with the populations of focus upon completion of the training program. See section 1.3 "Purpose." *Please upload as attachment in the Survey Monkey tool.* **(Max 2,500 words)**

ii. **For Implementation Track only applications** - Describe the entity's proposed timeline and approach for scaling the selected EBP/CDEP practice or program model. Please include specific goals, milestones and measurable objectives that are aligned with the stated purpose of the grant opportunity. See section 1.3 "Purpose." *Please upload as attachment in the Survey Monkey tool.* **(Max 2,500 words)**

iii. **For Integrated Track applications** *(entities that are applying for more than one track should submit an integrated proposal instead of separate proposals)* – Describe the entity's proposed timeline and approach for scaling the selected EBP/CDEP practice or program model. Additionally, please detail the training needs and timeline for completing the training activities. Include specific goals, strategies, milestones, and measurable objectives that are aligned with the stated purpose of the grant opportunity when discussing the plan for scaling as well as the required training. See section 1.3 "Purpose." *Please upload as attachment in the Survey Monkey tool.* **(Max 2,500 words)**

d. Individual/Entity Experience and Staffing Profile

i. Individual/entity experience:

a. **For Training Track only applications** - Describe the individual's education, training, knowledge of trauma-informed care, and experience implementing EBPs/CDEPs and/or similar programs. **(Max 500 words)**

b. **For Implementation Track only applications** – Describe the entity's staffing profile, knowledge of trauma-informed care, expertise and experiences implementing EBPs/CDEPs and/or similar programs. **(Max 500 words)**

c. **For Integrated Track applications** *(entities that are applying for more than one track should submit an integrated proposal instead of separate proposals)* – For the implementation component of this response, describe the entity's staffing profile, knowledge of trauma-informed care, expertise and experiences implementing EBPs/CDEPs and/or similar programs. For the training component of this response, describe the individual's education, training, knowledge of trauma-informed care, and

experience implementing EBPs/CDEPs and/or similar programs. **(Max 1000 words)**

ii. Describe the individual's/entity's current capacity to meet goals and objectives, and/or describe how funding could create capacity and resources to achieve these goals and objectives. **(Max 500 words)**

iii. If applicable, identify other organization(s) that you will partner with in the proposed project if additional expertise and/or support is required for the project (e.g., additional training in specific populations). Describe their experience providing services to the population(s) of focus, and their specific roles and responsibilities for this project. **(Max 500 words)**

iv. Provide a complete list of staff positions for the project, including the Key Personnel (Project Director and Evaluator) and other personnel as relevant. Describe the role of each, their level of effort, and qualifications, to include their experience providing services to the population(s) of focus and familiarity with their culture(s) and language(s). **(Max 500 words)**

v. Entity letter of support - provide a letter of support from community members, previous organizations, supervisors, or others that can attest to your background in trauma-informed services. If applying as an individual, please also provide an additional letter of support from organizational leadership. **(File Upload [max. 3])**

e. Data Collection and Performance Management

i. Provide information about your/your organization's experience in data collection (e.g., storage, management, analyzing) relating to service utilization and quality improvement (e.g., data that is used to enhance the organization's offerings rather than data stored in an electronic health record). **(Max 500 words)**

ii. Provide examples of reporting you/your organization has developed to showcase your organization's program outcomes and experience working with relevant social service agencies (e.g., annual report, grant monitoring report, letter to funders, etc.). **(File Upload [max. 3])**

iii. Provide a plan for data considering the following:

a. What electronic data collection software will be used, if any? **(Max 250 words)**

b. How often will data be collected? **(Max 250 words)**

c. The organizational process that will be implemented to ensure the accurate and timely collection and input of data. **(Max 250 words)**

d. The staff responsible for collecting and recording data. **(Max 250 words)**

e. The data source/data collection instruments that will be used to collect the data. **(Max 250 words)**

f. How well the data collection methods that will take into consideration the language, norms, and values of the population(s) of focus. **(Max 250 words)**

g. How the data will be stored securely. **(Max 250 words)**

h. If applicable, how will the data collection procedures ensure that confidentiality is protected, and that informed consent is obtained. **(Max 250 words)**

i. If applicable, how data will be collected from partners. **(Max 250 words)**

j. If applicable, how will the data collection process demonstrate that effective EBP scaling was facilitated by the award **(Max 100 words)**

iv. Please refer to Section 2.6 “Data Reporting Requirements” for additional information about data collection requirements. *Note: DHCS reserves the right to specify and/or add metrics at the time of grant award.*

f. Proposed budget (File upload)

i. Provide an estimated budget based on your understanding of the scope of your project. The budget total should equal the grant amount you are proposing for and be itemized by specific resource (e.g., staff salaries by level, supplies, etc.) tying back to key deliverables or other program goals mentioned in the Section 3.2.F. The budget should include expenditures over a maximum two-year period, as well as details on any anticipated subawards.

ii. Final budget and payment schedule will be determined in tandem with the applicant and DHCS or its designee (i.e., TPA). DHCS, or its designee, will provide interval payments based on delivery of standard deliverables.

g. Additional Practices and Programs Relating to Trauma-Informed Programs and Practices

This section is only to be completed by applicants that are submitting a proposal for a program or practice that is *not included* in the list of eligible programs and practices in Section 1.3 “Purpose.”

i. Provide a description of the program or practice, including:

   a. Program overview **(Max 500 words)**

   b. Target population (e.g., parents/caregivers, infants, children) **(Max 500 words)**

   c. Program goals (e.g., supporting the resilience of children and youth affected by ACEs, improving grief support for children and youth) **(Max 500 words)**

   d. Program delivery (e.g., recommended intensity, duration, delivery setting) **(Max 500 words)**

   e. Manuals and training (e.g., if they practice is manualized, level of training required, training modality) **(File upload)**

ii. Describe how this program or practice will improve outcomes and benefit populations of focus. **(Max 500 words)**

iii. Describe how you will monitor and ensure fidelity of program delivery if the program is considered "innovative" (e.g., does not have existing evidence-based, manual). **(Max 500 words)**

iv. Describe the evidence which supports that the selected EBP/CDEP or adaption will drive the outcomes contained in Section 1.2 "Equity-Driven Approach" and 2.6 "Data Reporting Requirements": **(Max 500 words)**

   a. For EBPs, include mention of the scientific evidence base that supports key outcomes related to the RFA (e.g., RCTs, peer-reviewed journal articles) as well as the rating from relevant clearinghouses, if applicable (California Evidence-Based Clearinghouse for Child Welfare[24], Title IV-E Prevention Services Clearinghouse[25], Federal Evidence-Based Practices Resource Center[26])

   b. For CDEPs or population-specific adaptations of EBPs, include findings from limited or informal evaluations, case studies and/or surveys or testimonies from program participants, family members, community members and/or other stakeholders as well as whether the CDEP is listed as an Innovative Practices in

[24] California Evidence-Based Clearinghouse for Child Welfare

[25] Title IV-E Prevention Services Clearinghouse

[26] SAMHSA Evidence-Based Practices Resource Center

the National Network to Eliminate Disparities in Behavioral Health resource library[27]

v. Describe the recommended path to sustainability for this program or practice (e.g., funding, reimbursement). **(Max 250 words)**

vi. If applicable, describe how scaling of this program or practice will add to the existing BH landscape. **(Max 500 words)**

h. Additional information

i. Is there any additional information you would like to add?

ii. Please attach any additional documents you would like to include

3.3 Application Scoring Criteria

The CYBHI EBP/CDEP grant funding is a competitive application grant program. DHCS will only fund proposals from applicants that are in good standing with all local, county, state and federal laws and requirements. Funding decisions will be based on a variety of factors, including but not limited to: practice selections, demonstrated need and ability to meet outcome objectives for populations of focus, ability to provide culturally relevant and responsive services to populations of focus, overall estimated impact of potential award, geographic distribution of applicants, and populations served.

A standardized scoring system will be used to determine the extent to which the applicant meets the selection criteria. Based on input from Think Tank[28] and Workgroup[29] discussions and DHCS OSP leadership, each application will be evaluated based on the strengths of the proposal and the responsiveness to the selection criteria and project aims, as follows:

- Increase early intervention so children and youth with or at high risk for BH conditions can access services before conditions escalate and require higher level care.
- Support the resilience of children and youth by mitigating the adverse effects (e.g., brain development, emotional and BH, among other conditions) of ACEs.
- Build knowledge of trauma-informed support and communication for parents, caregivers and individuals close to children and youth.
- Increase the capacity of child-serving service systems (e.g., child welfare, juvenile justice system) on trauma-informed practices.

[27] SAMHSA National Network to Eliminate Disparities in Behavioral Health

[28] Think Tanks Overview and Members

[29] Workgroup Member List

- Improve grief support for children and youth (e.g., death of a parent, loved one).

Additionally, DHCS reserves the right to prioritize applications that align with the aims of the broader CYBHI initiative (e.g., increasing care to populations of focus, mental health professional shortage areas).

Practices and programs not on the identified list of Round Two EBPs and CDEPs will be evaluated for efficaciousness, equity, sustainability, scalability, and whether the practice model is supplementary to the BH landscape. No application is guaranteed funding and applications will be reviewed holistically across the defined evaluation criteria.

Part 4: Administrative Details

4.1 Compliance with California Public Records Act

The application is a public record that is available for public review pursuant to the California Public Records Act (CPRA, Chapter 3.5 [commencing with Section 6250] of Division 7 of Title 1 of the Government Code). After final awards have been issued, DHCS may disclose any materials provided by the applicant to any person making a request under the CPRA. Applicants are cautioned to use discretion in providing information not specifically requested, such as personal phone numbers and home addresses. If the applicant does provide such information, they will be waiving any claim of confidentiality and will have consented to the disclosure of submitted material upon request.

4.2 Inquiries

1. Direct all grant inquiries to DHCS as indicated below. DHCS will respond directly to each applicant submitting an inquiry.

Grant Inquiries
Email Inquiries to: CYBHI@dhcs.ca.gov **Subject:** RFA CYBHI-EBP2023-RD2 – Trauma-Informed Programs and Practices

2. Please include the following in an inquiry:
    a. Applicant name, name of applicant's organization, mailing address, email address, area code, telephone number, or other information useful in identifying the specific problem or issue in question.
    b. A description of the subject or issue in question or discrepancy found.
    c. RFA section, page number, or other information useful in identifying the specific problem or issue in question.

4.3 Reasonable Accommodations

For applicants with disabilities, DHCS will provide assistive services such as reading or writing assistance, conversion of the RFA, questions/answers, RFA addenda, or other Administrative Notices to Braille, large print, audiocassette, or computer disk. To request copies of written materials in an alternate format, please use one of the following methods below to arrange for reasonable accommodations.

Reasonable Accommodations Requests
Email Address: CYBHI@dhcs.ca.gov **Subject:** RFA CYBHI-EBP2023-RD2 – Trauma-Informed Programs and Practices

4.4 Award Process

Successful applicants will receive a conditional award email with a Standard Agreement Contract from DHCS or its designee (i.e., the TPA entity). The agreement must be signed, returned, and fully executed before initial funding will be awarded. Depending on the applications received, DHCS may choose to partially or fully award eligible applicants based on the grant tracks of interest. In that case, DHCS would reach out to the potential awardee to inform them of the determination.

Applications that are not funded during Round Two: Trauma-Informed Programs and Practices may apply for future funding rounds, subject to the requirements and priorities of those rounds.

Applicants who are awarded grants must submit a budget proposal for the first 12-month budget period of the grant. Continued funding for each subsequent period will require submission and approval of documents needed to update workplans, target caseload and budgets.

Annual budget awards in subsequent years will be based on awarded applicant's satisfactory performance in achieving grant management responsibilities.

The grant award term dates will be agreed upon in the final executed contract with grant award winners.

4.5 Appeals

California law does not provide a protest or appeal process of award decisions made through an informal selection method. Applicants submitting a response to this RFA may not protest or appeal the award decision. DHCS's award decision shall be final.

4.6 State's Rights

a. DHCS may collect additional applicant documentation, signatures, missing items, or omitted information during the response review process. DHCS will advise the applicant orally, by fax, email, or in writing of any documentation that is required along with the submission timeline. Failure to submit the required documentation by the date and time indicated may cause DHCS to deem a response nonresponsive and eliminate it from further consideration.

b. The submission of a response to this RFA does not obligate DHCS to make a contract award.

c. DHCS reserves the right to deem incomplete responses as non-responsive to the RFA requirements.

d. DHCS reserves the right to modify or cancel the RFA process at any time.

e. The following occurrences may cause DHCS to reject a response from further consideration:

    a. Failure to meet the state applicant requirements by the submission deadline.

    b. Failure to comply with a request to submit additional documents in a timely manner, if needed.

    c. Failure to comply with all performance requirements, terms, conditions, and/or exhibits that will appear in the resulting contract.

    d. Failure to submit an RFA response by 5:00 pm PT on April 10, 2023.

Evidence-Based Practices and Community-Defined Evidence Practices Grant Program

DHCS

This document outlines the Department of Health Care Services' (DHCS) proposed grant strategy, including key design considerations, for the scaling of evidence-based and community-defined evidence practices for children and youth in behavioral health statewide.

1 Purpose

3 Overview of Grant Funding Opportunity

7 Stakeholder Engagement Process

10 Populations of Focus and Prioritized Outcomes

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Overview of Grant Funding Opportunity

Established in 2021, the Children and Youth Behavioral Health Initiative (CYBHI) is a $4.7 billion investment of state General Funds aimed at improving access to behavioral health services for all children and youth in California, regardless of payer (insurance coverage). The CYBHI is a multiyear, multi-department initiative focused on promoting social and emotional well-being, preventing behavioral health challenges, and providing equitable, appropriate, timely, and accessible services for emerging and existing behavioral health needs for children and youth ages 0-25 in California.

"In line with its legislative mandate,[1] the DHCS will distribute $429 million in grants to organizations seeking to scale evidence-based and/or community-defined evidence practices (EBPs/CDEPs) that improve youth behavioral health (BH) based on robust evidence for effectiveness, impact on racial equity, and sustainability."

In line with its legislative mandate,[1] DHCS will distribute $429 million in grants to organizations seeking to scale evidence-based and/or community-defined evidence practices (EBPs/CDEPs) that improve youth behavioral health (BH) based on robust evidence for effectiveness, impact on racial equity, and sustainability. By scaling EBPs and CDEPs throughout the state, DHCS aims to improve access to critical behavioral health interventions, including those focused on prevention, early intervention, and resiliency/recovery for children and youth, with a specific focus on children and youth who are from either or both of the following groups: Black, Indigenous, and People of Color (BIPOC) and the LGBTQIA+ community.

Through an extensive community engagement process, DHCS selected a limited number of EBPs and CDEPs to consider for scaling throughout the state, subject to further refinement based on an assessment of sustainable financing mechanisms, including Medi-Cal and commercial coverage and/or other funding streams. DHCS' approach to scaling these practices varies depending on program type, but generally falls into one of three categories:

1. **Expanding an organization's operations and capacity to provide services** by supporting training for BH professionals (both clinical and non-clinical), community-based or faith-based organizations, parents and caregivers, and others, as appropriate, to provide culturally responsive and gender-affirming behavioral health care and supports to children, youth, and their families and caretakers.

2. **Enabling the replication and adaptations of well-established practices** (e.g., practices contained in the Substance Abuse and Mental Health Services Administration's [SAMHSA] EBP Resource Center or the California Evidence-Based Clearinghouse for Child Welfare [CEBC] or practices that have been manualized for others to implement with fidelity; as well as practices determined to be effective by communities) by funding organizations that will expand the practices geographically or for additional populations of focus, and those organizations that will newly deliver the practices with additional implementation support

3. **Exploring potential policy innovations** that could lead to sustainable funding strategies.

During Fiscal Year 2022-2023, DHCS will scale the identified practices through six competitive grant rounds in the following areas of focus:

Round 1
Parent/caregiver support programs and practices (December 2022)

Round 2
Trauma-informed programs and practices (January 2023)

Round 3
Early childhood wraparound services (February 2023)

Round 4
Youth-driven programs (March 2023)

Round 5
Early intervention programs and practices (March/April 2023)

Round 6
Community-defined evidence programs and practices (approximate timeline for release: April 2023)

DHCS is partnering with the Mental Health Services Oversight & Accountability Commission (MHSOAC) to scale specified prevention and early intervention practices. An estimated $43 million of the total funding will be disbursed to MHSOAC as part of an interagency partnership agreement between DHCS and MHSOAC. DHCS is working closely with MHSOAC to define the terms of the interagency agreement, including the scope of work.

The Case for EBPs and CDEPs

Both EBPs and CDEPs play an important role in providing culturally relevant, identity-affirming BH services to California's children and youth. EBPs are those with documented, empirical evidence (e.g., randomly controlled trials, peer-reviewed studies, and publications) of effectiveness in improving children and youth BH. These programs and practices have been clinically reviewed and codified, meaning the practices have been manualized to ensure the fidelity of implementation in a variety of settings. At both the federal and state level, there are existing databases of EBP resources through SAMHSA[2] and CEBC[3], respectively. DHCS, with stakeholder input, identified a set of practices well-documented in the federal and state clearinghouses.

CDEPs are community-based BH practices that have reached a strong level of support within specific communities. In an ongoing effort, the California Reducing Disparities Project (CRDP), funded by the California Department of Public Health through its Office of Health Equity (OHE), aims to build the evidence base for 35 pilot CDEP programs. The CRDP is supporting the data collection and evaluation of these CDEPs to elevate practices that resonate with historically marginalized populations and identify strategies for systems change to pave the way for CDEPs in the public BH delivery system.[4] Through the EBP/CDEP workstream, DHCS seeks to build on CRDP's success and continue to support the scaling of CDEPs that are specific to children and youth.

Equity-Driven Approach

"Reducing health disparities and promoting health equity is a central component of the overall grant strategy."

Reducing health disparities and promoting health equity is a central component of the overall grant strategy. Equity-driven outcomes for populations of focus are a key focus for grant awards and data reporting for grant recipients. In selecting the theme for each round and specific EBPs/CEDPs, DHCS and its stakeholders were guided by the Department's guiding principles to achieving equity in BH, the bold goals included in its Comprehensive Quality Strategy, and Medi-Cal's Strategy to Support Health and Opportunity for Children and Families.

DHCS selected EBPs/CDEPs that:

- Maximize impact and reduced disparities for all children and youth with an emphasis on programs/practices that focus on marginalized communities
- Incorporate youth and family voices to ensure that the selected programs/practices resonate with a diverse audience
- Focus on the upstream continuum of care to reduce the risk of significant BH concerns in the future
- Affirm the right to access timely help and provide accessible, high-quality, appropriate care for all children and youth
- Destigmatize community support to enable every community to recognize the signs of BH concerns and be willing to support those with BH concerns without prejudice and discrimination.
- Have a data driven-approach to expand the use of evidence-based and community-defined evidence BH services

DHCS is also committed to working with stakeholders to design a grant strategy that promotes equity by attempting to address barriers for participation by community-based organizations, faith-based organizations and other trusted community providers.

DHCS' equity framework is anchored in the following six principles:

Awareness and Acceptance: Inclusion of diverse stakeholders from a variety of backgrounds in all stakeholder engagement sessions. As part of the stakeholder process, DHCS solicited the participation of multi-disciplinary experts and leaders representing a wide variety of programs, organization types, communities, and geographies. A core component of this stakeholder strategy included engaging youth, parents/caregivers, and community members in a series of listening sessions and focus groups to ensure workstream objectives aligned with the needs of children/youth in California. Based on stakeholder recommendations, DHCS reviewed more than 100 practices and programs across the continuum of care and applicable in a variety of clinic, home, and community-based settings

"DHCS reviewed more than 100 practices and programs across the continuum of care and applicable in a variety of clinic, home, and community-based settings."

Access: In collaboration with stakeholders, DHCS selected EBPs and CDEPs based on demonstrated effectiveness across multiple service settings (e.g., clinics, virtual, school, communities, etc.) to make the programs more accessible in communities for populations of focus. For example, SAMHSA notes that telehealth BH services can provide a "low-barrier pathway for clients and providers to connect."[5] Still, while technology facilitates access for some children and families, the digital divide creates additional access barriers for low-income and rural communities, which is why the grant program also includes a focus on other community settings where children and families already engage in services, such as childcare and preschool programs. The EBP/CDEP workstream focus on access reinforces DHCS' work as part of other CYBHI workstreams to ensure BH services are accessible across a variety of settings, including online (Virtual Services & E-consult Platform) and in schools (School-linked Partnership and Capacity Grants). Expanding the settings in which BH services are available enables providers to meet the needs of patients more readily.

In addition, DHCS is committed to ensuring that the grant selection process is accessible for a variety of organizations, including community-based organizations, that serve and have trusted relationships with communities prioritized in terms of populations of focus for each grant round.

Affordability: DHCS is exploring opportunities related to sustainability for those practices scaled through this effort to minimize potential financial burdens on children, youth, and families.

Appropriateness: DHCS intentionally selected CDEPs to elevate accepted interventions and existing practices deemed culturally appropriate, as demonstrated through the CRDP, and selected EBPs that have been normed or adapted for populations of focus

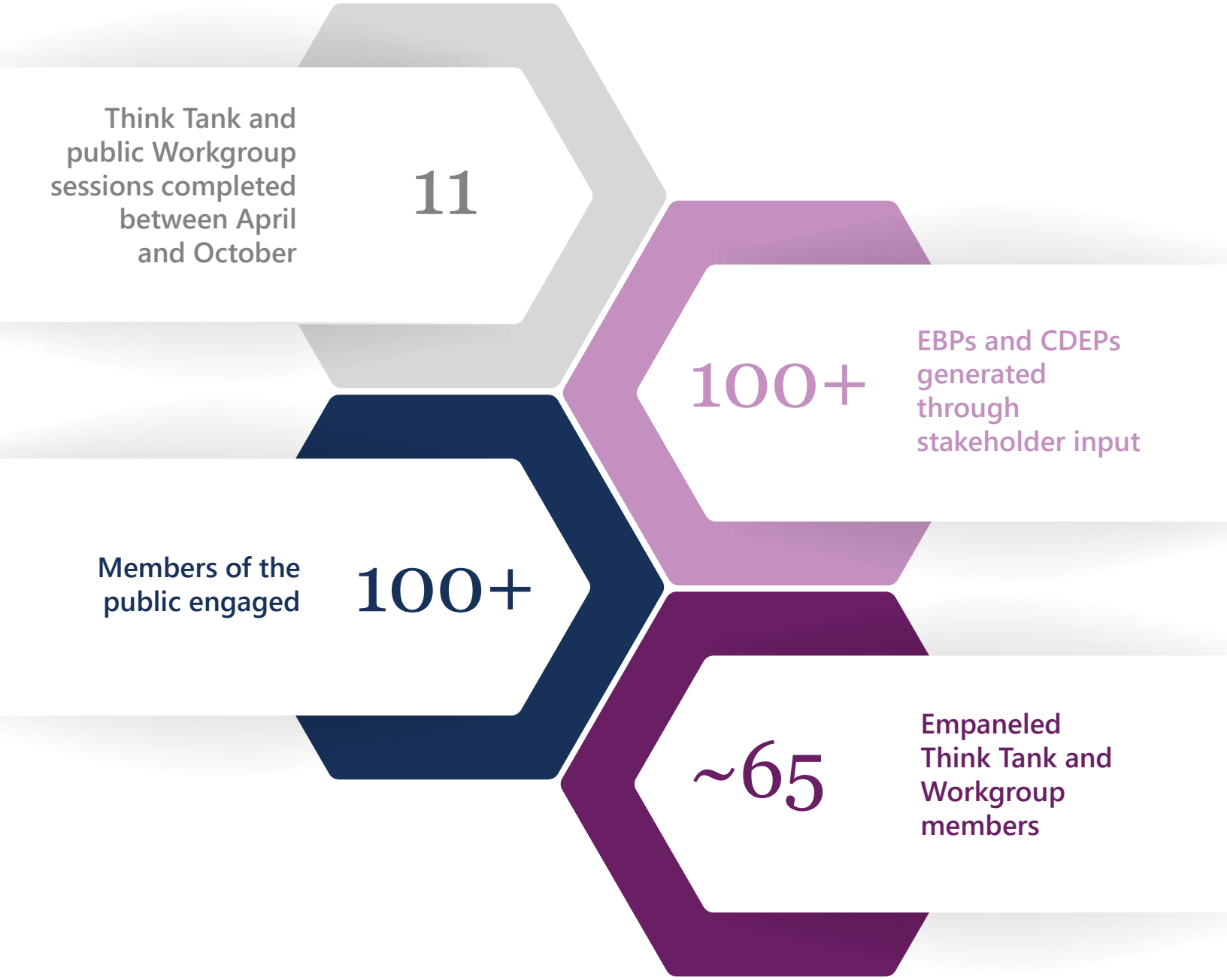
Accountability: As a component of the EBP/CDEP workstream strategy, DHCS will require accountability from grantees through data collection requirements, as mandated by statute.

The program will prioritize grants to programs or practices that scale and sustain engagement with populations of focus (e.g., underserved racial and ethnic groups, underserved geographies, underserved income-levels, LGBTQIA+ people, etc.) to increase health equity for California youth.

Stakeholder Engagement Process

In developing multiple facets of the EBP/CDEP workstream, DHCS employed a multi-pronged stakeholder-driven approach.

Figure 1: Summary of Stakeholder Engagement through October 2022



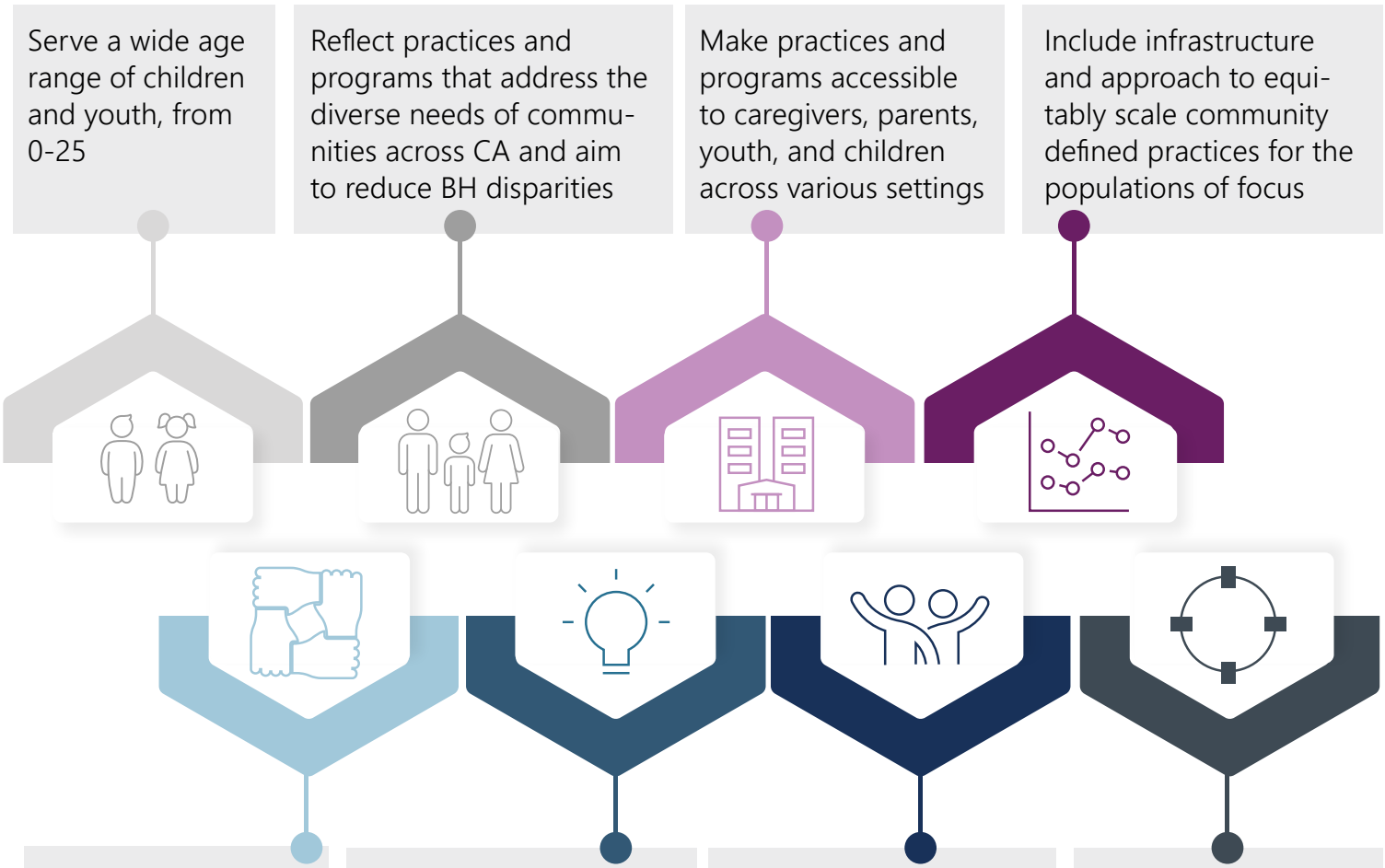
Between April 2022 and October 2022, DHCS convened a series of meetings with a Think Tank, comprised of leading experts from academia, government, and industry, as well as youth and relevant community members, in an interdisciplinary setting to ensure diverse representation and to promote meaningful development and refinement of program design. DHCS sought to select members representing diversity in terms of geography, type of expertise, health/behavioral health experience (e.g., primary care, behavioral health providers, plans, counties, community-based organizations), and those with lived experience or expertise serving BIPOC, LGBTQIA+, rural communities, and other special populations. For more information about Think Tank members, please review their biographies.

DHCS also established a Workgroup to convene additional experts to advise DHCS about the selection of EBP and CDEP that will be scaled statewide through a competitive granting process. DHCS sought input from the Workgroup to guide strategies fusing implementation science. Across three public sessions, Workgroup members provided critical insights that helped DHCS refine their perspectives and hypotheses on potential EBPs and CDEPs to scale. For more information about the Workgroup, please review the member list.

This diverse group of Think Tank and Workgroup members prioritized upstream, prevention-focused services and supports along the continuum of care; suggested outcomes the program should strive toward; identified 100+ EBPs and CDEPs for consideration; and developed five criteria (effectiveness, equity, scalability, sustainability, and being supplementary to the BH landscape) to narrow the list of practices and programs to ones that are likely to generate the most impact for California children and youth.

With stakeholder input, DHCS then conducted a holistic review of the portfolio of practices and programs to ensure the selected list of EBPs and CDEPs address the broad needs of children and youth. The holistic portfolio review was guided by the following elements to ensure that the practices together address the broad range of needs of children and youth in California:

Figure 2: Overview of holistic criteria for portfolio review



The result of this process is a tentative portfolio of six grant rounds, each focusing on a different priority in terms of the impact for BH outcomes for populations of focus. While each grant round has a specific theme and associated EBPs/CDEPs, the grant design is flexible to allow for program and practice adaptations, or the addition of practices within the priority category and with demonstrated efficacy, to meet the needs of populations of focus. The tentative selection of programs and practices may be subject to further refinement based on an assessment of sustainable financing mechanisms, including Medi-Cal and commercial coverage and/or other funding streams. Final details concerning eligibility, scope, and evaluation criteria will be released with the final grant design and funding announcement for each grant round.

Populations of Focus and Prioritized Outcomes

As part of DHCS' equity-driven approach to grant design, DHCS will prioritize grant proposals focused on enhancing BH services for populations of focus identified by the CRDP and OHE. Despite the state's commitment to a mental health system that provides "adequate and appropriate services to all persons," these communities–African Americans, Latinx, Asian and Pacific Islanders, Native Americans, LGBTQIA+ people[6]–have struggled to achieve parity in accessing BH services.

Additional populations include: Justice-involved; low-income; persons with physical, intellectual, and/or developmental disabilities; refugees, migrant workers, and immigrants; rural communities; non-English speakers; those experiencing housing insecurity and homelessness; and children in foster care.[7]

Also, DHCS will prioritize practices and programs that focus on reducing BH disparities for these populations of focus. During the stakeholder engagement process, Think Tank and Workgroup members also prioritized key outcomes:

Increase protective factors for children and youth, as measured by improvements in reported well-being for children, youth, parents, and caregivers

Build incremental capacity, access, integration, and uptake in selected evidence-based and community-defined evidence BH services, including in non-clinical settings

Support codification of practices that can be adapted or normed on populations of focus

High-Level Grant Design Strategy

A key goal of the grants will be scaling identified practices and programs, which can be done in several ways. Eligible recipients will be able to apply for grant funding in one of two tracks: the training track or the implementation track. Eligible recipients can submit a proposal to a single track or an integrated proposal that includes activities on multiple tracks. Specific details about each track and eligible organizations will be included in the Request for Applications (RFA) for each round; however, a high-level overview of the potential tracks is included below:

Training track: the training track is designed for individuals seeking access to manualized training and/or certification in a shortlisted EBP and CDEP (or related adaptation).

Implementation track: this track is designed for organizations seeking grant funding for one of the following activities:

- Start-up: the start-up track is designed for organizations that are seeking start-up funds to newly implement an EBP and CDEP (or related adaptation).
- Operational expansion: the operational expansion track is designed for organizations looking to:
  - Expand provision of short-listed EBP and CDEP (or related adaptation) that they currently provide
  - Scale delivery of a short-listed EBP and CDEP (or adaptation) by training or credentialing more providers.

For the life of the grant and per the legislation, grantees will be expected to collect standardized data and provide periodic reports to DHCS. Grantees from the operational expansion track or start-up track could also have the opportunity to participate in a learning collaborative or other cohort program to learn from other grantees and share insights on grant implementation. To ensure accessibility to a variety of organizations, technical assistance will be provided to grantees without the required capacity or skillset in billing, data collection, monitoring, or reporting.

Below is an overview of each grant funding round, including priority focus, proposed release date, rationale, and example practices within each category.

Note: DHCS's final list of selected programs and practices will be released in the RFA for each grant round. Selected programs and practices may be subject to further refinement based on an assessment of sustainable financing mechanisms, including Medi-Cal and commercial coverage and/or other funding streams.

Round 1: Parent/caregiver support programs and practices

"Research echoes the importance of early intervention with roughly 30 percent of California caregivers reporting moderate concerns over their child's social and emotional development and behavioral health, and 20-40 percent of those same caregivers reporting engaging in some ineffective type of parenting." [8]

Description of Priority Focus Area: The first grant round will fund programs and practices to increase support for and improve parental and caregiver involvement.

Proposed Release Date: December 2022

Rationale: Implementing effective prevention and early intervention programs that build on the strength of diverse parents and caregivers could lead to positive impacts on children and youth facing BH challenges. Research echoes the importance of early intervention with roughly 30 percent of California caregivers reporting moderate concerns over their child's emotional and BH and 20-40 percent of those same caregivers reporting engaging in some ineffective type of parenting.[8] This round of funding could complement work done to strengthen parenting practices by the First 5 Initiative, California Department of Social Services, and the Child Mind Institute, among others.

Priority Populations of Focus: To include populations identified by CRDP and OHE with a priority focus on parents and caregivers of children and youth with BH needs and parents and caregivers of children who benefit most from preventative strategies (e.g., young children 0-5 years of age).

Expected Outcomes/Key Metrics: Through funding these EBPs and CDEPs, DHCS expects to strengthen positive parenting practices, improve the response to emotional and behavioral challenges commonly experienced in childhood, promote child social and emotional development, improve caregiver involvement and relationships with children, and increase support for individuals that may be experiencing heightened levels of caregiver-related stress among other outcomes.

Example EBPs/CDEPs in Priority Category: Potential EBPs/CDEPs to be funded in this round include but are not limited to HealthySteps/ Dyadic Care Services; Incredible Years; Parent-Child Interaction Therapy; Positive Parenting Program (Triple P); and, Parents Anonymous®. DHCS will release the final list of selected programs and practices in the RFA for this grant round and will include allowances for other EBPs with demonstrated efficacy including, but not limited to, those that have a minimum of "promising" or "supported" rating in the Title IV-E Clearinghouse Prevention Services or the California Evidence-Based Clearinghouse for Child Welfare,[9] as well as CDEPs that have reached a strong level of efficacy within specific communities based on their perceived or reported positive outcomes. Selected programs and practices may be refined based on insurance coverage.

Round 2: Trauma-informed programs and practices

"Research indicates that 36 percent of children in California have been exposed to one or more ACEs." [10]

Description of Priority Focus Area: Round 2 will fund trauma-informed programs and practices to increase access to services that address BH needs and the impact of Adverse Childhood Experiences (ACEs).

Proposed Release Date: January 2023

Rationale: DHCS stakeholders emphasized that intervening early and increasing the availability of interventions that are trauma-informed can help reduce the negative effects of ACEs. Research indicates that 36 percent of children in California have been exposed to one or more ACEs[10] and 63.5 percent of all adults were exposed before age 18.[11] This round of funding could build upon work being done by DHCS, the California Department of Education, MHSOAC, and the California Office of the Surgeon General.[12]

Priority Populations of Focus: To include populations identified by CRDP and OHE

Expected Outcomes/Key Metrics: Through funding these EBPs and CDEPs, DHCS expects to expand access to early interventions, support the resilience of children and youth by mitigating the adverse effects of ACEs, build knowledge of trauma-informed support and communication, increase the capacity of child-serving service systems on trauma-informed practices, improve the understanding of how community trauma and racism impact child and youth well-being, and improve grief support for children and youth with COVID-related trauma among other outcomes.

Example EBPs/CDEPs in Priority Category: Potential EBPs/CDEPs to be funded in this round include but are not limited to Child-Parent Psychotherapy; Cognitive Behavioral Interventions for Trauma in Schools; Dialectical Behavioral Therapy; Family-Centered Treatment; Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems; and Trauma-Focused Cognitive Behavioral Therapy. DHCS will release the final list of selected programs and practices in the RFA for this grant round and will include allowances for other EBPs with demonstrated efficacy including, but not limited to, those that have a minimum of "promising" or "supported" rating in the Title IV-E Clearinghouse Prevention Services or the California Evidence-Based Clearinghouse for Child Welfare,[13] as well as CDEPs that have reached a strong level of efficacy within specific communities based on their perceived positive outcomes. Selected programs and practices may be refined based on insurance coverage.

Round 3: Early childhood wraparound services

"65 percent of California's children aged 0-3 have one or more risk factors for BH conditions." [14]

Description of Priority Focus Area: Round 3 will fund early childhood wraparound services to build family strength and overall well-being.

Proposed Release Date: February 2023

Rationale: 65 percent of California's children ages 0-3 have one or more risk factors for BH conditions,[14] and less than 50 percent of young children with emotional, behavioral, or relationship disturbances receive any treatments.[15] The inclusion of this round is consistent with stakeholder feedback that early engagement is crucial to mitigating BH issues in adulthood. This round of funding could complement other statewide behavioral health initiatives for young children, such as the Maternal Infant and Early Childhood Home Visiting Program, Early Childhood Mental Health Consultation Network, and Black Infant Health Program, all of which are implemented by various state and local agencies including First Five County Commissions.

Expected Outcomes/Key Metrics: Through funding these EBPs and CDEPs, DHCS expects to increase access to home visiting services and consultation services, improve coordination of services between pregnant and parenting/caregiving people and their support systems, improve parent/caregiver and child health, reduce ACEs, and reduce emergency department visits and substantiated child abuse calls due to child maltreatment among other outcomes.

Priority Populations of Focus: To include populations identified by CRDP and OHE, with a priority focus on parents and caregivers with young children (e.g., 0-5 years of age)

Example EBPs/CDEPs in Priority Category: Potential EBPs/CDEPs to be funded in this round include, but are not limited to, Healthy Families America, Nurse Family Partnership, and Infant and Early Childhood Mental Health Consultation. DHCS will release the final list of selected programs and practices in the RFA for this grant round and will include allowances for other EBPs with demonstrated efficacy, including, but not limited to, those that have a minimum of "promising" or "supported" rating in the Title IV-E Clearinghouse Prevention Services or the California Evidence-Based Clearinghouse for Child Welfare,[16] as well as CDEPs that have reached a strong level of efficacy within specific communities based on their perceived positive outcomes. Selected programs and practices may be refined based on insurance coverage.

Round 4: Youth-driven programs

"Research indicates that not only are youth peer coaches qualified to support other youth "because of their experience facing similar challenges" but this support is crucial for their peers suffering from serious mental health conditions." [17]

Description of Priority Focus Area: Round 4 will fund youth-driven programs to provide California children and youth the opportunity to shape their behavioral health services.

Proposed Release Date: March 2023

Rationale: Stakeholders expressed the importance of the youth voice in developing interventions that reach, are wanted by, and are appropriate for youth in their communities. Research indicates that not only are youth peer coaches qualified to support other youth "because of their experience facing similar challenges," but this support is crucial for their peers suffering from serious mental health conditions.[17] Youth expressed similar sentiments during the stakeholder engagement process, highlighting the potential for youth-driven programs and practices to make an impact on BH. This round of funding could serve to scale efforts by DHCS and California Department of Health Care Access and Information in creating a robust peer support specialist ecosystem in California by increasing foundational skills and fostering interest in mental health workforce pathways in youth, especially youth of color.

Expected Outcomes/Key Metrics: Through funding these EBPs and CDEPs, DHCS expects to increase accessibility to peer-to-peer support and other related programs that are informed through youth voice, provide non-clinical access to BH support, improve engagement in other BH-related services, improve self-reported well-being, and promote long-term recovery among other outcomes.

Priority Populations of Focus: To include populations identified by CRDP and OHE with a priority focus on youth between the ages of 12-25

Example EBPs/CDEPs in Priority Category: Potential EBPs/CDEPs to be funded in this round include, but are not limited to, peer support and youth drop-in centers (e.g., Allcove™). DHCS will release the final list of selected programs and practices in the RFA for this grant round and will include allowances for other EBPs with demonstrated efficacy including, but not limited to, those that have a minimum of "promising" or "supported" rating in the Title IV-E Clearinghouse Prevention Services or the California Evidence-Based Clearinghouse for Child Welfare,[18] as well as CDEPs that have reached a strong level of efficacy within specific communities based on their perceived positive outcomes. Selected programs and practices may be refined based on insurance coverage.

Round 5: Early intervention programs and practices

"National research has shown that 50 percent of all mental health conditions appear before age 14." [19]

Description of Priority Focus Area: Round 5 will fund early intervention programs and address BH needs more effectively earlier, and reduce reliance on more intensive services. This round of funding may include funding administered by an interagency agreement with MHSOAC.

Proposed Release Date: March/April 2023

Rationale: Research indicates that early BH intervention can reduce premature death, social isolation, poor function, and increase educational and vocational prospects;[19] however, less than 5 percent of eligible children covered by Medi-Cal receive a single mental health service.[20] National research has shown that 50 percent of all mental health conditions appear before age 14.[21] Early intervention programs and practices were identified by stakeholders as an important way to improve children and youth outcomes in adulthood.

Expected Outcomes/Key Metrics: Through funding these EBPs and CDEPs, DHCS expects to increase early identification of BH concerns, improve or properly address BH challenges preventing escalation to more intensive services, and improve coordination of services among other outcomes

Priority Populations of Focus: To include populations identified by CRDP

Example EBPs/CDEPs in Priority Category: Potential EBPs/CDEPs to be funded in this round include but are not limited to early psychosis programs (e.g., Coordinated Specialty Care) and Youth Crisis Peer Mobile Response. DHCS will release the final list of selected programs and practices in the RFA for this grant round and will include allowances for other EBPs with demonstrated efficacy including, but not limited to, those that have a minimum of "promising" or "supported" rating in the Title IV-E Clearinghouse Prevention Services or the California Evidence-Based Clearinghouse for Child Welfare,[22] as well as CDEPs that have reached a strong level of efficacy within specific communities based on their perceived positive outcomes. Selected programs and practices may be refined based on insurance coverage.

Round 6: Community-defined evidence programs and practices

"DHCS expects to increase the availability of culturally relevant BH services to communities across the state among other outcomes."

Description of Priority Focus Area: Round 6 will be dedicated specifically to community-defined evidence programs and practices to provide culturally competent prevention and early intervention services. While this round is dedicated to CDEPs, potential grantees that implement CDEPs are welcome to apply in any of the six funding rounds.

Approximate timeline for release: April 2023

Rationale: During Phase I of their research, CRDP found that marginalized communities have historically struggled to achieve "optimal mental health" despite a statewide system that was designed to provide services without regard to ethnicity or sexual orientation.[23] This lived experience was echoed during the stakeholder engagement process, in which several communities expressed their struggle to access culturally relevant and linguistically appropriate BH services. With its commitment to increasing health equity through the EBP/CDEP workstream, DHCS and its stakeholders recognize the importance of these CDEPs as an alternative to "traditional" BH services for populations of focus.

Expected Outcomes/Key Metrics: Through funding these EBPs and CDEPs, DHCS expects to increase the availability of culturally relevant BH services to communities across the state among other outcomes.

Priority Populations of Focus: To include a priority focus on populations of focus identified by CRDP

Example EBPs/CDEPs in Priority Category: Potential EBPs/CDEPs to be funded in this round include but are not limited to the 35 pilot projects funded during CRDP Phase II which include services for children and youth under 25. DHCS will release the final list of selected programs and practices in the RFA for this grant round. Selected programs and practices may be refined based on insurance coverage.

Grant Eligibility Considerations and Application Process

Final details concerning eligibility, scope, evaluation criteria, and the application process are still being determined in partnership with the Think Tank and Workgroup and will be announced at a later date. Formal guidelines will be released along with the RFAs for each grant round.

Eligible organizations may vary slightly per round and are likely to include but not be limited to:

- Community-based organizations that provide services to children, youth, and/or families
- Provider clinics (e.g., primary care, community mental health, behavioral health, pediatric clinics)
- County or city governments (e.g., county BH departments, public health)
- Early learning and care providers (e.g., childcare and preschool settings)
- Family resource centers
- Statewide and local agencies (e.g., First 5 associations)
- Faith-based organizations
- Regional centers
- Local Educational Agencies (County Offices of Education, school districts), public K–12 school sites, charter schools
- Institutions of higher education (i.e., California Community Colleges, California State University, University of California)
- Tribal entities
- Health plans
- Hospitals and hospital systems
- Others, as applicable

The criteria by which applications are evaluated may be tailored to the individual funding rounds; however, core criteria applicable across rounds could include but is not limited to:

- **Geographic distribution:** Applicants could be expected to show the demonstrated need for the expansion of a program or practice area. For example, grantees might include a county-level analysis for a particular EBP/CDEP to highlight where populations of focus could benefit from an expansion of the EBP/CDEP.

- **Organizational capacity:** In line with DHCS' goal to scale and codify EBPs/CDEPs across the state, potential grantees may be asked to describe their staff's experience with implementing BH programs and forecasted ability to implement new programs. For example, this could take the form of case studies on previous grant implementations and/or a hiring plan to show how the organization will use grant funds to bring appropriate talent onboard.

- **Proven relationships with populations of focus:** Several populations of focus have heightened sensitivity to BH interventions due to generations of disenfranchisement and lived oppression.[24] In their application, to demonstrate their commitment to serving and affecting change in populations of focus, grantees could showcase anonymized, aggregated client demographic data, provide evidence of recent outreach events, and highlight the experience of their boards or executive teams in working with these communities.

- **Sustainability plan:** DHCS CYBHI grants will not be recurring, so grant applicants could be expected to demonstrate how the funding will be used to generate short-term and long-term impact after the grant money is expended. This could include highlighting the number of new professionals that could be trained on an EBP/CDEP, detailing any matching funds opportunities or explaining proposed policy changes that could lead to Medi-Cal or commercial insurance coverage.

As mentioned in the Equity Driven Approach section, promoting health equity has been central to not only the grant design but also in determining the application process (taking into account the work of the Health in All Policies Initiative). Recognizing that not all organizations have the same resources for developing comprehensive grant proposals, DHCS will take steps to make its grant applications as accessible as possible, which may include: minimizing the content required in each proposal, reviewing applications on a rolling basis to lengthen the application window, and committing to work with a third-party administrator (TPA) that can provide technical support to under-resourced applicants.

If you have questions or would like to share feedback, please contact DHCS at CYBHI@dhcs.ca.gov.

Endnotes

1 W&I Code, section 5961.5

2 SAHMSA Evidence-Based Practices Resource Center

3 California Evidence-Based Clearinghouse for Child Welfare

4 California Reducing Disparities Project

5 SAMHSA

6 CRDP

7 OHE

8 Kids Data

9 California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale

10 California Health and Human Services Agency's and the California Department of Public Health's Let's Get Healthy Initiative

11 Ibid.

12 WestEd

13 California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale

14 Center for Disease Control and Prevention

15 Let's Get Healthy

16 California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale

17 UMass Med

18 California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale

19 BMI Journals

20 CA Children's Hospital Association

21 SAMHSA

22 California Evidence-Based Clearinghouse for Child Welfare Scientific Rating Scale

23 CRDP Strategic Plan Executive Summary

24 CRDP

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, February 1, 2023 4:36 PM
To: Works-Wright, Jamie
Subject: FW: Mental Health Advisory Board Retreat (February 4, 2023)
Attachments: MHAB 2023 Retreat Binder.pdf

Please see the attached document

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: MHB Communications, ACBH <ACBH.MHBCommunications@acgov.org>
Sent: Wednesday, February 1, 2023 11:23 AM
Subject: Mental Health Advisory Board Retreat (February 4, 2023)

Good morning,

Please see attached Mental Health Advisory Board Retreat Binder for the meeting scheduled for this Saturday, February 4, 2023.

Mental Health Advisory Board Retreat
Time: 10:00 AM – 1:30 PM Pacific Time (US and Canada)

Join from PC, Mac, Linux, iOS or Android:
https://us06web.zoom.us/j/85741452825?pwd=V3h4OXdWUERNMmtjUm1jTHNBV3FtQT09
Password: 787413
Meeting ID: 857 4145 2825

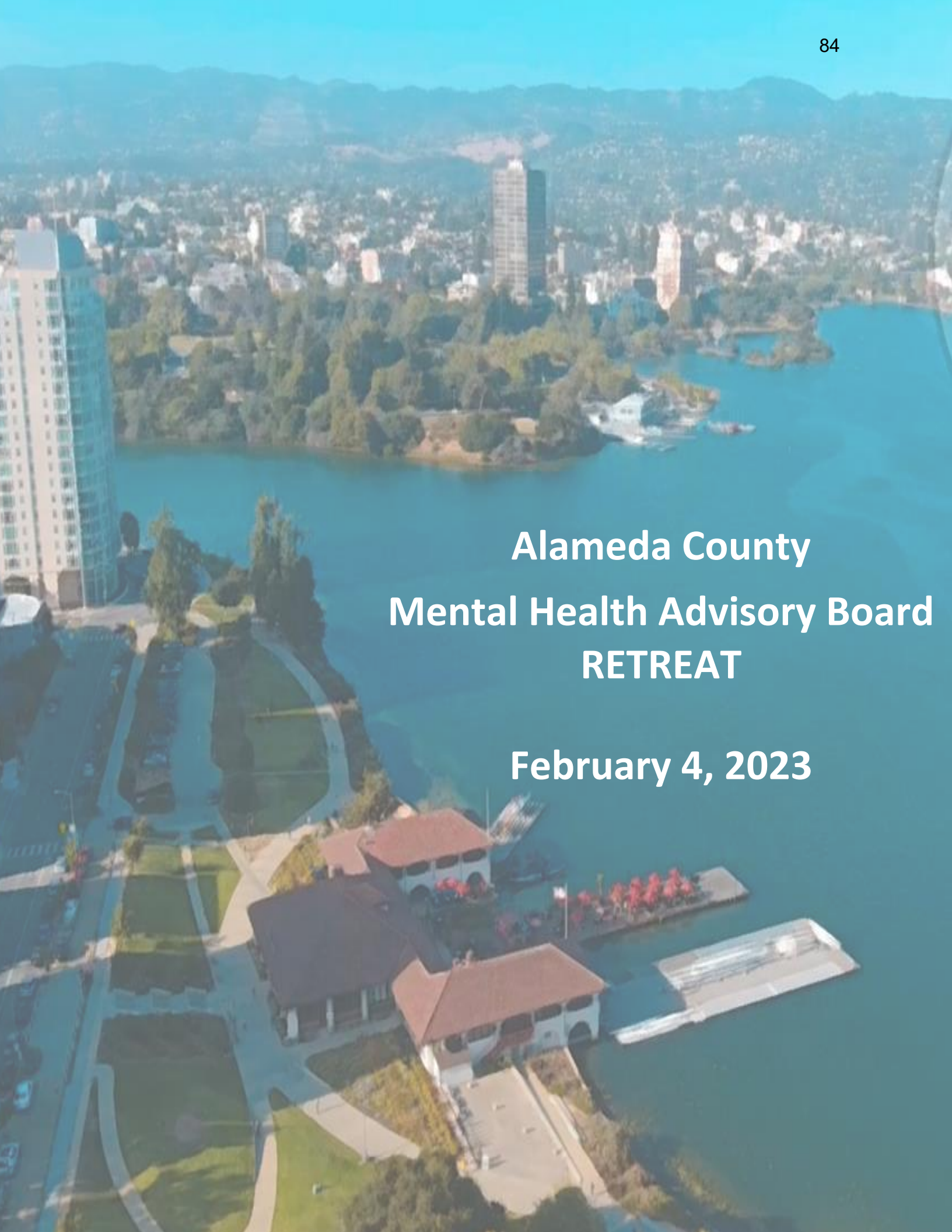
Or Telephone:

One tap mobile:
+14044436397,,,937417# US Toll
+18773361831,,,937417# US Toll-free

Dial:
USA 404 443 6397
USA 877 3361831 (US Toll Free)
Conference code: 937417

Find local AT&T
Numbers: https://www.teleconference.att.com/servlet/glbAccess?process=1&accessNumber=4044436397&accessCode=937417

Or Skype for Business (Lync):
https://us06web.zoom.us/skype/85741452825



Alameda County
Mental Health Advisory Board
RETREAT

February 4, 2023

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Alameda County
Mental Health Advisory Board

Contact the Mental Health Advisory Board at:

ACBH.MHBCommunications@acgov.org

February 1, 2023

Dear MHAB Members,

Our MHAB Retreat will be held virtually on **Saturday, February 4, 2023, from 10:00am to 1:30pm**.

We will focus on three main areas:

- Evaluation of the MHAB, including what we are doing well, what we might improve, and any opportunities or challenges we should be monitoring.
- Exploration of what it means to be a member and how to set our members up for success, including how we might use this information to recruit and retain new members.
- Short-term (three to six month) priorities and goals.

Please Come Prepared

Please carefully review the Retreat Agenda and the contents of this Pre-Retreat Packet before attending the Retreat. Each document was included to help you prepare for our discussions.

Information to help orient you to the meeting itself:

- Cover Letter to Board
- Retreat Agenda
- Board Members and Photos

Information to support evaluation:

- MHAB Bylaws
- California Association of Local Behavioral Health Boards & Commissions Best Practices
  - Please pay special attention to page 14 (duties of MHAB)

Information to support the discussions about recruitment and short-term priorities:

- Current MHAB Committees, Sub-Committees, Liaisons & Other Activities
- MHAB Members and Vacancies by Board of Supervisor District

- MHAB Annual Calendars
- California Association of Local Behavioral Health Boards & Commissions Best Practices
  - Please pay special attention to pages 21-23 on recruitment

Information to support the discussion on short-term priorities:

- MHAB Annual Report
  - Please focus on the recommendations if you have limited time.

Group Agreements
We will be using the following group agreements adopted at our 2022 Special Meeting.

- Practice active listening
- Everyone will participate
- Make space/take space
- Stay on topic/time
- Use "I" statements
- Build on others' ideas
- It's okay to disagree
- Assume good intentions
- Be mindful of impact

Food and Drink
There will be two short breaks during the meeting but no break for lunch. We encourage you to plan ahead so you have food and drink available if you would like to snack or have lunch while we work.

Other Things to Know in Advance
We will ask you to use the following Zoom functions during the meeting: "mute/unmute", "raise hand", and "chat". You may also want to have pen and paper available or some other method to capture your thoughts and notes.

Special Thanks
This Retreat would not have happened without the help and support of Dr. Tribble, Dainty Castro, Asia Jenkins, and our facilitator, Stacey Smith of SKS Consulting.

We look forward to seeing you there!

Your Retreat Planning Group,

Brian Bloom
Warren Cushman
Thu Quach
Julie Leftwich

Alameda County
Mental Health Advisory Board

Mental Health Advisory Board *Retreat* Agenda

Saturday, February 4, 2023 ◊ 10:00AM – 1:30PM

https://us06web.zoom.us/j/85741452825?pwd=V3h4OXdWUERNMmtjUm1jTHNBV3FtQT09

Teleconference: 1 (877) 336-1831 Webinar ID: 857 4145 2825
Passcode: 787413

This meeting will be conducted exclusively through videoconference and teleconference

MHAB Members:	**Brian Bloom** *(Interim Chair, District 4)* **Warren Cushman** *(Interim Vice Chair, Dist 3)* **Christina Aboud** *(District 1)* **Terry Land** *(District 1)* **Thu Quach** *(District 2)*	**Grant Quinones** *(District 2)* **Loren Farrar** *(District 3)* **Ashlee Jemmott** *(District 3)* **Anh Thu Bui** *(District 5)* **Juliet Leftwich** *(District 5)*

Adult Committee
Warren Cushman, Co-Chair
Thu Quach, Co-Chair

Children's Advisory Committee
Vacant

Criminal Justice Committee
Brian Bloom, Co-Chair
Juliet Leftwich, Co-Chair

Quality Improvement Committee
Vacant

MHSA Stakeholders Committee
Terry Land

Measure A Oversight Committee
Vacant

MHAB Mission Statement

The Alameda County Mental Health Advisory Board has a commitment to ensure that the County's Behavioral Health Care Services provide quality care in treating members of the diverse community with dignity, courtesy, and respect. This shall be accomplished through advocacy, education, review, and evaluation of Alameda County's mental health needs.

Time	Item	Facilitator
10:00 am – 10:05 am	Call to Order and Roll Call	Brian Bloom
10:05 am – 10:10 am	Agreement to Hold Virtual Meeting (Action Item)	Brian Bloom
10:10 am – 10:20 am	Welcome and Group Agreements	Brian Bloom Stacey Smith
10:20 am – 10:45 am	MHAB Member Introductions	Stacey Smith
10:45 am – 11:10 am	MHAB Evaluation	Stacey Smith
11:10 am – 11:15 am	**BREAK**	
11:15 am – 12:15 pm	MHAB Member Recruitment	Stacey Smith
12:15 pm – 12:30 pm	**BREAK**	
12:30 pm – 1:00 pm	MHAB Short-Term Priorities	Brian Bloom Stacey Smith
1:00 pm – 1:15 pm	Next Steps	Stacey Smith
1:15 pm – 1:20 pm	Closing Remarks	Brian Bloom
1:20 pm – 1:30 pm	Public Comment	Brian Bloom
1:30 pm	Adjourn	Brian Bloom

Alameda County
Mental Health Advisory Board

Mental Health Advisory Board
MEMBERS

Brian Bloom
MHAB Interim Chair
District 4

Warren Cushman
MHAB Interim Vice-Chair
District 3

Christina Aboud
District 1

Anh Thu Bui
District 5

Loren Farrar
District 3

Ashlee Jemmott
District 3

Terry Land
District 1

Juliet Leftwich
District 5

Thu Quach
District 2

Grant Quinones
District 2

Alameda County
Mental Health Advisory Board

Current MHAB Committees, Representatives and Other Member Activities

***Interim* MHAB Chair**: Brian Bloom
***Interim* MHAB Vice-Chair**: Warren Cushman

MHAB Committees

Adult Committee: Warren Cushman, Thu Quach, Terry Land
Criminal Justice Committee: Brian Bloom, Juliet Leftwich
Children's Advisory Committee: *Vacant*
Executive Committee: Brian Bloom, Warren Cushman, Thu Quach, Juliet Leftwich

MHAB *Ad Hoc* Committees

Data *Ad Hoc* Committee
Legislative *Ad Hoc* Committee

MHAB Representatives

Care First, Jail Last Task Force Representative: Brian Bloom
Mental Health Services Act Representative: Terry Land
Quality Improvement Committee Representative: *Vacant*

Contact the Mental Health Advisory Board at:

ACBH.MHBCommunications@acgov.org

Alameda County
Mental Health Advisory Board

Mental Health Advisory Board Vacancies

DISTRICT 1

- Christina Aboud
- Terry Land
- *Vacant*

DISTRICT 2

- Thu Quach
- Grant Quinones
- *Vacant*

DISTRICT 3

- Warren Cushman
- Loren Farrar
- Ashlee Jemmott

DISTRICT 4

- Brian Bloom
- *Vacant*
- *Vacant*

DISTRICT 5

- Anh Thu Bui
- Juliet Leftwich
- *Vacant*

BOARD OF SUPERVISORS REPRESENTATIVE

- *Vacant*

ALAMEDA COUNTY MENTAL HEALTH ADVISORY BOARD

BYLAWS

ARTICLE I

SECTION I - NAME

The name of this Board shall be the Alameda County Mental Health Advisory Board. "Board" shall reference the Mental Health Advisory Board, and the Board of Supervisors shall be referenced as such in full.

SECTION II - AUTHORITY AND PURPOSE

The authority of the Board is established by Welfare and Institutions Code Section 5604 et seq. In accordance with Welfare and Institutions Code Section 5604.2, the Board shall:

A. Review and evaluate the community's public mental health needs, services, facilities, and special problems in any facility within the county where mental health evaluations or services are provided, including but not limited to, schools, emergency departments, and psychiatric facilities.

B. Review any county agreements entered into pursuant to Welfare and Institutions Code Section 5650 and make recommendations regarding concerns identified within those agreements.

C. Advise the Board of Supervisors and the Alameda County Behavioral Health Care Services Director as to any aspect of the local mental health program. The Board may request assistance from the local patients' rights advocates when reviewing and advising on mental health evaluations or services provided in public facilities with limited access.

D. Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process. Involvement shall include individuals with lived experience of mental illness and their families, community members, advocacy organizations, and mental health professionals. It shall also include other professionals that interact with individuals living with mental illnesses on a daily basis, such as education, emergency services, employment, health care, housing, law enforcement, local business owners, social services, seniors, transportation, and veterans.

E. Submit an annual report to the Board of Supervisors on the needs and performance of the county's mental health system.

F. Review and make recommendations on applicants for the appointment of the Alameda County Behavioral Health Care Services Director. The Board shall be included in the selection process prior to the vote of the Board of Supervisors.

G. Review and comment on the county's performance outcome data and communicate its findings to the California Behavioral Health Planning Council.

H. Assess the impact of the realignment of services from the state to the county on services delivered to clients and on the local community.

I. Perform such additional duties as may be assigned to the Board by the Board of Supervisors.

SECTION III – RELATIONSHIP TO BOARD OF SUPERVISORS

The Board of Supervisors shall appoint members to the Board in accordance with Chapter 2.68 of the Alameda County Administrative Code and shall rely on the collective judgement of the Board for input on mental health-related issues.

SECTION IV – MEMBERSHIP

The Board shall be composed of 16 members, one of whom shall be the Chair of the Board of Supervisors or the Chair's designee. In accordance with Welfare and Institutions Code Section 5604:

A. The Board may recommend appointees to the Board of Supervisors. The Board's membership should reflect the diversity of the client population in Alameda County to the extent possible, and represent all geographic regions in the county and their demographics.

B. Fifty percent of the Board members shall be consumers, or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least 20 percent of the total membership shall be consumers, and at least 20 percent shall be families of consumers.

C. In addition to consumers and family members referenced in Paragraph B, the Board of Supervisors is encouraged to appoint individuals who have experience with and knowledge of the mental health system. This would include members of the community that engage with individuals living with mental illness in the course of daily operations, such as representatives of county offices of education, large and small businesses, hospitals, hospital districts, physicians practicing in emergency departments, city police chiefs, county sheriffs, and community and nonprofit service providers.

D. The term of each Board members shall be three years. The Board of Supervisors shall equitably stagger the appointments so that approximately one-third of the appointments expire in each year.

E. Except as provided in Paragraph F, a Board member or the member's spouse shall not be a full-time or part-time county employee of Alameda County Behavioral Health Care Services, an employee of the State Department of Health Care Services, or an employee of, or a paid member of the governing body of, a mental health contract agency.

F. A consumer of mental health services who has obtained employment with an employer described in Paragraph E and who holds a position in which the consumer does not have any interest, influence, or authority over any financial or contractual matter concerning the employer may be appointed to the Board. The member shall abstain from voting on any financial or contractual issue concerning the member's employer that may come before the Board.

G. Board members shall abstain from voting on any issue in which the member has a financial interest as defined in Section 87103 of the Government Code.

H. Board members shall reside in Alameda County. If it is not possible to secure membership as specified in this section from among persons who reside in the county, the Board of Supervisors may substitute representatives of the public interest in mental health who are not full-time or part-time employees of Alameda County Behavioral Health Care Services, the State Department of Health Care Services, or on the staff of, or a paid member of the governing body of, a mental health contract agency.

Board members shall not serve more than four consecutive terms. If prior to the expiration of a term of appointment a member ceases to retain the status which qualified such member for appointment to the Board, such membership shall terminate and there shall be a vacancy.

SECTION V - MEETINGS

Board meetings shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part I of Division 2 of Title 5 of the Government Code, relating to meeting of local agencies (The Brown Act).

Regular meetings shall be held at least 10 times a year. Special meetings shall be convened at the request of the Chair or a majority of Board members and public notification of such meetings shall be sent at least 24 hours in advance of the meetings.

SECTION VI – OFFICERS

Board officers shall consist of a Chair and Vice-Chair. Officers shall serve for a term of two years, or until their successor is elected.

SECTION VII – ELECTION OF OFFICERS

A Nominating Committee shall be appointed by the Chair in July of each year. The Chair and Vice-Chair shall not sit as ex-officio members of the Nominating Committee. The Nominating Committee shall seek nominations and propose a slate of officers for the coming year, secure the verbal consent to serve of those nominated and report back to the Board in August. The Chair of the Nominating Committee shall assume the duties of the Board Chair to accept further nominations and conduct the election of officers during the August meeting.

SECTION VIII – TERMS OF OFFICE

New officers shall begin their terms on September 1 and serve for two years, or until their successor is elected. No member shall serve more than three consecutive terms in the same office.

SECTION IX – VACANCIES IN OFFICE

In the event during the Chair's term there is a vacancy in the office, the Vice-Chair shall become Chair for the remainder of the term. In the event during the Vice-Chair's term there is a vacancy in the office, the Board shall hold an election to fill the vacancy for the remainder of the term.

SECTION X – POWERS & RESPONSIBILITIES OF OFFICERS

The Board Chair shall be the principal executive officer and carry out the policies of the Board and the Executive Committee. The Chair shall prepare the agenda for and preside over all regular and special Board meetings, appoint Committee Chairs, and be in regular consultation with the Director of Behavioral Health Care Services.

The Vice-Chair shall assist the Chair in the performance of the Chair's duties. The Vice-Chair shall exercise all the powers of the Chair in the event of the Chair's absence.

SECTION XI – REMOVAL OF OFFICERS

An officer may be removed from office, for cause, by the majority vote of all members of the Board at an official Board meeting at which a quorum is present. Adequate formal notice, in writing and in person or by U.S. certified mail, must be given to any officer of such an impending removal action.

SECTION XII – VACANCIES

When a vacancy occurs, other than in an elective officer position, the Chair shall contact the Board of Supervisors to determine if there is a candidate for the vacancy and/or if the Board of Supervisors would consider recommendations from the Mental Health Advisory Board. All such vacancies shall be filled by appointment by the Board of Supervisors.

SECTION XIII – QUORUM

A quorum is one person more than one-half of the appointed members of the Board.

SECTION XIV – COMMITTEES

A. Committees shall be created as needed to do the work of the Board. Each Board member shall serve on at least one committee and/or serve as a Board liaison to another entity or organization.

B. The existing standing committees are the Executive Committee, which plans the Board agenda and may act on behalf of the Board under emergency circumstances or as directed by the majority of the Board; the Adult Committee; the Children's Committee; and the Criminal Justice Committee. Other standing committees may be created with the approval of the Board as needed to fulfill its statutory responsibilities.

C. The Executive Committee is composed of the Chair, Vice-Chair and Chairs of the standing committees of the Board. Any Board member may attend the Executive Committee meetings as a member of the public.

D. Each standing committee shall be chaired by a Board member and conducted in accordance with the Brown Act.

E. Ad hoc committees shall be created or dissolved by the Board Chair to reflect the Board's interests and responsibilities.

F. The Board Chair shall appoint the Chair of each standing and ad hoc committee. Board members may choose the committee upon which they wish to serve or shall be appointed to a committee or liaison role by the Board Chair. Committees must include at least two Board members, but may not include more than a quorum of the Board.

G. Committee goals will be discussed by the Board at its annual strategy meeting. The function of a committee is to study an issue and advise the Board of its findings and recommendations. Committees shall not make recommendations directly to the Board of Supervisors.

H. The Chair may appoint a member of the Board as a liaison to another entity or organization to reflect the Board's interests and responsibilities.

I. The Chair, with the approval of the Board, may appoint a non-voting representative from another entity or organization to the Board to reflect the Board's interests and responsibilities not already represented by members appointed by the Board of Supervisors. Such a non-voting representative may provide reports or presentations to the Board at its meetings, in compliance with the Brown Act, and shall serve for a one-year term, subject to annual renewal by the Board.

SECTION XV – REMOVAL FROM THE BOARD

Board members shall contact the Chair and staff designated by the Director of Behavioral Health Care Services to serve as secretary to the Board prior to a meeting if they are unable to attend. Failure to do so will result in an unexcused absence. Absence at three consecutive Board meetings without just cause and advance notice shall be grounds for the Board to recommend removal of the member to the Board of Supervisors.

A Mental Health Advisory Board member may be removed by the Board of Supervisors in accordance with Section 2.68.060 of the Alameda County Administrative Code, which states: "In cases of misconduct, inability or willful neglect in the performance of his duties, any member may be removed by the affirmative vote of four members of the Board of Supervisors. Such member sought to be removed shall be given an opportunity to be heard in his own defense at a public hearing, and shall have the right to appear by counsel and to have process issued to compel the attendance of witnesses, who shall be required to give testimony, if such member of the advisory board so requests.

A full and complete statement of the reasons for such removal, if such member be removed, together with the findings of fact made by the Board of Supervisors, shall be filed by the Board of Supervisors, with the County Clerk and made a matter of public record."

SECTION XVI – CONFLICT OF INTEREST

Appointments to the Board will be subject to state and federal conflict of interest laws.

SECTION XVII – RULES OF ORDER

Board meetings shall be conducted in accordance with the Brown Act, the Board bylaws, and Robert's Rules of Order to allow open participation. The Chair may also set discussion time limits as appropriate. If in conflict, the Brown Act will take precedence, followed by the Board bylaws, and then Robert's Rules of Order, respectively.

SECTION XVIII – EXPENSES

Pursuant to Welfare and Institutions Code Section 5604.3 and the Alameda County Administrative Code, the Board of Supervisors may pay from any available funds the actual and necessary expenses of the Board members incident to the performance of their official duties and functions. The expenses of Board members may include travel, lodging, child care, and meals for Board members while on official business as approved by the Behavioral Health Care Services Director and the Board, except that expenses related to travel outside of the Bay Area counties must be authorized by the Board of Supervisors pursuant to Section 2.68.080 of the Alameda County Administrative Code. A yearly finance report shall be presented to the Board so that expenses can be reviewed and approved.

Welfare and Institutions Code Section 5604.3 states further that: "Governing bodies are encouraged to provide a budget for the local mental health board, using planning and administrative revenues identified in subdivision (c) of Section 5892, that is sufficient to facilitate the purpose, duties, and responsibilities of the local mental health board."

ARTICLE II

SECTION I – AMENDMENTS TO THE BYLAWS

These bylaws may be amended by a two-thirds vote of the appointed membership during any Board meeting and adoption by the Board of Supervisors. The bylaws shall be reviewed periodically to ensure that they comply with state law and adequately address the needs of the Alameda County community.

SECTION II – EFFECTIVE DATE

Once approved by the Board, these bylaws shall be submitted to the Board of Supervisors for its approval and final adoption. The bylaws shall be effective concurrent with the effective date of an ordinance amending Chapter 2.68 of the Alameda County Administrative Code to make changes corresponding with the revisions in these bylaws.

These bylaws were approved by the Board on July 19, 2021 and adopted by the Board of Supervisors on 12/21/21. The effective date of these bylaws is 12/21/21.

Signed:

Lee Davis

Lee Davis, Chair, Alameda County Mental Health Advisory Board

DocuSigned by:

F53BEE2E81BB437

L.D. Louis, Vice-Chair, Alameda County Mental Health Advisory Board

Supervisor Keith Carson, President, Alameda County Board of Supervisors

BEST PRACTICES

for California's

Local Mental / Behavioral Health Boards & Commissions

2023

California Association of Local Behavioral Health Boards and Commissions

BEST PRACTICES *for* Mental / Behavioral Health Boards & Commissions (MHBs)

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Resources: www.calbhbc.org/resources

Training: www.calbhbc.org/training

ADVOCACY: Addressing Issues

Elevating important issues to bring about needed change often requires advocacy efforts. In addition to advising the Board of Supervisors and Mental/Behavioral Health Director regarding the mental/behavioral health needs of the community, board/commission members want to make a difference, and know that their recommendations are heard and appropriate action is taken. *Note: "Advocacy" is not one of the defined duties in Welfare and Institution Code 5604.2, although it is often listed in local boards' action/annual plans and mission statements.*

THE RULES: It is important to act within:

1. Board/Commission Bylaws/Policies
    a. Processes: Use processes that provide opportunity for identifying and understanding issues, including discussion and board/commission approval of recommendations
    b. Mission: Stay within your board's mission. Issues should be related to mental/behavioral health needs, services, facilities, and special problems.
2. The Brown Act - As a public board, it is important to use open and public processes to discover issues important to the community. See: www.calbhbc.org/brown-act

THE TOOLS: Create allies and relationships as you research and identify recommendations.

1. Mental/Behavioral Health (MH/BH) Director: Often upon hearing about an issue, the MH/BH Director may direct their staff to take action, and will provide follow-up reports at board/commission meetings.
2. Speakers/Joint Meetings – Board leadership may invite related speaker(s) and/or commission(s) to board/commission meetings. Note: The Mental/Behavioral Health Director or County Supervisor can often provide advice/connections.
3. Ad Hoc Committees – Board leadership may choose to create an ad hoc committee for issues that require research:
    a. Conduct small group discussions ("Listening Sessions") to receive consumer/family member input. Personal stories around an issue provide valuable first-hand experience and ideas for improvement. Examples of venues for these discussions: Adult Resource Centers, Support Groups or NAMI meetings.
    b. Conduct research through meetings with Staff (County, City); County/City/School District/Law Enforcement/Commission Leaders; Contractors; Outside Counties that have solutions
    c. Review issue and/or program performance information: www.calbhbc.org
    d. Create a report detailing: 1) Issue; 2) Research; and 3) Recommendations. *(Include a concise Executive Summary.)*
4. Communication: Board Leadership should take the lead:
    a. Invite interested local advocacy groups, community leaders, boards, contractors and staff to your meeting when the report or recommendation letter is discussed/presented.
    b. Letter and/or presentation to Board of Supervisors (local Governing Body) and/or other local commissions
    c. Letters to the Editor of the local newspaper.
    d. For issues identified to be statewide issues, provide the report to:
        i. CA Association of Behavioral Health Boards & Commissions
        ii. CA Behavioral Health Planning Council

AD HOC COMMITTEES (Work Groups)

DEFINITION: Ad hoc committees:

1. Serve only a limited or single purpose
2. Are time limited and are dissolved when their specific task is completed.
3. Contain less than a quorum of board/commission members. (Note: In some counties, ad hocs may contain only 2 members due to local statutes.)
4. Do not meet on a regular fixed-meeting basis.
5. Are exempt from complying with the Brown Act if all of the above conditions are met.

FUNCTION: Special problems (e.g. lack of local residential facilities for adults with mental illness) and projects (such as Annual Reports, Data Notebooks, reviewing MHSA Plans, and individual Site/Program Visits)* are often best facilitated by a small committee that can work together outside of the board/commission meeting. The job of the ad hoc is to:

1. Conduct research meetings
2. Compile and analyze information
3. Report back (in writing and/or verbally) to the board/commission.

* **Reminder:** Ad Hocs are time-limited (usually a few months).

IMPLEMENTING an Ad Hoc: The following are *suggested* steps. Board leadership or the Chair may use a *less formal process*, provided that the ad hoc created is exempt from complying with the Brown Act (meets criteria in the definition above).

1. **Work Plan** (Written Draft). The draft work plan should include:
    a. An Ad Hoc (or Work Group) Name
    b. A description of the purpose of the Ad Hoc that links the proposed work to one or more of the WIC 5604.2 Duties or Annual Goals.
    c. The number of proposed members for the workgroup
    d. A description of how the work group will accomplish its purpose (identify people to meet with, documents to review, etc.)
    e. An approximate schedule of tasks and target date of completion (begin, submit report to Executive Committee, report to board)
2. **Role of Executive Committee** (EC) (or Chair in counties that do not have an EC):
    a. Review each ad hoc proposal submitted in writing.
    b. Review and approve or deny the request.
    c. Review and identify aspects of the plan that require revisions, including, but not limited to:
        i. Areas that are unclear or too broad.
        ii. Areas that may be unnecessary or out of the scope of the board/commission duties or goals.
        iii. Clarifications regarding how the work group plan goals can be met.
    d. EC or Board/Commission Chair appoints an ad hoc chairperson
    e. EC provides written approval

[Name of Board/Commission]
Ad Hoc Proposal Form

Ad Hoc Chair: **Date of Proposal:**

Name of Ad Hoc:

Maximum number of members in Ad Hoc: _____ maximum

WIC 5604.2 Duty(s) or Annual Goals that Ad Hoc will contribute toward (Please list):

PURPOSE of Ad Hoc:

HOW will Ad Hoc accomplish its purpose:

Example Response:

1. *Research Meetings with [list individuals, agencies or organizations]*
2. *Listening Sessions with [list organizations]*
3. *Identify successful programs or practices by reviewing [List Documents or on-line resources to Review])*

SCHEDULE OF TASKS with target dates for completion

Example Response:

1. *Begin [Date]*
2. *Submit Draft Report to Executive Committee [Date]*
3. *Report to [Mental/Behavioral health Board/Commission] [Date]*

APPROVED BY: [Executive Committee or Chair]

DATE:

COMMENTS:

ANNUAL REPORTS

I. PURPOSE: *CA Welfare & Institutions Code, Section 5604.2 (5), requires: "Submit an annual report to the governing body on the needs and performance of the county's mental health system."*

- What changed in the mental health system/community during the past year? Analyze the mental health system including successes & areas for improvement. **What do you advise?**
- Writing the Annual Report is an opportunity to list the Board's recommendations and accomplishments. [Note: accomplishments are different from "activities."]
- "Write to your reader!" While the mandate specifies "governing body", the report may be read by mental health advocates, providers, and other interested parties
- Opportunity for a strong call to action – needs to clearly state what the Board **advises**

II. CONTENT:

- Concise Executive Summary that lists major findings and recommendations (and refers to pages with detailed recommendations.)
- Structure: Use Legislative mandate (WIC 5604.2 on next page) and/or Annual Goals as outline: list site/program reviews and findings, resolutions, any special reports, including presentations, hearings, testimony, committees (e.g. Director Selection Committee, CIT, CALBHB/C). List Board members/officers and staff
- Size: Recommend limit of ten pages

III. FORMAT:

- Concise language, limit personal pronouns, limit long narratives
- Cover – title (Annual Report, FY XX), County Logo, Name of Board/Commission
- Table of Contents (with page numbers) (can be included on Executive Summary page).
- Include page numbers

IV. DISSEMINATE:

- Cover letter – written by Board Chair (one page);
- Send e-mail with link to report to Board members, Providers, Public Health officials, Board of Supervisors, Mayor, CALBHB/C, Advocacy Groups, etc.
- Present the Annual Report in person to the Governing Body (in most cases, the Board of Supervisors.) Ask MH/BH board/commission members to attend. **Remember to advise!**

[County Logo]

ANNUAL REPORTS *Continued* - SAMPLE

[Name of Board or Commission]
[Year] Annual Report

[Insert Picture of Chair]

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Meet the Board Members #

Acknowledgements #

Executive Summary

The [Name of Board or Commission] has a dedicated, engaged and diverse membership that cares very much about the mental [or behavioral] health services, programs and facilities available in our county.

Along with the following pages that outline our membership and activities for the year, there are two reports attached that provide research findings and recommendations of two [MHB] work groups:

1) School-Based Mental Health Services Needs Assessment and Stigma Reduction Workgroup (Attachment A) – Recommendations Include:
   a. Full implementation of AB114 – Educationally-related Mental Health Services (This shifted responsibility of mental health services from county mental health departments to school districts.)
   b. Adding "Wellness Centers" to high schools, (Napa County Middle Schools now have them.) This is a place to go for any health-related need, including mental illness.
   c. Providing Youth Mental Health First Aid training to staff and administrators to ensure potential issues can be recognized, assessed, screened and treated before reaching crisis level.
2) Employment Workgroup Report (Attachment B) Recommendations include adjusting the Department of Rehabilitation Model of employment support, to incorporate training for employers, and to tailor job programs to better fit the needs of adults with mental illness.

It is also important to acknowledge the many accomplishments of the [Name of County] [Mental/Behavioral Health Agency], under the leadership of [Mental/Behavioral Health Director [Name]].

Through public meetings, site visits, work groups, speakers, and reports from MH Division Staff and contractors, the MHB works to understand and advise the Board of Supervisors and the [Mental/Behavioral Health] Director regarding [Name of County]'s mental health offerings and challenges. [Name of County] [Mental/Behavioral Health Board] members are appointed by the Board of Supervisors. It is part of our mandated duties to provide the Board of Supervisors with an annual report reviewing the needs and performance of the county's mental health system. This report documents our membership and activities for [Year].

Annual Report Sample Continued:

Status of the [Mental Health Board]

Meetings: Regular MHB meetings were held on the 2nd Monday of each month. A notice of all regular and special MHB meetings was made public, and an agenda was followed which allowed for public comment. MHB meeting agendas and minutes are available on the County website. A quorum was established at all twelve meetings. Board member attendance ranged from 58% to 100%, with average attendance: 72%.

In February, we held a hearing for review and comment on the proposed Mental Health Division's Mental Health Services Act (MHSA) Annual Plan Update Fiscal Year (FY) 2015-16. In June, we held a public hearing for review and comment on proposed MHSA Innovation Plan Projects: 1) On The Move: Work for Wellness; 2) COPE Family Center: Adverse Childhood Experiences (ACE); 3) NVUSD: Support for Filipino Community; 4) Suscol Intertribal Council: Support for Native Americans.

We held three other special meetings in American Canyon, St. Helena and at Napa's Innovations Community Center.

Committees & Workgroups:

Executive Committee: [Board/Commission Member Names & Positions]
Data Notebook Workgroup [Year]: [Board/Commission Member Names]
Employment Workgroup: [Board/Commission Member Names]
School-based Mental Health Services Workgroup: [Board/Commission Member Names]
Annual Report: [Board/Commission Member Names]
Quality Improvement (QIC): [Name of Board/Commission Liaison(s)]
Stakeholders Advisory (SAC): [Name of Board/Commission Liaison(s)]
MHSA Innovations Planning Advisory: [Board/Commission Member Names]
CA Assoc. of Local Behavioral Health Boards/Commissions: [Board/Commission Liaison(s)]

Board Member	District at Time of Appointment	Appointment Date	Term Ends
Name	4	11/3/2015	1/1/2019
Name	1	1/06/2015	1/1/2018
Name	4	1/12/2015	1/1/2018
Name	4	11/3/2015	1/1/2019
Name	4	1/06/2015	1/1/2018
Name	3	11/3/2015	1/1/2019
Name	2	1/26/2015	1/1/2019
Name	4	1/06/2015	1/1/2018
Name	4	1/06/2015	1/1/2018
Open	1	10/10/2016	1/1/2020
Open	3	2/15/2017	1/1/2020

Annual Report Sample Continued:

Goals & Accomplishments

The following objectives and goals for [year] were developed by the [MHB] Executive Committee and approved by the [MHB]. We have detailed the work done by the [MHB] on each of these goals.

A. Objective: Fulfill the Mandated Responsibilities and Core Purposes of the Mental Health Board

1. **Goal:** *Review and evaluate* the community's mental health needs, services, facilities, and special problems [5604.2 (a)(1)] Welfare & Institutions Code (WIC)
   Accomplishments: List related accomplishments (such as speakers, public hearings, site visits and work groups)

2. **Goal:** *Review and comment* on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council (CMHPC) [WIC 5604.2 (a)(7)]
   Accomplishments: List related accomplishments and short summary of findings.

3. **Goal:** *Review and approve* the procedures used to ensure citizen and professional involvement at all stages of the planning process [WIC 5604.2 (a)(4)].
   Accomplishments: List related accomplishments (such as review of MHSA Community Program Planning process, providing accessible public meetings, conducting meetings in different parts of the county and/or providing teleconference access)

4. **Goal:** *Review* any county agreement entered into pursuant to Section 5650 of the Welfare & Institutions Code.
   Accomplishments: List related accomplishments (such as board member participation reviewing new proposals for services, reviewing contracts prior to site visits, receiving budget overview by staff, and/or listing of contracts, agreements, reports and applications that were provided for review during the year.)

B. Objective: Maintain an active, involved [Mental Health Board]

1. **Goal:** *Achieve full MHB membership that reflects the diversity of the populations served.*
   Accomplishments: Describe current membership.
2. **Goal:** *Maintain a high attendance and participation at all MHB meetings, including all committees and/or workgroups.*
   Accomplishments (Sample):
   - Board Meetings were held monthly without exception and a quorum was established at every meeting. Board member attendance ranged from 58% to 100%, with average attendance: 72%.
   - The Executive Committee also met monthly without exception and a quorum was established at every meeting.
   - Workgroups function as "Ad Hoc" Committees with membership generally ranging from 2-4 members.

Annual Report Sample: *Goals & Accomplishments Continued*

3. **Goal:** *Maintain representation on appropriate local, regional and state boards, committees, councils, etc., and regular reporting to the [Mental Health Board] (for example: CALBHB/C, Quality Improvement Committee, etc).*
   Accomplishments: List names of members and involvement

4. **Goal:** Complete 100% of site visits
   Accomplishments: Written reports were submitted to the Executive Committee for review, followed by a presentation to the entire [MHB] and any public present at the meeting, for discussion for the following site visits:
   - Provide Listing of Site Visits
   - Provide Listing of Virtual Meetings with Providers (during pandemic)

5. **Goal:** Provide training opportunities to [MHB] Members
   Accomplishments: Provide Listing

Additional Pages:

Meet the Board Members - Provide pictures and short bios of current members, and members leaving the board during the past year.

Acknowledgements - Thank the staff, supporting agencies, community groups and guest speakers.

CONDUCT

In addition to following the Brown Act, and abiding by adopted meeting rules (e.g. Roberts Rules), the following guidelines are provided to help local mental/behavioral health boards/commissions (MHBs) function as effective advisory bodies.

A. Conduct Agreement – A listing can be printed on agendas and/or read at the beginning of each meeting. The following list is an example:

1. Active Listening
2. Focus on Issues
3. Person-First Language (see below)
4. No Swearing
5. No Personal Attacks or Criticism (of self or others)
6. One person speaks at a time—no side bars
7. Keep comments short if possible—do not monopolize discussion
8. Limit the Use of Acronyms—"When in doubt, spell it out."
9. Turn Off or Silence Cell Phones

B. Person-First Language

When talking about people with mental illness, it is important to be mindful and use "person-first language". MHB members should set an example and lead the way in using terminology when speaking or writing that is positive and reflective of the person first.

Generic phrases such as "the mentally ill" or "psychologically disturbed" are not appropriate since they convey a lack of appreciation for and depersonalize the individual. These terms communicate and reinforce the discriminatory notion of a special and separate group that is fundamentally unlike the rest of "us."

The use of person-first language such as "a person with schizophrenia," "an individual with bipolar disorder," or "people with mental illnesses," communicates first that they are people and second that they have a disability. Use of person-first language, although sometimes wordy, is important and requires that we be mindful of what we present to the public.

Language to Avoid

• Crazy • Mentally ill • The Mentally Ill • Mentally or emotionally handicapped • Crazy, nuts, etc. • Emotionally challenged • Differently-abled • Victim or sufferer

Person-First Language:

• Individual with lived experience of mental illness • Person with schizophrenia • Person with a mental illness • Person with bipolar disorder • Individual living with mental illness • Person with a psychiatric disability

C. "Unconscious Bias" **Also, see recorded training:** www.calbhbc.org/unconsciousbias

Avoid Micro-Aggressions (Inequalities): Comments or actions that are subtly and often unintentionally hostile or demeaning to a member of a minority or marginalized group. (Such as looking at your cell phone while someone is speaking.)

Be intentional about treating everyone with dignity and respect. (The Public, Speakers, MHB Members, Staff, Contractors, etc.)

CULTURAL REQUIREMENTS: Eliminating cultural, ethnic & racial disparities

Addressing disparities across the entire mental health system is integral to providing effective, accessible and equitable programs and services.

BEST PRACTICES *for* Boards & Commissions

RECRUIT to achieve diverse membership:

Seek out and recommend qualified/diverse individuals for appointment by the Board of Supervisors (or Governing Body) (per WIC 5604(2)(A)) See Recruitment, Page 24.

LISTEN: for issues, gaps and successes.

- Invite organizations and individuals to your meetings that can speak to the needs of diverse communities.
- Listen to the public, treating all with dignity and respect.
- Review CALBHB/C's "Unconscious Bias" Training: www.calbhbc.org/unconsciousbias

REVIEW: Penetration rate, data, programs and planning procedures, including review of:

- Staff reports. County data is also available at: www.calbhbc.org/performance
- Plans, services and facilities to ensure they meet diverse community needs.
- Planning Process: Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process (5604.2(4)), including Cultural Competency Plans and MHSA Community Program Planning (CPP), Page 19.
- Specific racial, ethnic, cultural and LGBTQ issue and program info at: www.calbhbc.org/cultural-issues

ADVISE the BH Director and local leadership [usually Board of Supervisors]. Recommend goals and services that meet the diverse mental/behavioral health needs of your community! See Recommendations, Page 23.

COMMENT on performance outcome data specific to culture/race/ethnicity and age to the CA Behavioral Health Planning Council.

REQUIREMENTS *for* Local & State Agencies

3-Year Cultural Competency Plan /Annual Update Requirements

CA Law requires cultural competence in all mental health services and programs at all levels. Local systems of care should:

Acknowledge and incorporate the importance of culture, the assessment of cross-cultural relations, vigilance towards dynamics resulting from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs.

Recognize that culture implies an integrated pattern of human behavior, including language, thoughts, beliefs, communications, actions, customs, values, and other institutions of racial, ethnic, religious, or social groups.

Promote congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities. WIC 600.2 (g)

DATA NOTEBOOK

The Welfare and Institutions Code (WIC) Section 5604.2 describes one of the duties of the local mental or behavioral health board/commission to "Review and comment on the county's performance outcome data, and communicate its findings to the California Behavioral Health Planning Council (CBHPC)."

To assist with this responsibility, the CBHPC annually develops the Data Notebook for each local board/commission to complete. Each year the Data Notebook focusses on a specific area of interest, with a variety of questions to be answered.

The completed Data Notebook is provided to the CBHPC, who then compile the responses from the local mental/behavioral health boards/commissions into an overview report. The information is used by the CBHPC to fulfill its mandate to inform the California legislature about the status of mental health services in California.

COMPLETION OF THE DATA NOTEBOOK:

- Boards/commissions are encouraged to complete the Data Notebook in partnership with the staff of the local mental/behavioral health agency
- The board/commission may also connect with other local agencies, organizations or experts in their county
- The completed Data Notebook should be approved by the local mental/behavioral health board/commission.
- Submit the approved Data Notebook report to the CBHPC: DataNotebook@cbhpc.dhcs.ca.gov

EDUCATION AND ADVOCACY: The completed Data Notebook can be shared with:

- The county's Board of Supervisors to provide local data, and to educate, report and comment on local mental health performance
- Other local agencies and organizations
- Local policy makers and legislators to educate, report and comment on local mental/behavioral health performance.
- CA Association of Local Behavioral Health Boards & Commissions (CALBHB/C). (Individual and compiled Data Notebook overviews are posted at: www.calbhbc.org/data-notebooks)

EXAMPLES: Completed Data Notebooks are available at www.calbhbc.org/data-notebooks

CONTACT INFORMATION: DataNotebook@cbhpc.dhcs.ca.gov

DUTIES: Alcohol & Drug
Component of Behavioral Health Boards/Commissions

Many California counties now have integrated Mental Health and Alcohol & Drug Boards. Below are duties historically addressed by Alcohol & Drug Boards.

Duties:

1. Advise the Board of Supervisors, the local Department of Health and Human Services, the Division of Behavioral Health Services, and/or the Alcohol and Drug Services unit on policies and goals of County alcohol and drug programs.
2. Participate in the county-wide alcohol and drug program planning process.
3. Provide recommendations regarding alcohol and drug program related matters.
4. Review the scope of alcohol and drug programs in County-funded agencies/departments and the community at large.
5. Evaluate the community's alcohol and drug program needs, services, facilities, and special programs.
6. Encourage and educate the public to understand the nature and impact of alcohol and drug problems.
7. Promote support throughout the County for the development and implementation of effective alcohol and drug programs.
8. Ensure citizen and professional involvement at all stages of the process leading to the formation and adoption of the County alcohol and drug program plans.

State/National Resources:

1. California Behavioral Health Planning Council: www.dhcs.ca.gov/services/MH/Pages/CBHPC-PlanningCouncilWelcome.aspx

2. Substance Abuse and Mental Health Services Administration (SAMHSA): Mental and Substance Use Disorders Page: https://www.samhsa.gov/disorders

DUTIES: Related to Mental Health (WIC 5604.2)

The local mental health board shall do all of the following:

1. **Review and evaluate the community's public mental health needs, services, facilities, and special problems** in any facility within the county or jurisdiction where mental health evaluations or services are being provided, including, but not limited to, schools, emergency departments, and psychiatric facilities.
2. **Review any county agreements entered into pursuant to Section 5650**. The local mental health board may make recommendations to the governing body regarding concerns identified within these agreements.
3. **Advise the governing body and the local mental health director as to any aspect of the local mental health program.** Local mental health boards may request assistance from the local patients' rights advocates when reviewing and advising on mental health evaluations or services provided in public facilities with limited access.
4. **Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.** Involvement shall include individuals with lived experience of mental illness and their families, community members, advocacy organizations, and mental health professionals. It shall also include other professionals that interact with individuals living with mental illnesses on a daily basis, such as education, emergency services, employment, health care, housing, law enforcement, local business owners, social services, seniors, transportation, and veterans.
5. **Submit an annual report to the governing body** [usually the Board of Supervisors] on the needs and performance of the county's mental health system.
6. **Review and make recommendations on applicants for the appointment of a local director of mental health services.** The board shall be included in the selection process prior to the vote of the governing body.
7. **Review and comment on the county's performance outcome data** and communicate its findings to the California Behavioral Health Planning Council.
8. **This part does not** limit the ability of the governing body to transfer additional duties or authority to a mental health board.

(b) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall **assess the impact of the realignment of services** from the state to the county, on services delivered to clients and on the local community.

Also, pursuant to W&I Code Section 5848, the local mental health board **conducts a public hearing on** the county's MHSA Three Year Program and Expenditure Plan and Annual Update.

Mental Health Director Duties related to MH/BH board/commission: WIC Section 5608(c) Recommend to the governing body **after consultation w/the advisory board**, the provision of services, establishment of facilities, contracting for services or facilities and other matters necessary or desirable in accomplishing the purposes of this division.

MENTAL HEALTH SERVICES ACT (MHSA): Role of MH/BH Board/Commission (MHB)
MHSA: 3-YEAR PLANS, ANNUAL UPDATES, INNOVATIONS PLANS

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." (CA WIC 5848)

I. ROLE OF THE MHB

A. Assure Citizen & Professional Involvement: Members of the MHB may be involved by ensuring stakeholder involvement in the Community Program Planning (CPP*) process through

1. Receiving reports from staff describing plans and execution of the CPP.
2. Attending focus groups/stakeholder meetings re: MHSA Plans.
3. Providing opportunity for public input at MHB meetings. *See CPP on next page.

B. Review & Advise: The review and analysis of the MHSA Three-Year Plans, Annual Updates and Innovations Plans can be major undertakings for MHBs. The Plan documents are lengthy and complex (including program descriptions, populations served, penetration rates, charts, graphs, and fiscal documents). Processes for review and comment by MHBs vary, including**:**

1. Agendizing presentation(s) by MH/BH Staff to explain the major components of MHSA plans.
2. Dividing up sections of plans by small workgroups (ad hocs), who then report on their section to the MHB.
3. Convening a single ad hoc committee to review the document and advise the MHB.
4. Review and comment by individual MHB members.
5. Voting on substantive written recommendations* by the MHB.
   *"Substantive recommendations" means recommendations approved by a majority vote during a public hearing. Also see Recommendations, Page 20

C. Conduct Public Hearing: The Public Hearing on the Three-Year MHSA Plan can take place following the 30-day public review period during a regularly scheduled MHB meeting, with 72-hour notice to the public and inclusion on the MHB published agenda. Identifying and inviting stakeholders (consumers, family members, law enforcement, school officials, college board members/staff, etc.) to the public hearing increases engagement and accountability in this process.

II. ROLE OF THE MENTAL/BEHAVIORAL HEALTH DIRECTOR: The MHSA Three Year Plans and Annual Updates to the MHSA Three Year Plans must include the following elements:

a. Certification to ensure county compliance with pertinent regulations, laws and statutes of the Act, including stakeholder engagement and non-supplantation requirements, and
b. Certification by the County MH Director and County Auditor-Controller that the County has complied with fiscal accountability requirements, and all expenditures are consistent with the Act.
c. The local MH/BH agency must provide an annual report of written explanations to the local governing body and the State Deparment of Health Care Services for any substantive recommendations made by the local MHB that are not included in the final plan or update.
d. Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan or update shall summarize and analyze the recommended revisions.

III. ROLE OF THE BOARD OF SUPERVISORS (or GOVERNING BODY): After the required 30-day public review process, "Updates to the Annual Plan", the "Three Year MHSA Integrated Plans" and "Innovations Plans" are to be adopted by the County Board of Supervisors and submitted to the state of CA within 30 days after adoption by the Board of Supervisors (or Governing Body).

MHSA: COMMUNITY PROGRAM PLANNING (CPP)

DEFINITION: Community Program Planning (CPP) is the state-mandated, community collaboration process that is used to: assess the current capacity, define the populations to be served and determine strategies to provide effective MHSA-funded programs that are: 1) Culturally Competent; 2) Client & Family-Driven; 3) Wellness, Recovery and Resilience-focused; & 4) Provide an Integrated Service Experience for Clients and their Families. *(See below for state code (CCR and WIC).)

PARTICIPANTS

1) **Stakeholders**
   a. Adults & Seniors with severe mental illness (SMI)
   b. Families of children, adults & seniors w/SMI
   c. Providers of Mental Health and/or Related Services
   d. Law Enforcement Agencies
   e. Educators and/or Representatives of Education
   f. Social Services Agencies
   g. Veterans
   h. Representatives from Veterans Organizations
   i. Providers of Alcohol and Drug Services
   j. Health Care Organizations
   k. Other important Interests
2) **Underserved**: Representatives of unserved &/or underserved populations & family members.
3) **Demographic Diversity:** Reflects the diversity of the local demographics, including but not limited to: a. Geographic Location b. Age c. Gender d. Race/Ethnicity

PROCESS

1) **Staffing –** The county shall designate positions and/or units responsible for the coordination and management of the CPP Process to include facilitating participation by the participants listed above.
2) **Training** for county staff and stakeholders as needed.
3) **Outreach** to clients with serious mental illness and/or serious emotional disturbance, and their family members, to ensure the opportunity to participate
4) **Local Review** must occur prior to submitting 3-year plans and Annual Updates to include a 30-day public comment period followed by a public hearing. The MH/BH board/commission (MHB) shall: **a)** Review & approve procedures used to ensure citizen & professional involvement in all stages of planning process; **b)** Review adopted plan or update & make recommendations; **c)** Conduct MHSA Public Hearings at the close of 30-day public comment periods.
5) **Documentation**: MHSA 3-Year Plans and Updates must include a description of the local stakeholder process including:
   a. Date(s) of the meeting(s)
   b. Any other planning activities conducted
   c. Description of participants in planning process in enough detail to establish that the required stakeholders were included
   d. Description of how stakeholder involvement was meaningful
   e. Dates of the 30 day review process
   f. Methods used by the county to circulate for the purpose of public comment the draft of the plan to representatives of the stakeholder's interests and any other interested party who requested a copy of the draft plan
   g. Date of the public hearing held by the local mental health board or commission
   h. Summary and analysis of any substantive recommendations received during the 30-day public comment period
   i. Description of substantive changes made to the proposed plan
   j. The local MH/BH agency must provide written explanations in an annual report to the governing body and DHCS for any substantive recommendations made by the MHB that are not included in the final plan or update.

***CCR, 9 CA ADC § 3200, 3200.060, 3200.270, 3200.90, 3300, 3315, 3320 & WIC 5848(a,b,f) & 5604.2(4)**

MENTAL HEALTH SERVICES ACT (MHSA): DEFINITION

The Mental Health Services Act of 2004 passed by the voters as "Proposition 63," increased overall State funding for the community mental health system by imposing a 1% income tax on California residents with more than $1 million per year in income. The stated intention of the proposition was to "transform" local mental health service delivery systems from a "fail first" model to one promoting intervention, treatment and recovery from mental illness. A key strategy in the act was the prioritization of prevention and early intervention services to reduce the long-term adverse impacts of untreated, serious mental illness on individuals, families and state and local budgets.

According to WIC 5813.5, MHSA Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
(2) To promote consumer-operated services as a way to support recovery.
(3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.
(4) To plan for each consumer's individual needs.

SIX COMPONENTS:

The funds are divided into six components. County mental health agencies are required to develop detailed plans for the use of MHSA funds in each of these components, then submit those plans to the Mental Health Services Oversight and Accountability Commission (MHSOAC) or State for approval. The following are the components.

1. **Community Program Planning:** Community Program Planning (CPP) refers to the state-mandated, participatory process implemented by counties in partnership with stakeholders to determine appropriate uses for available MHSA funds. Counties are tasked with developing CPP processes in line with the needs and culture of their communities.

   The planning process requires extensive community input. Counties identify local "underserved populations" most severely affected by, or at risk of, serious mental illness and then develop "culturally and linguistically competent approaches" to connect with and meet the needs of those underserved populations (such as: interpreters and translation services; culturally appropriate mental health services; strategies for outreach to racial and ethnic county-identified target populations).

   The CPP process is used to: 1) Assess the current capacity; 2) Define the populations to be served; 3) Determine the strategies for providing effective services.

   The MHSA work plan is developed from this process.

2. **Community Services and Supports (CSS)** Community Services and Supports are the programs, services, and strategies that are being identified by each county through its stakeholder process to serve unserved and underserved populations, with an emphasis on eliminating racial disparity. It is the largest component of the MHSA. The CSS component is focused on community collaboration, cultural competence, client and family driven services and systems, wellness (which includes concepts of recovery and resilience), and integrated service experiences for clients and families. Housing is also a large part of the CSS component. County MHPs have three years to spend CSS funds.

3. **Prevention and Early Intervention (PEI):** The goal of PEI is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from

untreated mental illness. The PEI component requires collaboration with consumers and family members in the development of PEI projects and programs.

4. **Innovation:** The goal of Innovation is to increase access to underserved groups, increase the quality of services, promote interagency collaboration and increase access to services. Counties select one or more goals and use those goals as the primary priority or priorities for their proposed Innovation plan. "Innovation projects are novel, creative and/or ingenious practices/approaches that contribute to learning and that are developed within communities through a process that is inclusive and representative, especially of unserved, underserved and inappropriately served individuals" (Page 3 Innovations Guidelines). Innovation Projects are required to:
    a. Introduce a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention, or
    b. Make a change to an existing practice in the field of mental health, including but not limited to application to a different population, or
    c. Apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings.

    County MHPs have three years to spend each annual INN allocation (five years for Counties with population 200,000 or less).

5. **Capital Facilities and Technology Needs (CFTN)**: The CFTN component works towards the creation of a facility that is used for the delivery of MHSA services to mental health clients and their families or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and cost-effective services and supports for clients and their families.

6. **Workforce Education and Training**: The goal of the Workforce Education & Training (WET) and WET Regional Partnerships component is to develop a diverse workforce, with the following goals:
    a. Addressing identified shortages in occupations, skill sets, and individuals with unique cultural and linguistic competence in urban and rural county mental health programs and private organizations providing services in the Public Mental Health System; and
    b. Education and training for all individuals who provide or support services in the Public Mental Health System, to include fostering leadership skills. This education and training contributes to developing and maintaining a culturally competent workforce, to include clients and family members who are capable of providing client and family-driven services that promote wellness, recovery and resilience, and lead to measurable, values-driven outcomes.

    Regional partnerships are an important part of WET because schools and training sources serve individuals across county lines. For example, community colleges, universities, graduate and professional programs serve individuals across various geographic regions of California.

MENTAL HEALTH SERVICES ACT (MHSA): FISCAL INFORMATION
MHSA: 3-YEAR PLANS, ANNUAL UPDATES, INNOVATIONS PLANS

By law, the State allocates MHSA funds from the Mental Health Services Fund (MHSF) to County Mental Health Plans (MHPs)[1] for three components: Innovation (INN), Prevention and Early Intervention (PEI) and Community Services and Supports (CSS) [2]. Funds are made available to County MHPs on a month-to-month basis according to a formula specified in law: 5% for INN, 19% for PEI and 76% for CSS.

TIMEFRAMES:

3 Years: CSS, PEI, and INN components must be spent within three years (or within five years for INN for Counties with population 200,000 or less).

10 Years: Capital Facilities and Technological Needs (CFTN), Workforce Education and Training (WET) and WET Regional Partnerships must be spent within ten years of allocation.

UNSPENT FUNDS: The law requires any unspent MHSA funds held by County MHPs to be kept in interest-bearing accounts. County MHPs are required to treat any interest earned as additional revenue for the specific component. County MHPs have differed in their use of interest earned. Some have spent it as it is earned while others have allowed interest to accumulate as a cash reserve.

Funds not spent within their mandated timeframes are to be returned to the State for re-allocation to County MHPs, a process called "reversion".

Prudent Reserve funds are not time limited and may remain with the County MHP until needed.

ON-LINE DATA:

Annual Revenue & Expenditure Reports are available on the CA Department of Health Care Services (DHCS) website:

www.dhcs.ca.gov/services/MH/Pages/MHSA-Fiscal-Oversight.aspx

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[1] In California, Medi-Cal mental health waivers establish Mental Health Plans (MHPs), which have the responsibility to provide psychiatric inpatient hospital services and outpatient specialty mental health services within their region. The 59 County MHPs include 57 county regions (including Sutter and Yuba Counties combined as one region) along with two city regions, including the City of Berkeley and Tri-City (Pomona, Claremont and La Verne within Los Angeles County).

[2] Once funds are received, County MHPs are permitted to meet local needs by transferring funds from CSS to three other components: Capital Facilities and Technological Needs (CFTN), Workforce Education and Training (WET) and WET Regional Partnerships. Counties are also permitted to transfer some portion of CSS funds to a Prudent Reserve account, a "rainy-day" fund used to protect levels of service when MHSA funding is not sufficient to support ongoing programming.

RECOMMENDATIONS

DEFINITION

A recommendation is a suggestion or proposal as to the best course of action, especially one put forward by an authoritative body. Synonyms: advice, counsel, guidance, direction.

ROLE OF MHB

The (local mental/behavioral health board or commission (MHB) shall advise the **governing body (usually the Board of Supervisors)** and the **local mental (or behavioral) health director** as to any aspect of the local mental health program. Local mental health boards may request assistance from the local patients' rights advocates when reviewing and advising on mental health evaluations or services provided in public facilities with limited access. (WIC 5604.2, # 3).

ROLE OF THE BEHAVIORAL HEALTH AGENCY (WIC 5848 (b)(a). updated 10/19)

For Mental Health Services Act (MHSA) plans and updates, the Mental/Behavioral Health (MH/BH) agency must include substantive written recommendations for revisions in adopted plans. The plan or update shall also summarize and analyze the recommended revisions.

The local mental/behavioral health agency, must provide an annual report of written explanations to the Board of Supervisors (or local Governing Body) and the State Department of Health Care Services for any "substantive" [*see below] recommendations made by the local mental health board that are not included in the final plan or update.

> * "**Substantive recommendations**" made by the local mental health board" means any recommendation that is brought before the board and approved by a majority vote of the membership present at a public hearing of the local mental health board that has established its quorum. 5848 (f)

PROCESS (Suggested Process)

1. **Issue Raised** by member of the MHB, public, staff or contractor.
2. **Refer to Leadership** - Executive Committee (E.C.) discusses issue and possible action.
3. **Study or Draft** Recommendation - E.C. decision to study (by E.C. or ad hoc) and/or decision to draft a recommendation or resolution.
4. **Draft** Recommendation to be published with the MHB meeting agenda.
5. **Discussion** - At MHB meeting, the item should be discussed by the MHB with public input prior to a vote. [May be revised at meeting prior to final vote.]
6. **Vote**. [Minutes to note recommendation and outcome of vote.]
7. **Memo or Letter**: When passed, provide recommendation/resolution via memo to MH/BH Director and/or letter to Board of Supervisors (BOS (or Governing Body).
8. **Annual Report**: Include resolutions or recommendations in your annual report, along with the response from the mental/behavioral health agency.

RECRUITMENT of Board/Commission Members

ROLE OF MHB

Local mental/behavioral health boards and commissions (MHBs) may recommend appointees to the County Board of Supervisors (or Governing Body). Counties are encouraged to appoint individuals who have experience with and knowledge of the mental health system. The board membership should reflect the ethnic diversity of the client population in the county. *WIC 5604 (a)(1)*

STRATEGIES

In order to achieve a diverse membership (ethnic, racial, sexual orientation) that includes a good mix of consumers, family members and people with experience and knowledge of the mental health system, it is important to be intentional about inviting potential members to apply. Individual contact with people (phone call, meet for coffee) can be effective in both attracting people to the MHB, and creating relationships for future interaction with the MHB. To represent various facets of the community that interact with Mental Health, MHB's may want to reach out to:

1. County Veterans Services Office (Requirement in the case of veteran/veteran advocate vacancy)
2. Community Organizations, such as the Hispanic Chamber of Commerce or Tribal Organizations
3. Mental Health Adult Resource Centers, Consumer Groups
4. Commissions on Aging/Older Adult Groups
5. County Offices of Education/School Districts, First 5 Commissions
6. Criminal Justice (e.g. Sheriff, Public Defender, District Attorney)
7. College/Community College Boards/Staff

PROCESS

It is important to use a process that is fair and respects people's privacy.

1. Public posting of MHB openings (usually done by county staff)
2. On-line or printed application publicly available (usually on county website)
3. Board/Commission Chair and/or Executive Committee receives redacted applications (from staff) for follow-up interviews.
4. Two or more MHB members conduct a private interview (with set list of questions) followed by possible recommendation to the MHB. (Suggested interview questions are provided at: www.calbhbc.org/templatessample-docs (under Recruitment))
5. The MHB votes to recommend individuals for possible appointment by the Board of Supervisors (or Governing Body)
6. The Board of Supervisors receives the recommendations, and makes appointments.
7. It may be necessary to follow-up (usually done by board/commission administrative liaison) to remind the Supervisors/county staff to make appointments.

RULES FOR MEMBERSHIP

- See Membership Criteria (WIC 5604) **Page 35**

Recruitment of Board/Commission Members *Continued*

[County Logo]

Contact:
[Name, Position]
[Phone]
[Email]

Sample Flyer or Press Release

Applicants sought for [Name of Mental or Behavioral Health Board/Commission]

The County Executive Officer announces two vacancies on the [Name of County Mental/Behavioral Health Board/Commission]. These vacancies represent the following categories (categories may overlap):

1) Consumer (an individual with lived experience of mental illness), with the terms expiring [Date(s)]
2) Family Member of Consumer, with the terms expiring [Date(s)]
3) Veteran / Veteran Advocate (A "veteran advocate" can include a parent, spouse, or an adult child of a veteran, or an individual who is part of a veterans organization, including the Veterans of Foreign Wars or the American Legion.)
4) Interested & Concerned Citizen, with the terms expiring [Date(s)]

The [Mental Health Board] meets at [time] on the [day] of each month at [address][and by teleconference]. The [15-member Mental Health Board] represents the categories of consumers, family members of consumers, interested and concerned citizens and a member of the Board of Supervisors. Applicants need not have any specialized or professional background.

With the exception of consumers (under certain conditions), no member of the Board or his or her spouse shall be a full-time or part-time employee of a county mental health service, an employee of the State Department of Health Care Services, or an employee, or a paid member of the governing body of a Mental Health contract agency.

Anyone interested in consideration for appointment must submit a completed application form. Application forms are available at the County Executive Office, [address], telephone [phone number] or online at [web address].

[Example Instructions: Click on "application for appointment" under the "Current Openings" heading and follow the application instructions.]

Recruitment will remain open until vacancies are filled.

Recruitment of Board/Commission Members *Continued*

Recruitment Policy (Sample)

[Name of Chair], [Name of Board/Commission] Chair
[Name of Vice Chair], [Name of Board/Commission] Vice Chair

Policy #[Insert number]

Purpose
The purpose of this policy and procedure is to ensure an efficient and fair process for filling existing and anticipated vacancies on the [Name of County] [Mental/Behavioral Health Board/Commission] [(MHB)]

Policy
All existing and anticipated vacant positions on the [MHB] will be filled in a timely manner. Recruitment and member selection processes will meet all [MHB] CA WIC 5604. requirements in order to ensure adequate consumer, family member, veteran/veteran advocate and general citizen representation, with an emphasis on achieving a diverse membership (ethnic, racial, sexual orientation) of individuals who have experience with the mental health system and/or the sectors which it intersects.

Procedures:

1) **Notify Clerk of the Board of Supervisors:** When [MHB] positions become vacant, the [Name of Board/Commission] [staff liaison] will immediately inform the Clerk of the Board of Supervisors, providing the following information:
    a) The date of the vacancy
    b) The type of vacancy (i.e. consumer, family member, interested/concerned citizen)
2) **Application Review:** The [Name of Board/Commission] [staff liaison] shall review applications to ensure that the applicant meets the criteria for [MHB] membership (See "Membership Criteria" (WIC 5604) Page 33)
3) **Interviews:** Each applicant will be interviewed by at least two representatives of the [MHB]. Sample Interview Questions.

    The representatives shall recommend candidates to the full [MHB] and the [MHB] at its next regularly scheduled meeting shall finalize its recommendations to the Board of Supervisor(s) (In some counties, individual Supervisors make appointments for their district) for their consideration of appointment onto the [MHB]).

4) **Reappointments:** Current members who wish to serve an additional 3-year term are also interviewed, and potentially recommended as outlined in #3 (above). [Adhering to term limit [MHB] bylaw requirements (if any)]

REVIEW: Key Considerations and Roles

"Review" means to examine or assess (something) formally
with the possibility or intention of instituting change if necessary.

Key Considerations - The following are suggested as key elements for mental/behavioral health board/commission members to consider when reviewing mental/behavioral health offerings.

1. **Accessibility** - Are programs accessible to all?
    a. Culturally Relevant - Understanding and effectively responding to racial, ethnic, cultural, LGBTQ, and age needs across the entire behavioral health system is integral to providing effective, accessible and equitable offerings.
    b. Scaled to meet the needs of the community
    c. Integrated programs in: schools, senior centers, work-settings, hospitals, religious institutions, wellness-centers, etc.) Aligning mental health and substance use disorder resources with health care, education and social service offerings is fundamental to providing access to an effective and accessible continuum of care.
    d. Communicated
        i. Website, Media, Signage**:** Availability of services and how to access them is clearly communicated and includes languages of the local population.
        ii. Messaging**:** Widespread mental/behavioral health education and messaging reaches all age groups, cultures, ethnicities, races, LGBTQ+ and all sectors (schools, senior centers, work-settings, hospitals, community centers, religious institutions, wellness-centers, etc.)

2. **Recommended Practices** - Do offerings provide evidence-based or promising practices?
    a. Client & Family Driven
        i. Peer Providers are an essential component
        ii. Clients and family members are treated with dignity and respect and are included in decision-making
        iii. Program leadership and staff includes individuals with lived experience and family members (such as on non-profit boards and as employees)
    b. Evidence-Based Practices
    c. Trauma-Informed Practices
    d. Community-Defined Evidence Practices

3. **Sustainability** - Are programs sustainable?
    a. Financially Viable: Sustainable funding mechanisms for county agencies, local agency partners and community-based organizations
    b. Workforce: Development of Workforce, Competitive Wages, Education, Training

4. **Performance** - What is the impact of the behavioral health offerings?
    Measuring performance is integral to identifying, providing, scaling and improving programs. Collecting, analyzing and sharing data that tracks the impact of behavioral health programs on individuals and communities (Children & Youth, Criminal Justice, Employment, Hospitalizations, Housing) is key to justifying and supporting ongoing implementation and funding. www.calbhbc.org/performance (Local performance outcome reporting is required in MHSA Plans/Updates, and Annual Medi-Cal EQRO Reports, and SAMHSA Grant Applications.)

REVIEW Continued

Roles:

Mental/Behavioral Health Director - to CONSULT with Advisory Board

WIC Section 5608 (c): The Mental/Behavioral Health Director is required to recommend to the governing body [usually the Board of Supervisors], after consultation with the advisory board [the local mental/behavioral health board/commission], the provision of services, establishment of facilities, contracting for services or facilities and other matters necessary or desirable in accomplishing the purposes of this division.

Mental/Behavioral Health Board/Commission Members - 6 Areas to Review*:

1) **Mental/behavioral health** needs, services, facilities and special problems
2) **County agreements** entered into pursuant to Section 5650.**
3) **Community Planning**: Procedures used to ensure citizen and professional involvement at all stages of the planning process.
4) **Mental/ Behavioral Health Director** applicants
5) **Performance Outcome Data**
6) **Realignment**: Assess the impact of the realignment of services from the state to the county, on services delivered to clients and on the local community.

* Full Duty Descriptions: www.calbhbc.org/duties

** *Section 5650 refers to the annual Performance Contract between local mental behavioral health agencies and CA's Department of Health Care Services. The Performance Contract sets forth conditions and requirements that counties must meet in order to receive the following funding: Mental Health Services Act (MHSA), Projects for Assistance in Transition from Homelessness (PATH), Community Mental Health Block Grant programs and community mental health services provided with realignment funds.*

RUNNING A GOOD MEETING

I. ATTENDANCE

- Remind mental/behavioral health (MH/BH) board/commission (MHB) members by mail, email, phone and/or text)
- Invite - Depending on agenda topics, be intentional about inviting (by email/phone):
    - Consumer/family member organizations, Community Groups
    - County agencies (such as Older Adults, Veterans Officer, Drug & Alcohol)
    - School District, Law Enforcement, Community College, Providers

II. THE RULES

The Brown Act - Also see: www.calbhbc.org/brown-act

- Public Comment
    - Publish rules on front of agenda (Sample: calbhbc.org/templatessample-docs
    - Allow time for Open Public Comment (on topics not on agenda)
    - Public Comment before or during agenda items
    - Speak to public before beginning meeting regarding when they will have a chance to speak
- Agenda
    - Follow the agenda that was posted 72 hours in advance (24 hours in advance for Special Meetings)
    - If the order of the agenda needs to be changed, or an item removed, the chair may say "If there are no objections…" *If there are no objections, there does not need to be a vote.* Agenda items may not be added, and should not be vague.

Voting - Also see "Parliamentary Procedure", Page 29

- Motion *(if needed, Chair says "Do I hear a motion?")*
- Second *(if needed, Chair says "Do I hear a second?")*
- Discussion *(Chair says "Any Discussion"?)*
- Teleconference Voting by Roll Call
- In Person Voting
    - All In Favor *(Chair asks "All in favor?")*
    - Opposed *(Chair asks "Opposed?")*
    - Abstaining *(Chair asks "Abstaining?")*

III. THE CONTENT

- Agenda (Samples: https://www.calbhbc.org/templatessample-docs)
- Speakers
    - Who can address the priorities identified by board members/concerns of public
    - Who can speak about access and effectiveness of MH/BH Services
    - Who can speak about MH/BH needs and issues
- Housekeeping – keep it limited (Use Executive Committee (or chair and staff in very small counties) to address board organizational topics.)

IV. HANDLING DIFFICULT PEOPLE

- Stay on Agenda
- "The action is in the reaction." Quietly move on to the next person or agenda item.
- Security – Take precautions if you anticipate a problem.

V. FACILITATING THE MEETING

Before

- Include Physical Location(s) and/or Teleconference Connection information with Meeting Notification and Agenda
- Comfortable chairs and table space for MHB members to take notes;
- Water (and snacks if possible) accessible
- Name plates/placards placed in front of each Board Member and Staff;
- Cell phones are placed on silent;

During

- Meeting starts and ends on time
- Minutes (including attendance and votes) of the proceedings accurately recorded;
- Public attendance and comments welcomed
    - Everyone (board members, public) has an opportunity to talk;
    - All opinions are valued
    - Listen for Issues (from Board Members, Public, Speakers, Staff, etc.)
- Civility reigns - See Conduct, Page 10
    - The Chair follows and sticks to the agenda
    - The Chair recognizes people who want to speak (e.g., raise hand, stand up name plate)
    - Public comments are limited (Suggestion: Up to three minutes depending on number of comments)
        - Request that organizations choose a spokesperson;
        - Timer with buzzer/bell if needed *(although not recommended*)
    - Motions - See next page "Parliamentary Procedure"
    - No one should be allowed to monopolize the discussion
    - Side-bar conversations (including on-line chat or emails) are not permissible;
- Take notes & follow-up on issues of concern with Executive Committee
- Any non-agenda/new issues raised should be referred to the Executive Committee or Chair for future consideration
- Presenters should be graciously thanked for their presentations

Adjourn

- No meeting should last more than two hours;
- Motion to Adjourn, Second and Vote.
- Do not continue meeting after adjournment (avoid quorum conversation.)

Running A Good Meeting ***Continued***

PARLIAMENTARY PROCEDURE

Board/commission bylaws often specify rules of parliamentary procedure, such as: Robert's Rules of Order, Roberta's Rules of Order, Rosenberg's Rules of Order. Below are definitions and suggested procedures.

Agenda: Provides a listing of the standard order of business. The agenda will include a 'call to order", reading and approval of minutes, reports and other business.

Motions:

1. **Having the Floor** - Before a member can speak at a meeting, she or he should be recognized by the chairperson. Once recognized, the speaker should not be interrupted, except by the chairperson.
2. **Making Motions** - A motion is made to propose a course of action (such as approving the minutes, or making a substantive recommendation). If another member agrees that the motion should be entertained, they will "second the motion". Additional discussion pertaining only to the motion can follow.
3. **Amending Motions** - Amendments can be motions as long as the person who moved the original motion is agreeable to the amendment. If the originator of the motion is not agreeable, then the group must vote on the original motion.
4. **Tabling the Motion** - If more information is needed to consider a motion fairly, then a motion to "table" the discussion can be made. The length of and reason for tabling the motion must be included in the motion to "table". A majority of members must support the tabling for it to pass.
5. **Calling the Question** - When having difficulty closing discussion on a motion (and it appears that discussion is no longer productive), the "question" can be called with a two-thirds vote of the members present. If the "Calling the Question" vote passes, it is followed by an immediate vote on the motion.

Quorum: The minimum number of members who must be present at a meeting in order to conduct business (such as take a vote.) Usually a quorum is more than half of membership.

Voting

- Motion *(if needed, Chair says "Do I hear a motion?")*
- Second *(if needed, Chair says "Do I hear a second?")*
- Discussion *(Chair says "Any Discussion"?)*
- Teleconference Voting by Roll Call
- In Person Voting
  - All In Favor *(Chair asks "All in favor?")*
  - Opposed *(Chair asks "Opposed?")*
  - Abstaining *(Chair asks "Abstaining?")*

SITE VISITS - Suggested Procedures

I. PURPOSE

With the goal of providing high quality, accessible, culturally responsive mental/behavioral health services and programs, delivered efficiently and effectively, with client-centered outcomes, site visits can assist with the following WIC 5604.2 duties:

1. Review and evaluate the community's mental health needs, services, facilities and special problems.
2. Review any County agreements entered into pursuant to Section 5650.
3. Advise the Board of Supervisors (or local governing body) and the local Mental/Behavioral Health (MH/BH) Director as to any aspect of the local mental health program.

II. ROLE OF MENTAL HEALTH BOARD (MHB)

1. Learn about program, service and/or facility, including successes and challenges.
2. Educate the Mental/Behavioral Health Board/Commission (MHB) member(s) about the program/facility;
3. Educate the program and clients/consumers about the role of the MHB;
4. Learn about client and family-member satisfaction and concerns;
5. Make recommendations to the MH/BH Director and/or public officials based on site visit findings.

III. ROLE OF COUNTY MENTAL HEALTH/BEHAVIORAL HEALTH SERVICES STAFF

It is important to understand the MH/BH services staff's role overseeing contractors. Program monitoring is measured by various means and processes:

1. Quantity: number of clients served, number of referrals, admissions, discharges, reduction of waiting lists, etc.
2. Quality: improve an illness, restore or improve social and vocational functioning, maximize client and family members sense of well-being and personal fulfillment, prevent injury to others and to the client, specific percentage improvement upon completion of specific task, upgrading efficiency, stimulating morale, utilization of staff, appropriate supervision, training, evidence based programs utilized, etc.
3. Time: timeliness of service, deadlines met, frequency, number of days to complete, etc.
4. Cost: use of budgetary resources, percent variance from allocation, cost per client, cost per service unit, etc.
5. Consumer/Client satisfaction written surveys examine the adequacy and appropriateness of the services being provided and the extent of the desired outcomes from the client's perspective.

IV. RECOMMENDED MHB SITE VISIT PROCEDURES

A. **Make Contact -** MHB staff (or MHB member) makes contact with the provider, describing purpose of the site visit, and requesting date for site visit.

Continued on Next Page

B. **Review Contract -** MHB Staff will provide MHB members who plan to conduct the site visit (less than a quorum) with the current county contract (including budget) related to the site to be visited.

C. **Tour facility** - MHB Members (less than a quorum):
   1. Observe interaction between staff and clients/consumers. (Is it respectful? Are clients/consumers comfortable interacting with staff?)
   2. Take note of condition of facility, including:
      1. Common Areas
      2. Dining Area
      3. Program Areas
      4. Client/Consumer Bedrooms (if invited/appropriate)
      5. Outdoor Areas
   3. Check to see if there are Posted Grievance Procedures and/or Access to Patients Rights Advocate Contact Information (Call the number posted to ensure it works.)
   4. Meeting with site/facility staff (before or after tour): Discussion with program/facility director/staff. Discussion could be guided by questions in the Site Visit Observation Form (Sample)

D. **Report to MHB**
   1. Provide completed "Site Visit Observation Form" to the Executive Committee (or chair and staff support in very small counties)
   2. Once reviewed by the Executive Committee and the MH/BH director or staff, and approved for presentation to the MHB by the Executive Committee, the report can be placed on the agenda for presentation at an upcoming MHB meeting.
   3. MHB staff (or Executive Committee) will send a courtesy copy of the report to the contractor, along with the date/time that the report will be heard by the MHB.
   4. The MHB shall request County staff to follow-up with the MHB whenever major deficiencies are identified.

Welfare & Institution Code (WIC)

Legislation for Mental/Behavioral Health Boards/Commissions

www.calbhbc.org/legislation-mhb-wic

Items in **bold** reflect the 2019 and 2022 CA legislative updates.

I.	**WIC 5604.5**	**Bylaw Requirements**
II.	**WIC 5604.2 & 5848**	**Duties**
III.	**WIC 5604.3**	**Expenses**
IV.	**WIC 5604.**	**Membership**

I. BYLAW Requirements (WIC 5604.5)

The local mental health board shall develop bylaws to be approved by the governing body which shall do all of the following:

(a) Establish the specific number of members on the mental health board, consistent with subdivision (a) of Section 5604.

(b) Ensure that the composition of the mental health board represents **and reflects the diversity** and demographics of the county as a whole, to the extent feasible.

(c) Establish that a quorum be one person more than one-half of the appointed members.

(d) Establish that the chairperson of the mental health board be in consultation with the local mental health director.

(e) Establish that there may be an executive committee of the mental health board.

Samples of Bylaws: https://www.calbhbc.org/templatessample-docs.html

II. A. DUTIES WIC 5604.2 (Items in **bold** reflect the 2019 and 2022 legislative updates.)

The local mental health board shall:

1. Review and evaluate the community's **public** mental health needs, services, facilities, and special problems **in any facility within the county or jurisdiction where mental health evaluations or services are being provided, including, but not limited to, schools, emergency departments, and psychiatric facilities.**

2. Review any county agreements entered into pursuant to Section 5650. **The local mental health board may make recommendations to the governing body regarding concerns identified within these agreements.**

3. Advise the governing body and the local mental health director as to any aspect of the local mental health program. **Local mental health boards may request assistance from the local patients' rights advocates when reviewing and advising on mental health evaluations or services provided in public facilities with limited access.**

4. Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process. **Involvement shall include individuals with lived experience of mental illness and their families, community members, advocacy organizations, and mental health professionals. It shall also include other professionals that interact with individuals living with mental illnesses on a daily basis, such as education, emergency services, employment, health care, housing, law enforcement, local business owners, social services, seniors, transportation, and veterans.**

5. Submit an annual report to the governing body on the needs and performance of the county's mental health system.

6. Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.

7. Review and comment on the county's performance outcome data and communicate its findings to the California Behavioral Health Planning Council.

8. **This part does not** limit the ability of the governing body to transfer additional duties or authority to a mental health board.

(b) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients and on the local community.

Duties Continues on Next Page

II.B. DUTIES MHSA (WIC 5848)(b)(f) (Items in **bold** reflect the 2019 legislative update.)

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the local **mental health agency or local behavioral health agency, as applicable, for revisions. The local mental health agency or local behavioral health agency, as applicable, shall provide an annual report of written explanations to the local governing body and the State Department of Health Care Services for any substantive** [see (f) below] **recommendations made by the local mental health board that are not included in the final plan or update.**

(f) **For purposes of this section "Substantive recommendations made by the local mental health board" means any recommendation that is brought before the board and approved by a majority vote of the membership present at a public hearing of the local mental health board that has established its quorum.**

III. EXPENSES MHSA WIC 5604.3 & 5892 (c) (Items in **bold** reflect the 2019 legislative update.)

WIC 5604.3

(1) The Board of Supervisors may pay from any available funds the actual and necessary expenses of the members of the Mental Health Board of a community mental health service incurred incident for the performance of their official duties and functions. The expenses may include travel, lodging, childcare and meals for the members of an advisory board while on official business as approved by the director of mental health programs.

(b) **Governing bodies are encouraged to provide a budget for the local mental health board, using planning and administrative revenues identified in subdivision (c) of Section 5892 [see below], that is sufficient to facilitate the purpose, duties, and responsibilities of the local mental health board.**

WIC 5892 (c)

The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848 . The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process ...

IV. MEMBERSHIP MHSA WIC 5604. (Items in **bold** reflect the 2019 and 2022 legislative updates.)

(a)(1) Each community mental health service shall have a mental health board consisting of 10 to 15 members, depending on the preference of the county, appointed by the governing body, except that boards in counties with a population of **fewer** than 80,000 may have a minimum of five members. A county with more than five supervisors shall have at least the same number of members as the size of its board of supervisors. This section does not limit the ability of the governing body to increase the number of members above 15.

(2) (A) The board serves in an advisory role to the governing body, and one member of the board shall be a member of the local governing body. Local mental health boards may recommend appointees to the county supervisors. The board membership should reflect the diversity of the client population in the county to the extent possible.

(B) Fifty percent of the board membership shall be consumers, or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least 20 percent of the total membership shall be consumers, and at least 20 percent shall be families of consumers.

(C) (i) In counties with a population of 100,000 or more, at least one member of the board shall be a veteran or veteran advocate. In counties with a population of fewer than 100,000, the county shall give a strong preference to appointing at least one member of the board who is a veteran or a veteran advocate.

(ii) To comply with clause (i), a county shall notify its county veterans service officer about vacancies on the board, if a county has a veterans service officer.

(D) In addition to the requirements in subparagraphs (B) and (C), counties are encouraged to appoint individuals who have experience with and knowledge of the mental health system. This would include members of the community that engage with individuals living with mental illness in the course of daily operations, such as representatives of county veterans services offices, county offices of education, large and small businesses, hospitals, hospital districts, physicians practicing in emergency departments, city police chiefs, county sheriffs, and community and nonprofit service providers.

(3) (A) In counties with a population that is **fewer** than 80,000, at least one member shall be a consumer, and at least one member shall be a parent, spouse, sibling, or adult child of a consumer, who is receiving, or has received, mental health services.
(B) Notwithstanding subparagraph (A), a board in a county with a population that is **fewer** than 80,000 that elects to have the board exceed the five-member minimum permitted under paragraph (1) shall be required to comply with paragraph (2).

(b) The mental health board shall review and evaluate the local public mental health system, pursuant to Section 5604.2, and advise the governing body on community mental health services delivered by the local mental health agency or local behavioral health agency, as applicable.

(c) The term of each member of the board shall be for three years. The governing body shall equitably stagger the appointments so that approximately one-third of the appointments expire in each year.

Membership Continues on the Next Page

(d) If two or more local agencies jointly establish a community mental health service pursuant to Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 of Title 1 of the Government Code, the mental health board for the community mental health service shall consist of an additional two members for each additional agency, one of whom shall be a consumer or a parent, spouse, sibling, or adult child of a consumer who has received mental health services.

(e) (1) Except as provided in paragraph (2), a member of the board or the member's spouse shall not be a full-time or part-time county employee of a county mental health service, an employee of the State Department of Health Care Services, or an employee of, or a paid member of the governing body of, a mental health contract agency.

(2) A consumer of mental health services who has obtained employment with an employer described in paragraph (1) and who holds a position in which the consumer does not have any interest, influence, or authority over any financial or contractual matter concerning the employer may be appointed to the board. The member shall abstain from voting on any financial or contractual issue concerning the member's employer that may come before the board.

(f) Members of the board shall abstain from voting on any issue in which the member has a financial interest as defined in Section 87103 of the Government Code.

(g) If it is not possible to secure membership as specified in this section from among persons who reside in the county, the governing body may substitute representatives of the public interest in mental health who are not full-time or part-time employees of the county mental health service, the State Department of Health Care Services, or on the staff of, or a paid member of the governing body of, a mental health contract agency.

(h) The mental health board may be established as an advisory board or a commission, depending on the preference of the county.

(i) **For purposes of this section, "veteran advocate" means either a parent, spouse, or adult child of a veteran, or an individual who is part of a veterans organization, including the Veterans of Foreign Wars or the American Legion.**

Alameda County
Mental Health Advisory Board

2023

Mental Health Advisory Board Meeting 3rd Monday of every month 3:00 pm – 5:00 pm **Chair: Brian Bloom**	Meeting Link: https://us02web.zoom.us/j/87366080958?pwd=YWZaQkd5RWEwZW1sbjRTVTh4Q3pNUT09 Password: 774947
Executive Committee Meeting 2nd Thursday of every month 3:30 pm – 5:00 pm **Chair: Brian Bloom**	Meeting Link: https://us02web.zoom.us/j/85824656373?pwd=WElaa1JSN2poKytSL3JUaHpxaU1iZz09 Password: 927248
Adult Committee Meeting 4th Tuesday of every month 4:00 pm – 5:30 pm **Co-chairs: Warren Cushman and Thu Quach**	Meeting Link: https://us02web.zoom.us/j/83540276005?pwd=UjNHRkZmSFNlMGtFdys5L2RiK05SUT09 Password: 880228
Criminal Justice Committee Meeting 3rd Wednesday of every month 4:30 pm – 6:00 pm **Co-chairs: Brian Bloom and Juliet Leftwich**	Meeting Link: https://us02web.zoom.us/j/84804314905?pwd=VVU4dFY0dHpWK0dXYWc0WCtOV3dydz09 Password: 973454
Children's Advisory Committee Meeting **Chair: (Vacant)**	**Cancelled Until Further Notice**

January 2023

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*County Holidays noted in red.

MHAB CALENDAR OF ANNUAL PROJECTS

January Annual Retreat Start Annual Banquet Ad hoc	**February**	**March**	**April**
May Annual Banquet Annual MSHA Presentation-Board Comments Officer Nominations	**June** Annual Election	**July** Midyear Retrospective Meeting Annual MHAB Mixer	**August**
September Presentation and vote on Data Notebook	**October** Data Notebook Due Presentation and vote on Data Notebook	**November** Start MHSA Review	**December** Submit Annual Report

Alameda County
Mental Health Advisory Board

Contact the Mental Health Advisory Board at:

ACBH.MHBCommunications@acgov.org

September 19, 2022

Alameda County Board of Supervisors
1221 Oak Street, #536
Oakland, CA 94612

Re: Mental Health Advisory Board Annual Report FY 2021-22

Dear Alameda County Board of Supervisors:

The Alameda County Mental Health Advisory Board (MHAB) is pleased to provide this Annual Report for FY 2021-2022. As discussed below, the MHAB has worked diligently over the last year to carry out its statutory duties. In accordance with its primary role as an oversight and advisory body, the MHAB sets forth ten recommendations to the Board of Supervisors in this report. These recommendations are the culmination of numerous regular and special MHAB board and committee meetings and are informed by the extensive input of experts and community members. The MHAB urges the Board of Supervisors to seriously consider and publicly discuss these recommendations.

MHAB Statutory Authority and Expertise

The MHAB's authority is established by California Welfare and Institutions Code Section 5604 *et seq*. In accordance with Welfare and Institutions Code Section 5604.2, the Board is statutorily required, among other things, to:

- Review and evaluate the community's public mental health needs, services, facilities, and special problems in any facility within the county where mental health evaluations or services are provided, including but not limited to, schools, emergency departments, and psychiatric facilities.
- Advise the Board of Supervisors and the Alameda County Behavioral Health Care Services Director as to any aspect of the local mental health program.
- Review any county agreements entered into pursuant to Welfare and Institutions Code Section 5650 and make recommendations regarding concerns identified within those agreements.
- Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.
- Submit an annual report to the Board of Supervisors on the needs and performance of the county's mental health system.

- Perform such additional duties as may be assigned to the Board by the Board of Supervisors.[1]

The MHAB is composed of a diverse group of individuals with differing backgrounds and expertise who bring unique perspectives to the complex issues associated with the provision of behavioral health services in Alameda County.[2] As we have in prior years, the MHAB is again providing a variety of recommendations to the Board of Supervisors for their thoughtful consideration and implementation.[3]

The MHAB appreciates the invitation to present the preliminary findings of its Ad Hoc Data Committee, discussed below, at the joint hearing of the Board of Supervisors' Health Committee and Public Protection Committee on October 24, 2022. The MHAB hopes that the upcoming hearing, together with the recommendations contained in this report, will help create the opportunity for increased engagement between the Board of Supervisors and the MHAB moving forward.

Overview of MHAB Activities in FY 2021-2022

Much of the MHAB's work over the last year focused on ways to help implement the Board of Supervisors' directive to reduce the number of seriously mentally ill (SMI) individuals at Santa Rita Jail. The MHAB commends the Board of Supervisors for its public commitment to shift priorities from incarceration to evidence-based behavioral health treatment, as embodied in its "Care First, Jail Last" resolution. The MHAB is represented on the Care First, Jail Last Task Force and looks forward to its monitoring role once the Task Force's work is completed.[4]

In addition to the regular monthly meetings the MHAB held last year, it convened two special meetings, an annual strategy meeting/retreat**,** and monthly meetings of its Executive Committee, Criminal Justice Committee and Adult Committee.[5] The MHAB also formed two new ad hoc committees: the Ad Hoc Data Committee, to gather and analyze data about the SMI population at Santa Rita Jail, and the Ad Hoc Legislation Committee, to create a process for the MHAB to consider recommending that the Board of Supervisors take positions on

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[1] State law also authorizes the MHAB to review and make recommendations on applicants for the appointment of the Alameda County Behavioral Health Care Services Director, review and comment on the county's performance outcome data, and assess the impact of the realignment of services from the state to the county on services delivered to clients and on the local community.

[2] Short bios of each member of the MHAB, as well as their committee assignments, can be found at: https://www.acbhcs.org/mental-health-advisory-board/

[3] As noted by the Alameda County Civil Grand Jury in their most recent annual report:

> "The MHAB has written thoughtful letters to the BOS over the last several years about relevant issues, such as the Santa Rita Jail issues and the need for more transparent data, but the BOS has not responded to those letters nor invited members to present at a BOS meeting. Thoughtful communications deserve a response." (See Alameda County Grand Jury Final Report (2021-2022) ("Grand Jury Report") at p. 25). The report also notes that "[t]he Mental Health Advisory Board, which has strong, knowledgeable, and experienced members and generates excellent ideas, is not used effectively by the Board of Supervisors." (See Grand Jury Report at p. 27.)

[4] In addition to the Care Fist, Jail Last Task Force, the MHAB was also represented on the county's Justice Involved Mental Health Task Force (JIMH), which concluded its work in early 2021. The MHAB is also currently represented on Alameda County's MHSA Stakeholder Committee, the MHSA Community Program Planning Process Committee, and ACBH's Budget Stakeholder Advisory Committee.

[5] Each month, the MHAB full board meets on the third Monday 3:00-5:00; the Executive Committee meets on the second Thursday 3:30-5:00; the Adult Committee meets on the fourth Tuesday 4:00-5:30, and the Criminal Justice Committee meets on the third Wednesday 4:30-6:00. All of these meetings are open to the public and public comment and participation are encouraged. Past agendas, minutes, and presentations at these meetings can be found at: https://www.acbhcs.org/mental-health-advisory-board/

behavioral health-related state legislation.[6]

The COVID pandemic has underscored how existing inequities are further exacerbated during times of crisis. Accordingly, the MHAB has discussed exploring ways to consider behavioral health issues with an equity lens, emphasizing how factors such as cultural, language and disability barriers further impact access to quality mental health services. The MHAB also discussed concerns regarding the unprecedented mental health provider shortage in the midst of significant growing demand for mental health services, both in terms of people needing such services and the depth of services needed for untreated illnesses, caused in large part by the pandemic and increasing violence. Lastly, the specific recommendations set forth below are aimed at improving behavioral health care outcomes for county residents, to satisfy unmet needs, and to fill gaps in the continuum of care. Current ACBH-funded programming that is effectively providing behavioral health care treatment services should not in any way be diminished or compromised in order to implement the additional services recommended herein.

Summaries of the work of the MHAB's Criminal Justice, Adult and Ad Hoc Data Committees are provided below.

MHAB Committee Work

Criminal Justice Committee

Last year's meetings of the Criminal Justice Committee meetings were well attended and included robust participation by a variety of groups, including mental health care providers from the County as well as from Community Based Organizations (CBOs); family members of those suffering from serious mental illness; and members of various law enforcement agencies. Discussion topics included, among other things, litigation against Alameda County alleging appalling conditions for mentally ill people incarcerated at Santa Rita Jail, increased opportunities for diverting defendants out of the criminal justice system and into the medically appropriate level of community-based mental health treatment, and the need for better discharge planning when defendants leave Santa Rita Jail and/or John George Psychiatric Hospital and re-enter the community.

The Committee appreciated the variety of expert speakers who helped inform these discussions, including, but not limited to:

- Kara Jannsen, lead counsel for plaintiffs in the *Babu v. Ahern et al* litigation, who discussed the Consent Decree and subsequent expert monitoring reports filed in the case;
- Dr. Noha Aboelata, CEO of Roots Community Health Center, who spoke about the Safe Landing Project, a program that offers services to newly released inmates via a trailer parked outside of the jail;
- Juan Taizan and Yvonne Jones, Director and Associate Director, respectively, of ACBH Forensic, Diversion and Re-Entry Services, who discussed forensic and non-forensic Full-Service Partnerships in Alameda County.
- Department of Justice Attorney Jessica Polansky, who spoke about the April 22, 2021 Report of the U.S. Department of Justice Civil Rights Division, "Investigation of Alameda County, John George Psychiatric Hospital and Santa Rita Jail," which describes serious gaps in the County's mental health care system and details the unsafe conditions at Santa Rita Jail.
- Francesca Tannenbaum, director of Patients Rights Advocates in Alameda County, and her colleagues, who discussed the treatment of mentally ill Santa Rita inmates who are "5150'd" to John George, the impact "Murphy" conservatees have on county resources, and the potential for LPS conservatorships to be a "diversion route" out of jail and into long-term, community-based mental health treatment.

The Criminal Justice Committee also dedicated one of its meetings to a discussion of important mental health-related state legislation, leading to the creation of the MHAB's new Ad Hoc Legislation Committee, and another meeting to formulating some of the recommendations set forth in this report.

[6] The MHAB Children's Committee is currently on hiatus.

Adult Committee

The MHAB Adult Committee focuses on adult and/or older adult systems of care. The Committee's monthly meetings over the last year included discussions of a variety of topics, including:

- State legislation to establish "Care Courts;"
- Pathways to Wellness Clinic's history and current services;
- Deaf Community counseling services;
- California Advancing & Innovating Medi-Cal (CalAIM);

The Adult Committee was grateful for the informative presentations it received by Kate Jones, ACBH's Adult and Older Adult System of Care Director, and by leaders of NAMI (National Alliance of Mental Illness) Alameda County. The different presentations have highlighted a key theme around equity, and how disability and cultural and linguistic factors impact access to and receipt of quality mental health services. The Committee is exploring how to incorporate an equity framework in its ongoing discussions, analysis and recommendations, to ensure equitable mental health services for vulnerable populations, including but not limited to communities with disabilities, limited English proficient individuals, and communities of color.

Ad Hoc Data Committee

Alameda County's efforts to reduce the population of seriously mentally ill individuals at Santa Rita Jail will not be successful unless it understands the unmet treatment needs of those individuals, particularly the group of "high utilizers" who cycle in and out of jail, John George Psychiatric Hospital and homelessness. The MHAB Ad Hoc Data Committee was formed to gather and analyze information about this group, with the ultimate goal of using the information to: (1) evaluate the efficacy of existing programs intended to reduce recidivism; and (2) create a dashboard allowing public access to the data.

ACBH and other Alameda County agencies collect a tremendous amount of data. Although there are gaps in the data, and information has historically been siloed within different agencies, what is most notably missing is robust data analysis. Tough questions are not being asked, and meaningful connections are not being made between the data that exists. The data is also not made public and transparent so that the community can participate in the process of systemic improvement.

At the committee's request, ACBH provided de-identified individualized data on the high utilizer population as defined by the Committee.[7] The Committee's work is ongoing, but some initial observations are clear: the data reflects key gaps in access to services for African Americans and individuals with a dual diagnosis of substance abuse disorder and mental illness (so-called co-occurring disorders). This de-identified data also suggests barriers to treatment access for those incarcerated at Santa Rita Jail and in need of psychiatric crisis stabilization at John George Psychiatric Hospital.

Aggregate data allows us to see broad trends, but asking the right questions about de-identified individualized data could provide a key to seeing disparities in a tangible way and, as a result, allow for systemic changes that could lead to better outcomes. This kind of data analysis could be used, for example, to explore the efficacy of different FSPs, the relationship to housing status on outcomes, or be applied to any number of different queries. This data could allow us to assess not only where we are currently, but track potential improvements over time.

The MHAB found several areas in which ACBH could not provide data. It appears that currently ACBH and Santa Rita Jail do not effectively track housing status for high utilizers. ACBH also was not provided data from the Jail on the severity of charges for these individuals. The MHAB Ad Hoc Committee found these gaps

[7] The Committee greatly appreciates the invaluable ongoing assistance it has received from Chet Meinzer of Alameda County Data Services, who assisted the Committee in providing requested data and refining the Committee's data requests.

significant in evaluating solutions. Accordingly, housing status should be collected at intake and discharge from the jail and from John George.

The Ad Hoc Committee's work to date has informed several of the recommendations set forth below.

MHAB Recommendations

The MHAB urges the Board of Supervisors to do the following:

1. **Conduct a comprehensive needs assessment and evaluation of existing programs serving the seriously mentally ill in Alameda County.**

An overarching concern of the MHAB - one it has expressed repeatedly over the last year and in years past - is the lack of data regarding county-wide service gaps in the full continuum of behavioral health care, as well as the efficacy of current programming for those suffering from serious mental illness. With a thorough knowledge of where the gaps in service are and which needs are currently not being met, the county will be able to more accurately assess both what resources are necessary to fund a full continuum of care, and how services can be provided in the most cost-effective manner.

This concern was echoed in the Grand Jury report which concluded that "there is not a recent broad-based, Alameda County mental health needs/gaps assessment that explores where in the county there are service needs, equity disparities [including but not limited to race/ethnicity, language and disability barriers, immigration status], successful interventions, and that reviews current best practices and gaps in service availability, both inside and outside MHSA. One witness described funding choices by ACBH as shooting in the dark."[8]

An assessment of unmet needs must be conducted through an equity lens so that the county can eliminate the unjust disparities in mental health services for African Americans and other marginalized communities in the high utilizer category. Specifically, the county should evaluate the extent to which these individuals were receiving appropriate, clinically indicated services prior to incarceration, and if so, what was lacking in the treatment that contributed to the individual becoming justice-involved. Similarly, the county must assess, and improve where necessary, the quality of discharge planning and re-entry services both from jail and from John George.

The county should also provide data regarding the economic cost of high utilizers in the behavioral health system. The cost of frequent incarceration in Santa Rita Jail and multiple, recurring stays at John George Hospital amongst the high-utilizers should be quantified and compared to the cost of upstream investments in services and infrastructure to fill the identified gaps in the full continuum of behavioral health care. The incarceration of so many mentally ill individuals is not only morally objectionable but also is arguably not cost-effective.

The MHAB is aware that the Board of Supervisor's "Reimagining Adult Justice Initiative (RAJI)" is currently in the process of acquiring and analyzing some, but not all, of the data referred to herein. By way of a public-facing "dashboard," and other such transparent means, the county should promptly make available to the public the work of the RAJI, as well as the study of unmet needs and cost-effectiveness recommended above.

[8] See Grand Jury Report at p. 21. The Grand Jury Report also noted that the problems it identified were with the system and not with the people working within it. The MHAB agrees completely. Our meetings and communications with a wide variety of mental health providers and ACBH personnel have consistently shown them to be dedicated, hard-working professionals who care deeply about the people they serve.

2. **Fully fund ACBH's Forensic Plan.**

The MHAB was encouraged when, at the budget hearings in June 2022, the County Administrator was directed to bring to the Board of Supervisors a proposal for fully funding ACBH's "Forensic Plan" to "reduce forensic involvement with behavioral health clients" As reported in the Grand Jury report, the county appears to have sufficient available funds from MHSA, CalAIM and other sources to fund Dr. Tribble's thoughtful and comprehensive request. As documented by the Grand Jury Report, as well as by various lawsuits and legal settlements, we suffer in Alameda County from a shortage of services to prevent, respond to, manage, and support recovery and stability for persons with serious mental illness and substance use disorders. The situation will not improve without focused attention from the Board of Supervisors and additional funding. ACBH's Forensic Plan now before the Board of Supervisors is a necessary first step, and will help the county serve the unmet needs of those who are suffering.

3. **Expand the capacity of court-based and other diversion programs.**

As the Board of Supervisors has acknowledged by unanimously passing the Care First, Jail Last resolution last year, jails are no place for people who suffer from serious mental illness and/or substance abuse disorders. Yet, because the county has not devoted necessary resources to fund a full continuum of behavioral health care for all county residents, the Santa Rita Jail has become one of the largest providers of mental health treatment in the county.[9]

Data received from ACBH reveals that people diagnosed with a serious and persistent mental illness make up over 20% of the incarcerated population and the county spends an increasing amount of its resources to improve jail-based mental health services. Notably, the burden of incarcerating mentally ill individuals disproportionally impacts the African-American population in the county. While comprising approximately 10% of the county's population, African-Americans constitute almost half of the incarcerated population that are receiving mental health services.

The MHAB recognizes that the county must provide top quality mental health care to those who are incarcerated in Santa Rita Jail. However, the MHAB recommends that rather than focus on jail-based mental health care, the county should significantly reduce the number of seriously mentally ill people who are incarcerated at the jail (thereby reducing the need to spend resources on jail-based behavioral health care). In addition to various "upstream" solutions described below, one means of accomplishing this goal is for criminal defendants who suffer from serious mental Illness and/or substance abuse disorders to be diverted out of jail and into medically appropriate treatment facilities that can effectively treat their underlying behavioral health needs. Accordingly, capacity in all of the county's various diversion programs, set forth below, should be expanded.

- As the Grand Jury noted in its 2021-22 Final Report, the Behavioral Health Court ("BHC") in Alameda County is underutilized. The BHC has reduced recidivism and improved mental health outcomes for those who have participated in the program.[10] However, the BHC only has capacity for approximately 100 participants at any one time due to resource limitations. With approximately 2,200

[9] In its 2021 Investigation and Report ("DOJ Report"), the U.S. Dept. of Justice (DOJ) noted that the MHAB has consistently reported to the Board of Supervisors that Alameda County places seriously mentally ill people at heightened risk of incarceration due to the lack of alternative appropriate treatment options: "the [MHAB] observed in 2015 that 'Police officers in the field responding to individuals with mental illness have few options other than bringing them to Santa Rita or John George.'" (See DOJ Report at p. 10, fn. 8). The DOJ Report further noted that since 2015, the MHAB has alerted the Board of Supervisors that "Santa Rita Jail has become a warehouse for people with mental illness. Since there is nowhere to place individuals with mental health disabilities, they languish in jail, often isolated in jail cells. We need to develop a system so that this population can be diverted out of the criminal justice system and into treatment." (See DOJ Report at p. 19, fns. 21 & 22.)

[10] See "Unrecognized and Underutilized Potential: The Behavioral Health Court of Alameda County" (Urban Strategies Council, 2021) at p. 18.

people in jail and over 20% of them diagnosed with a serious mental illness, the BHC is clearly not meeting the current demand. Capacity of BHC should be significantly expanded. To accomplish this, the county must increase funding for the community-based and appropriate medical treatment programs with which BHC partners.

- In addition to the BHC, the county supports eight separate "Collaborative" Courts (two drug courts, a Veterans' court, two re-entry courts, and three treatment courts in the family dependency department of the court system) which together are currently diverting from jail and treating approximately 170 participants. These collaborative courts, like the BHC, have proven successful in reducing recidivism, increasing positive health outcomes, and re-unifying families. To thrive and expand, however, these collaborative courts need stable, predictable, and sustained funding. The MHAB recommends that the county make a commitment to fully fund all of the Collaborative Courts.

- The C.A.R.E.S. Navigation Center redirects individuals engaging in low-level criminal offenses into support services, mental health and/or substance use treatment and away from incarceration and the criminal justice system. As of now, it is the only point-of-arrest diversion program in Alameda County allowing police officers to bring clients directly to the Center to connect to services and keep people with mental illness and/or substance use disorder out of jail and the criminal justice system. These Navigation Centers should be expanded and fully funded so that residents in all areas of the county have access to them.

- The I.S.T. Diversion Programs diverts in-custody felony defendants who have been found by the court to be Incompetent to Stand Trial ("IST") and who currently languish in jail for up to six months or longer waiting for a treatment bed to become available at the State Hospital. To help reduce the size of the waiting list for state hospital beds, Alameda County received significant funding from the Dept. of State Hospitals to divert these individuals into local treatment. However, as reported to the MHAB, very few of the in-custody defendants who are eligible for this program have actually been diverted. Accordingly, the MHAB recommends that the Board of Supervisors make it a priority to address this problem so that the state monies the county is receiving are used effectively to provide these defendants with the appropriate level of acute or sub-acute treatment in the community.

4. **Create Full-Service Partnerships ("FSPs"), Collaborative Courts, and other programs focused specifically on the needs of those who suffer from Co-Occurring Disorders.**

Frequently, an individual's substance abuse issues are too severe for BHC and conversely, their mental health needs are too pronounced for Drug Courts or other Collaborative Courts. In fact, over 50% of the high utilizers of county services are diagnosed with co-occurring disorders. The MHAB recommends that the county invest in the kinds of treatment programs which can effectively address the unique needs of this population of people who often fall between the cracks in the existing diversion and other treatment programs.

5. **Expand the services and capacity of the Safe Landing Project.**

The Safe Landing Project (SLP), located in a recreational vehicle parked on the grounds outside of Santa Rita Jail, began in June of 2020. Operated by Roots Community Health Center, SLP provides re-entry support services to newly released inmates. One impetus for the creation of the project was the tragic 2018 death of Jessica St. Louis, an inmate who was released at 1:30 a.m. without transportation or other services and found dead at the Dublin/Pleasanton BART station 4 hours later. SLP currently operates from 2:00 - 10:00 p.m. and seeks to connect individuals leaving Santa Rita with a variety of services, including transportation. Based on discussions with, and a presentation by, Roots CEO Dr. Noha Aboelata, the MHAB recommends that SLP be expanded to: 1) provide services 24/7; 2) operate out of a permanent structure; and 3) have a presence inside the jail so staff has an opportunity to engage with inmates prior to their release.

6. **Expand Effective Full-Service Partnerships ("FSPs").**

FSPs, which stay faithful to an Assertive Community Treatment model, support people with the highest mental health needs in the county. Almost all of the FSPs in the county are provided for, on a contract basis, by various CBOs. The county must ensure that all FSP clinical teams are available 24/7, that the clinician-to-client ratio allows for as much face-to-face contact as necessary for the clients' recovery and stabilization, and that there are effective means for keeping clients in treatment and compliant with their medications as necessary. Moreover, FSPs must be able to respond to crises, including coordination of services if a client is 5150'd or incarcerated in jail. FSPs can serve the crucial function of reducing arrest and incarceration, lengthy institutionalization, and emergency room use. However, the FSP capacity in Almeda County is far from sufficient. Currently, Alameda County has funded capacity for approximately 1,000 adults in FSPs at any given time. The MHAB believes the need is far greater, perhaps four times this amount. The MHAB urges the Board of Supervisors to assess the need and increase the capacity of FSPs as appropriate. This assessment should include a quality-of-care review of the various FSPs in the county as well as a review of whether the length of time a client is in FSP services is sufficient to maintain long-term mental health stability and reduce recidivism.

7. Significantly increase the capacity of residential treatment beds countywide (including those at Villa Fairmont) to ensure that effective, humane treatment is available at all levels of need.

Alameda County must invest in the expansion of treatment bed capacity to provide a robust continuum of care – from acute crisis facilities to treatment at sub-acute facilities, crisis residential facilities and licensed board and cares – each with the capacity to provide the clinically indicated type and length of treatment. Without the expansion of residential treatment capacity, Santa Rita Jail will remain the county's primary locked mental health treatment facility.

In the immediate term, the MHAB recommends that the county expand capacity at the Villa Fairmont Mental Health Rehabilitation Center (MHRC). Villa Fairmont provides intensive sub-acute mental health and psychiatric treatment services for those in the community who are in need of that level of mental health care. Villa Fairmont is operated by Telecare and is licensed for 97 beds.[11] However, Alameda County purchases only 70 of these beds, leaving the remaining 27 beds unavailable to county residents. The MHAB urges the Board to buy back these 27 beds so that the sub-acute treatment portion of the continuum of behavioral health care is sufficient to provide this level of care for those who need it. Specifically, the MHAB recommends that the county consider whether these additional beds could be used to divert those in jail mentioned above who are eligible for IST and other court-based diversion programs but, for lack of a clinically appropriate treatment facility, are languishing in jail.

8. **Provide better treatment options for incarcerated individuals who are "5150'd" from Santa Rita Jail to John George Psychiatric Hospital.**

According to data acquired by MHAB's Ad Hoc Data Committee, in the 2020 calendar year 131 unique individuals incarcerated at Santa Rita were suffering so severely from mental illness that they met 5150 criteria (gravely disabled, a threat to themselves, and/or a threat to others) and had to be transferred to John George for treatment and care.[12] Of these 131 individuals, 68 were admitted to a unit at John George hospital.

In contrast, during the same time period, 956 high utilizers were admitted from the community to John

[11] The county 's only other MHRC for the treatment of those diagnosed with serious mental illness is the Gladman MHRC. However, the 39 available beds at Gladman are used primarily for long term patients who are on so-called "Murphy" and regular LPS conservatorships.

[12] Data concerning average length-of-stay is still outstanding. For instance, the MHAB does not know the extent to which these individuals received necessary lasting treatment in an acute or sub-acute facility as opposed to being quickly returned to Santa Rita Jail.

George PES, with 65 high utilizers being admitted to John George PES more than 10 times during 2020. This data raises the question: are high utilizers treated differently if they are 5150'd from jail as opposed to if they are coming from the community? And if so, why? Since the jail is not a licensed 5150 treatment facility and has no ability to provide involuntary treatment, there is no clear rational for why John George would treat a referral from the jail would be treated any differently than a referral from the community.

As reported to the MHAB, while at John George, incarcerated people must remain in a locked room under armed guard, and therefore are not provided with the milieu therapy and other treatments that are available to all other patients at the hospital. Moreover, it appears that too many of these individuals are simply medicated and returned immediately to the jail without receiving the necessary treatment that would be provided to a non-incarcerated person suffering from serious mental illness and in need of acute treatment. The MHAB recommends that the county assess the quality of the care provided to incarcerated persons sent to John George, including continuity of care between John George and the jail, the types and the quality of services provided to incarcerated clients and subsequent outcomes including any subsequent suicide attempts or further 5150s.

9. **Support the repeal of the IMD (Institution for Mental Disease) Medicaid Exclusion.**

The IMD exclusion is the federal law that prohibits Medicaid reimbursement for treatment provided in a mental health treatment facility of more than 16 beds. Since the 1960s, this law has effectively denied patient care, disproportionately discriminating against poor and other marginalized communities. Medicaid reimbursement for inpatient care for our most ill citizens should be available no differently from inpatient care for heart disease, cancer, and other severe illnesses. The IMD exclusion, which discriminates against persons with mental illness, should end immediately. The MHAB urges the Board of Supervisors to support federal legislation, such as H 2611, which calls for the outright repeal of the IMD Exclusion. Moreover, we urge the Board of Supervisors to encourage its state partners to apply for the "IMD waiver" which would develop federal funding for the more acute levels of care needed by county residents who suffer from the most advanced stages of serious mental illness.

10. Prioritize strategies to address the mental health workforce shortage.

In the midst of the greatest demand for mental health services, our state is experiencing the greatest provider shortage. While there are efforts at the state and local levels to overhaul our mental health system, it would be hard to create transformative change if we do not address this crippling provider shortage. The workforce crisis was happening well before the pandemic, and has since worsened significantly. Training programs are not producing enough accredited providers, many providers are leaving jobs at county mental health departments and community-based organizations (CBOs) to go to higher-paying jobs or create their own private practice. Even if they remained, there are not enough providers to meet the significant increase in demand. Those providers who remained have increased workload, leading to burnout.

This urgent situation requires both long-term and short-term solutions. Salary increases for both county providers and those at CBOs are necessary for recruitment and retention. Additionally, there needs to be more investment in training programs at all stages of career development that would produce more therapists, especially culturally and linguistically competent trainees who can provide such care to vulnerable populations. Furthermore, we need to consider team-based models that move away from sole reliance on licensed therapists, but also includes case managers, peer providers, community health workers and others, who can help support in the comprehensive mental health care for the clients. While some CBOs have been using these team-based models, the payment structure does not always (sufficiently) reimburse for services provided by these lay mental health professionals. CalAIM is just beginning to recognize the work of community health workers, including providing some reimbursements for their services. We need to expand on this concept to help spread the work in caring for each client. Not only will this meet the increasing demand in services, but will also help to balance out the workload for existing mental health providers, and help to reduce their risks of burnout.

Conclusion

The MHAB is proud of its work over the last year and appreciates the opportunity to be of service to the Board of Supervisors and to the community. As noted in the Grand Jury Report, the Board of Supervisors should better utilize the expertise and perspective of the MHAB. Most important, at this juncture, the MHAB urges the Board of Supervisor to fill the vacant MHAB positions, including the position of the Board of Supervisors' representative to the MHAB, so that the MHAB is in the best position to exercise its statutory obligations.[13] The MHAB looks forward to working more collaboratively with the Board of Supervisors in the future, and asks that the Board provide a response to the recommendations contained in this report.

Sincerely,

Lee Davis

Lee Davis, MHAB Chair

L.D. Louis, MHAB Vice-Chair

[13] In addition to the vacant slot for the Board of Supervisor's representative (which is mandatory pursuant to Welfare and Institutions Code section 5604(a)(1), Supervisorial Districts 1,2, 4 and 5 all have one opening apiece on the MHAB.

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, February 1, 2023 4:35 PM
To: Works-Wright, Jamie
Subject: FW: Election Info for MHC Officers - begin serving March 23, 2023 at in-person meeting

Hello Commissioners,

Please see the information below from Margaret Fine

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Wednesday, February 1, 2023 10:49 AM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Election Info for MHC Officers - begin serving March 23, 2023 at in-person meeting

Dear Jamie,

Would you please kindly send this information to the Commissioners?

Dear Commissioners,

As you know, we will elect a Chair and Vice-Chair at our next meeting to begin serving at the in-person meeting on Thursday, March 23, 2023 and Jamie is adding this item to our next agenda.

There are some considerations from the Commissioners' Manual about the elections that may be of interest:

1. Unless otherwise provided by ordinance, the chair and vice-chair are elected by the majority of the commission for a one-year term and hold office until their successors are elected or until their terms as members of the commission expire.

2. No commissioner shall serve as Chair for more than two consecutive years. There is no term limit for vice-chair. Unless otherwise provided for in the enabling legislation, the annual election of commission officers should occur during the month of February.

3. If there are multiple nominees for Chair or Vice-Chair, the commission may wish to use a process by which all nominations can be made prior to voting. Full discussion of nominations is recommended, including the ability of nominees to speak on behalf of their own candidacy.

4. Additional regulations for officer elections: Nominations for chair and vice-chair require a motion (with second). A commissioner may nominate himself or herself. Any member of the commission, regardless of length of tenure on the commission may be elected Chair or Vice-chair.

5. Motions to nominate must be voted on in the public forum, and no secret ballots are allowed. A roll call vote is recommended for votes on commission officers, and is required if any commissioner requests a roll call vote. The results of the vote must be publicly announced and the vote recorded in the minutes (Resolution No. 60,531-N.S.).

6. A commissioner may not be elected chair if he or she will not be able to finish the term due to the two-year limitation.

I hope this information is useful. Thanks for taking the time to read it.

Best wishes,
Margaret

Margaret Fine
Chair, Mental Health Commission
Berkeley, CA
Cell: 510-919-4309

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, February 1, 2023 10:20 AM
To: Works-Wright, Jamie
Subject: MHC Feb Agenda topics and deadlines

Hello Commissioners,

I hope this email finds you well. Please provided me with any topic you would like added the February meeting by Monday, February 6th and anything you would like added the packet by Monday, February 13. Our office will be closed on February 13 and 20, so I have less time to work on the packet, so sooner the better.

Also a reminder that we hold our annual election of chairperson and vice-chairperson at this month meeting:

- Commissions should hold their annual election of chairperson and vice-chairperson in February (unless otherwise provided by ordinance). Please review the Commissioners' Manual pages 35-36, *Election of Officers and Terms of Office,* to refresh your understanding of the election process. Commissions are encouraged to agendize discussion of elections well in advance to formulate and agree upon the nomination process and timing for nominations (if no policy has been enacted by the commission) and to add clarity for commissioners and the public.

Thank you

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Saturday, January 28, 2023 11:32 AM
To: Works-Wright, Jamie
Subject: FW: FW: Retreat Agenda, Saturday, January 28, 2023, 10 am - 2 pm

Notes below

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Judy Appel <jappel@gmail.com>
Sent: Saturday, January 28, 2023 10:47 AM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Cc: monica jones <mjberkeleycommissioner18@gmail.com>; Margaret Fine <margaretcarolfine@gmail.com>
Subject: Re: FW: Retreat Agenda, Saturday, January 28, 2023, 10 am - 2 pm

Here is a summary from Jeffrey Buell re our conversation about collaboration between the Division and Commission. support. Jamie, can you please send to everyone on the commission? Thx

What are ways that you see that the commission can support MH Division?

1. Mental Health Goals:
    a. So, we haven't had a Division process to come up with a strategic plan or Division goals yet, but Mental Health will follow after the HHCS Department plan is developed. Generally, Mental Health seeks to serve clients, community members eligible for services, and to provide information/access to anyone who is interested. We know that services look different ways to different people, and not all services are available to everyone. Some services might be about routing or directing folks to long term or appropriate services, which may not be at Berkeley Mental Health, and that's still important.
    b. In order to make information accessible, we need to make it low barrier, easily reached. The City website was overhauled recently, and while it's more welcoming and friendly, it needs to be more accessible for information gathering and responsive to community needs. There is a basic level of information on the website at the moment, and one challenge is to figure out how we make it more navigable or useful to the public. How do we do this? Surveys? Feedback from practitioners? How do we

get input from people who need the services but who don't receive them or access websites? Mental Health had created small green outreach flyers just prior to the pandemic, and is in process of reviewing and updating them. Commission may be interested in helping gather/produce/support such a resource. Currently, the resource linkage function for Adult Services is with the CAT/TOT team, which performs the intake/assessment function for Adults, and Allyson Nakayama is the supervisor contact for this team.

c. One of the key information needs for the MH Division is marketing/advertising so that community understands what services the Division performs. The goal is not just to increase the number of people served by the system, but also to let the public know who is served, how they're served, and where to find the services in which the public may be interested. One powerful piece of marketing is word of mouth: peer reviews tend to be personal and important to the community. People tend to trust others' experience and review of a service. One concern in the past was that extra marketing would overwhelm the Division with needs for service, but the truth is that anyone who is eligible and interested in service should be able to know what is available and how to access it.

2. Mental Health Services:
   a. BMH Adult services have sometimes been compared to the County Hospital (Highland): they serve those with the greatest need who also have the lowest resources. Moderate to severe MH impairments are the purview of long term BMH adult services, and mild to moderate MH situations are served by the County and other County contractors. BMH services Medi-Cal and uninsured residents; those with private insurance receive services through one of their insurance company's contracted providers.
   b. Funding: MHSA funds have actually grown rather than contracted during the pandemic. California taxes increased the budget surplus, the wealthiest Californians collected more wealth, and this resulted in higher MHSA revenues, one of the funding streams available to MH programs (with much oversight and process). Grants and other funding streams have come up through the pandemic, which might also be good options for the Commission to look into. CalAIM is transforming the Medi-Cal landscape, hopefully into a lower barrier and easier to access system.
   c. Reorganization of the Mental Health Division: I'm pushing forward a relatively large Division reorganization, with the primary goal to right size the staffing and oversight for the workload. Two new programs will be created by separating and reordering existing programs: FSP Services (for adults) and High School Mental Health. This will expand infrastructure (and some staff positions), plus plan for future service expansion. Teams will be grouped with similar purposes, and the new configurations will support synergy between like services. Among the new positions added, we will be including: an SUD services staff for High School Mental Health, a workforce development/recruitment staff, a program evaluation person for RBA, and several program and direct service staff.
   d. MHSSA: this is still early in the process. A community needs assessment will be performed in the first year, and other services will be brought to bear over the next few years. It's reasonable for the Commission to have periodic updates on MHSSA progress, including supportive requests. Based on the requests of the community, there will likely be continued service need, even with the bolstering of MHSSA. Finding ways to best leverage current resources and bringing more to bear will be important.
   e. It's important for BMH to be accessible, collaborative community partners. A lot of community understands BMH services to be Mobile Crisis, despite the fact that this program is designed as a small fraction of the services provided to the community.
   f. City resources are constrained: BMH does not have excess space for staffing. In fact, with the planned reorganization, there is not enough existing space for all of the staff if all were to be in the office at the same time. Remote and field work have been an important part of BMH service, and will continue to be with the small facilities footprint. A lot of older technology is currently still the backbone of mental health services. BMH does not have a full electronic health record, requiring that paper charts to be the official record keeping method. The relationship with the County is complicated, and navigating that is important and challenging. HHCS Director Lisa Warhuus had worked at the County most recently, and is a good resource and liaison for these relationships.
   g. Transparency is important for our processes and services, especially so that the Commission and the Community can have a fuller understanding of the existing system, and ways to help it evolve.

Jeffrey Buell, LCSW
he/him

Manager of Mental Health Services
Health, Housing & Community Services
jbuell@berkeleyca.gov or jbuell@cityofberkeley.info
Tel: 510.981.7682
Fax: 510.981.5265

Judy
(510)499-4303

On Sat, Jan 28, 2023 at 12:27 AM Margaret Fine <margaretcarolfine@gmail.com> wrote:

> On Sat, Jan 28, 2023 at 12:26 AM Margaret Fine <margaretcarolfine@gmail.com> wrote:
>
> Hi Judy,
>
> Thanks for your email.
>
> The retreat agenda is designed for our Commission members to develop a Work Plan 2023 with specific goals as a team in 4 areas of interest: diversion, services, youth, and building a diverse membership. We have set aside this time so, as Commissioners, we create a Mental Health Commission Work Plan 2023 as a team with specific goals and further hear from our Commission Secretary about her expectations in working with us.
>
> When we saw each other last Saturday during the Division tour with Jeff Buell, I thought you were meeting with Monica and Jeff this week. My understanding was that you would collaborate together. I let Monica know that you would connect with her. Did you talk with her this week? It seems beneficial if you're able to work together, collaborate, and accomplish goals together as a Youth Subcommittee of the Mental Health Commission.
>
> Monica is facilitating this retreat session. She established the Youth Subcommittee including immediately connecting with the Director of HHCS in May/June 2022. She worked with Jonathan to develop our MHC program on youth services at BUSD and the Division of Mental Health last October 2022. She is currently caring for her grandchild who attends Berkeley public schools and has been an active, involved grandparent at his schools for years. When our mom was desperately ill, Monica lead the Mental Health Commission meeting in October 2022. Our mom died on January 7, 2023.
>
> Our focus is the Mental Health Commission and developing our specific goals and the Work Plan 2023. Our overarching state law duties include reviewing and evaluating needs, services, facilities, etc of the public mental health and substance use system in the City of Berkeley as it applies in Alameda County for Berkeley people.
>
> Our Commission has a specific duty to advise the governing body, the Berkeley City Council, about this public system including on school-based mental health services that involve coordination with Alameda County. I understand Rosina plans to present tomorrow at the retreat session and describe the current status of the $2.5 million dollar grant. That sounds great. It would be beneficial if you're able to contribute your insights about this grant and contribute to

developing the Mental Health Commission's work plan goals for the Youth Subcommittee and during our other sessions.

I look forward to seeing you soon.

Best wishes,
Margaret

Margaret Fine
Chair, Mental Health Commission
Berkeley, CA
Cell: 510-919-4309
LinkedIn: Margaret Fine
Twitter: @margaretfinephd

On Fri, Jan 27, 2023 at 9:09 PM Judy Appel <jappel@gmail.com> wrote:

> Thanks for the agenda. I have not planned to facilitate the youth section even though I helped get the speaker. Am I supposed to be prepare to do this with other committee members?
> Judy
>
> On Friday, January 20, 2023, Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info> wrote:
>
> > Public
> >
> > Internal
> >
> > Hello Commissioners,
> >
> > Please see the email from Margaret below
> >
> > Thank you for your time.
> >
> > **Jamie Works-Wright**
> >
> > *Consumer Liaison & Mental Health Commission Secretary*

City of Berkeley

2640 MLK Jr. Way

Berkeley, CA 94704

Jworks-wright@cityofberkeley.info

Office: 510-981-7721 ext. 7721

Cell #: 510-423-8365

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Friday, January 20, 2023 1:29 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Retreat Agenda, Saturday, January 28, 2023, 10 am - 2 pm

Dear Jamie,

Dear Commissioners,

During January 2023, Mental Health Commissioners have expressed deep interests and passions about the mental health and substance use related topics for our work this upcoming year. The attached retreat agenda is designed to reflect developing Work Plan goals for 2023 that reflect those deep interests and passions. The retreat is structured so we focus on our discussion of those areas where Commissioners are willing to commit to doing work and contributing to our community.

Currently the Mental Health Commission is focusing in four areas: 1) youth, 2) diversion, 3) evaluation of mental health and substance use services, resources, facilities (including site visits), and 4) membership including appealing to those with lived experience and from diverse demographic and identity groups. Mental Health Commissioners have established the Youth and Diversion Subcommittees, and we can establish Evaluation and Membership Subcommittees where Commissioners have expressed their commitment to do this work.

To conclude, we will discuss developing the Annual Report 2022 and creating an Annual Report 2022 Subcommittee to research and write this report. This Subcommittee will do a comprehensive review about the content of our work and develop recommendations to the Berkeley City Council for submission to the Mental Health Commission and thereafter the Berkeley City Council. The Agenda Packet will continue the Alameda County Mental Health Advisory Board, Annual Report 2022 which provides an excellent model for this process and your review.

I look forward to seeing you next Saturday.

Best wishes,

Margaret

Margaret Fine

Chair, Mental Health Commission

Berkeley, CA

Cell: 510-919-4309

-

--
Judy
(510)499-4303

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Thursday, January 26, 2023 12:37 PM
To: Works-Wright, Jamie
Subject: FW: BCC Legislation - 911 Needs Assessment and Crisis Capacity Assessment for Alameda County
Attachments: 911 Needs Assessment and Capacity Assessment BCC Legislation.docx

Please see the message below from Margaret and Andrea

Thank you for your time.

Jamie Works-Wright
Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
2640 MLK Jr. Way
Berkeley, CA 94704
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Thursday, January 26, 2023 8:03 AM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: BCC Legislation - 911 Needs Assessment and Crisis Capacity Assessment for Alameda County

Dear Jamie,

I hope you're doing well.

Below I have attached the Berkeley City Council legislation that provides funding for a 911 needs assessment for Berkeley and a crisis capacity assessment about services and resources available in Alameda County. The crisis capacity assessment is designed to inform meeting crisis needs in Berkeley. This municipal legislation passed as part of the budget last June 2022.

This Saturday during our retreat, we will have a session led by Andrea Prichett and Ned Opton about evaluating service delivery for the Division of Mental Health (and substance use). Andrea has asked that everyone read this legislation as they will presenting on this topic and facilitating a discussion that includes this material.

Thank you so much!

Best wishes,
Margaret

Margaret Fine
Chair, Mental Health Commission
Berkeley, CA
Cell: 510-919-4309
LinkedIn: Margaret Fine

Kate Harrison
Vice Mayor, District 4

CONSENT CALENDAR
May 24, 2022

To: Honorable Mayor and Members of the City Council

From: Vice Mayor Harrison

Subject: Budget Referral: Fund Behavioral Health, Crisis Response, and Crisis-related Services Needs and Capacity Assessments

RECOMMENDATION

Refer to the FY 23 and FY 24 Annual Budget Process $100,000 to provide Health, Housing & Community Services Department and Berkeley Fire Department the means study or hire a consultant(s) to:

1. conduct a service needs assessment based on 911 and non-911 calls for service, dispatch, and response, to address the needs of Berkeley people with behavioral health issues and/or are unhoused[1] using computer aided dispatch (CAD) or other data from the Berkeley dispatch, other dispatch agencies, BPD, BFD, and any other relevant data during the COVID pandemic from at least March 2020 through the present; and

2. conduct a capacity assessment of crisis response and crisis-related services available to Berkeley people in Berkeley and Alameda County, including but not limited to with respect to the Specialized Care Unit (SCU), respite, and sobering centers.

CURRENT SITUATION AND RATIONALE FOR RECOMMENDATION

CAD Needs Assessment Study

Currently the City of Berkeley has a Public Safety Communications Center (Center) where call takers and dispatchers answer 911 and non-911 calls on a 24/7 basis for police, fire, medical, behavioral health, and other calls for service. This Center is managed under police leadership and located in the Berkeley Police Department. At this Center, the call takers input call information into the Computer Aided Dispatch (CAD) system and transfer the information to fire/EMS and police dispatch staff.[2] The dispatchers coordinate all police-related calls requiring a response from law

[1] Behavioral health refers to both mental health and substance use for purposes of this recommendation. It is noted that call takers may transfer crisis calls to alternative hotlines or dispatch responders depending on the nature of the call for service.

[2] Auditor Report, 2021, 8.

2180 Milvia Street, Berkeley, CA 94704 ● Tel: (510) 981-7140 ● TDD: (510) 981-6903 ● Fax: (510) 644-1174
E-Mail: KHarrison@cityofberkeley.info

enforcement and enter all officer-initiated incidents into the CAD system such as pedestrian and traffic stops; they maintain radio contact with field staff as well.[3] It is noteworthy that City of Berkeley's call takers and dispatchers use BPD's general communications center procedures, which are not specifically tailored for behavioral health (mental health, substance use) and/or homelessness calls for service and/or dispatching first responders into the community.

As part of the omnibus package for reimagining public safety in Berkeley, the Berkeley City Council directed the City's elected Auditor to perform an analysis of the City's 911 calls for service and responses. On July 2, 2021, the Auditor issued the final report, "Data Analysis of the City of Berkeley's Police Response" to calls for service. In this Auditor Report, the Auditor analyzed the CAD data and assessed the number of events related to mental health and homelessness in Berkeley from 2015-2019.[4] The overall data involved 350,000+ calls for service from 2015-2019.[5] In the context of the Auditor Report, "events" refer to situations entered into the CAD data system that resulted in a response by at least one sworn officer.[6] The CAD system is the computer aided dispatch (CAD) system used for call information, assigning call types, inputting narrative descriptions about calls for services as they progress, dispatching responders, and tracking emergency incident using computers.

Based upon the elected City Auditor's study, the Auditor recommended identifying all calls for service that have an apparent mental health and homelessness component in a manner that protects the privacy rights of individuals involved.[7] Specifically, there is a need to create clear mechanisms for identifying mental health, substance use, and homelessness call types and to use them consistently during 911 call taking and dispatching, including when they are not the primary reason for the call. There is also a need to consistently follow standardized language to describe mental health, substance use, and homelessness-related events in the narrative descriptions for every call. And, there is a need to use behavioral health procedures and protocols, including using consistent, reliable de-escalation techniques during call taking and dispatching the most suitable first responders to people in need. Overall, the ability to realize these goals rests on conducting a needs assessment about 911 and non-911 calls for service, dispatch, and responses for a diversity of people experiencing behavioral health (mental health, substance use) and homelessness crises in the community. While the Auditor did not address substance use, it is critical to include it. It is also key that the needs assessment reflect the demographic populations served where possible.

In addition, this type of needs assessment can inform the level of need for licensed behavioral health clinicians and medical workers including the appropriate education, training and licensing to screen, assess, de-escalate and stabilize people who are experiencing mental health, substance use, and homelessness crises over the phone

[3] Id.
[4] Id., 53-58.
[5] Id., 17.
[6] Id., 10, 13.
[7] Id., 2021, 5.

and in the community. This study may further inform coordination about appropriate levels of care that community members need in order to avoid hospital emergency rooms—which can be crowded, chaotic and harmful to people experiencing behavioral health and homelessness crisis. The study can also inform how to relieve law enforcement and fire/EMS from addressing behavioral health and homelessness needs whenever possible—particularly so they can focus on crime, violence, fire, and natural disasters.

Moreover, this 911 needs assessment can review calls for services, dispatch, and/or response in the community to address any structural police, fire, and/or EMS issues that disproportionately impact diverse and vulnerable people experiencing a behavioral health and/or homelessness crisis. The 911 needs assessment can also assess any reduction in risks of injury and death by police and how diverting calls for service away from police and towards dispatching alternative responders can alleviate trauma for diverse and vulnerable groups: Black, Latinx, Indigenous, AAPI, immigrant, LGBTQIA+, disabled, young, old, unhoused, formerly incarcerated and additional groups.

Overall, this needs assessment can inform operating an effective, empathetic alternative responder program that fundamentally improves the well-being for diverse and vulnerable people experiencing behavioral health crisis in the community. Cities such as Eugene (CAHOOTS), Portland, Seattle, Olympia, Sacramento, San Francisco, Oakland, Santa Cruz, Los Angeles, San Diego, Austin, Houston, Denver, Atlanta, Chicago, Ithaca, New York City and others have already done so with success. Further this needs assessment can improve well-being when call takers transfer people to alternative hotlines with mental health and/or substance use specialists. It is noted that the national 988 mental health hotline will be live beginning July 2022 for call takers to transfer calls to this service. Ultimately, these approaches to 911 call processing and dispatching are key to providing a holistic, equitable, and community-centered public safety approaches for our most diverse and vulnerable communities and for reimagining public safety in Berkeley with reliability and fidelity.

Capacity and Needs Assessment of Crisis Services Available to Berkeley People in Alameda County

Earlier in January 2020, the Division of Mental Health Division released a request for proposal to evaluate the current mental health crisis system in Berkeley and following a robust selection process, the City of Berkeley selected Research Development Associates (RDA). The assessment focused solely on crisis response through the co-responding police and mobile crisis team in the City of Berkeley and not other crisis related services available to Berkeley people in Alameda County. While the City of Berkeley is a unique jurisdiction for certain public mental health services such as this mobile crisis response team, the RDA evaluation did not assess the capacity and quality of county crisis services available to Berkeley people. This type of assessment is critical for assessing the availability of and access to crisis stabilization, sobering and withdrawal centers, crisis peer services and peer respite services, and additional crisis related services in Alameda County. Overall, this capacity assessment is further critical

to taking a diversion approach to transferring calls for service to behavioral health crisis lines and to dispatching alternative responders into the community instead of police.

HHCS staff indicate that the SCU-related portion of this study should occur after the SCU has been operating for at least six months to a year. However, it is expected that from the outset that the SCU will need to incorporate internal analytical tools to capture data and metrics from initial call or referral to ultimate disposition, aiding in in the longer-term needs and capacity study contemplated in this item.

BACKGROUND

On July 14, 2020, the Berkeley City Council adopted an omnibus package to reimagine public safety and policing in the City of Berkeley. The omnibus package consisted of numerous elements including: 1) having the City Auditor perform an analysis of the City's emergency 911 calls for service and police responses; 2) analyzing and developing a pilot program to re-assign non-criminal police service calls to an alternative non-police responder, the Specialized Care Unit; and 3) creating plans and protocols for calls for service to be routed and assigned to alternative preferred responding entities and consider replacing dispatch in the Fire Department or elsewhere outside the Police Department (see Reimagining Public Safety Task Force website).

The City Auditor reported that mental health and homelessness events identified in the CAD data do not represent the total number of events that may have had a mental health or homelessness component as a result of data limitations. First, the report reflected that call types in the CAD system reveal the primary reason for a call which may not capture events where the individuals involved are experiencing a mental health issue or homelessness.[8] The CAD system has some call types to identify when the primary reason for the call is a mental health issue, such as a "suicide attempt" or "5150" for someone experiencing a mental health crisis.[9] However, if the primary reason for the call is another issue, dispatchers are trained to assign those to call types that reflect the primary reason, such as family disturbance or pedestrian stop, which do not capture an accompanying mental health issue.[10] According to the Berkeley Police Department, if the event involves a potential crime, dispatchers will always log it using a corresponding crime code and not a mental health call type.[11] Lodging in public is further the only call type for homelessness.[12]

Moreover, the City Auditor's analysis identified 42,427 unduplicated events with a mental health component, or 12 percent of all events from.[13] The City Auditor's analysis further identified 21,683 events involving homelessness, which represent 6.2 percent of all events during the same time period.[14] The City Auditor stated that mental health and

[8] Auditor Report, 2022, 53.
[9] Id.
[10] Id.
[11] Id.
[12] Auditor Report, 2022, 57.
[13] Auditor, 2021, 56.
[14] Auditor, 2021, 57.

homeless call types are "significantly undercounted."[15] The City Auditor's study did not analyze call types associated with substance use, which is recommended for inclusion in a future needs assessment study. Overall, there appears to be a sizable number of behavioral health and homelessness calls for service that need attention.

It is also noted that while the Berkeley Police Department formally began using "H" for homeless and "MH" for mental health disposition codes when closing out any call involving a homeless or person with mental health issues on July 1, 2021, officers have discretion about using these codes.[16] Per this Reference Guide, officers were instructed that they were not required to ask people about housing status unless necessary for identification purposes or mental health issues unless related to the call.[17] Moreover, according to this Reference Guide if the basis for the disposition code is criminal—despite involving a person who experiencing homelessness and/or mental health issues, then the officer may further not record the disposition code with an "H" or "MH."

FISCAL IMPACTS OF RECOMMENDATION
Impact on General Fund of $100,000. However, the benefit of analyses could generate budgetary efficiencies and better outcomes for Berkeley residents.

ENVIRONMENTAL SUSTAINABILITY
No discernable impact.

CONTACT PERSON
Vice Mayor Kate Harrison, (510) 981-7140

[15] Auditor, 2021, 53-58.
[16] Reimagining Public Safety Reference Guide, 2022, 39.
[17] Id.