Orange County Health Care Agency

Mental Health Services Act Planning Advisory Committee
(MHSA PAC)
August 17, 2023

Welcome

HOUSEKEEPING

GROUP AGREEMENTS

AGENDA FOR TODAY

Today's Agenda

Time	Topic	Presenter
10-10:10	**Welcome and Introductions**	• Michelle Smith
10:10 – 10:30	**Ice Breaker: Common Thread**	
10:30 – 11:00	**MHSA PAC: Purpose and Overview**	• MHSA Team
11:15 - 11:30	**Break**	
11:30 – 12:00	**MHSA PAC: Stakeholder Identified Priorities and Dialogue**	• Michelle Smith
12:00- 12:30	**LUNCH**	
12:30 – 1:40	**MHSA Policy Overview, Proposed Legislative Changes, and Finance Update**	• Michelle Smith
1:30- 2:00	**Debrief, Next Months Priorities, Announcements, and Closing**	• Michelle Smith
Next Meeting	**September 21, 2023** **Topic: High Clinical Risk and Psychosis** **10am – noon** **Via Zoom**	

Mental Health Services Act (MHSA) Planning Advisory Committee (PAC) Overview

MHSA-PAC

- Stakeholder involvement is critical for ensuring that public mental health services are meeting the needs of the local community.
- Stakeholders are engaged in a variety of ways, including community surveys, focus groups, and key informant interviews.
- The MHSA PAC is being established as an ongoing stakeholder committee to support MHSA planning, implementation, and evaluation activities.

MHSA Policy Advisory Committee (PAC) Overview

- The MHSA Planning Advisory Committee (PAC) is a structured way for individual stakeholders to **share their opinions and perspectives, study programs, services, and issues, and develop recommendations in a focused, group structure**.
- The primary **purpose** of the MHSA Planning Advisory Committee (PAC) is to provide thoughtful recommendations or observations, from a diverse stakeholder perspective, to MHRS as related to MHSA programs, implementation, evaluation, quality improvement, finance, and policy.
- The PAC is an open forum for all interested stakeholders.

MHSA PAC Overview

PAC activities are dynamic and intended to enable the PAC to discuss and formulate thoughtful input and/or recommendations related to MHSA in a timely manner.

Examples of activities may include:

- Study of issues, policy changes, or review of current programs
- Overviews of data, research or program/service evaluation information
- Review of staff reports
- Review of recommendations

MHSA PAC Overview

In making MHSA related decisions, the MHRS considers:

- Stakeholder comment,
- MHSA Planning Advisory Committee recommendations,
- Staff recommendations,
- BOS and CEO priorities and goals,
- DHCS directives,
- Laws, statute, and local policies,
- Research and background information, and
- Other subject matter expert perspectives.

MHSA PAC Overview

- MHRS expects to receive recommendations from the PAC
- The MHSA Coordinator or designee is the liaison for the PAC and holds responsibility for communication.
- MHRS also expects that staff will present recommendations from their respective professional perspectives.
- There may be times when the professional opinions and recommendations of staff differ in part or in whole from individuals or that of the committee, and that's okay.
- There also may be times when the PAC's recommendations will not be implemented AND we still want you to participate! You are important.

MHSA PAC Overview

What you can Expect:

- All PAC meetings are open and available to the public.
- Each participant has opportunity to comment and offer their unique perspective on topics.
- Individual committee participants and the collective group will be fair, impartial, and respectful of the diverse public, staff, and each other.
- PAC participants will strive to appreciate differences in approach and point of view.
- Each participant will have an opportunity to contribute to the group's discussions
- The MHSA Coordinator or designee will work to ensure that participants have a fair, balanced, and respectful opportunity to share their knowledge and perspectives.

Table Discussion

MHSA PAC Discussion

1. At your tables, please take 5 minutes to discuss how your role will support MHSA PAC and how your perspective (professionally and/or personally) will benefit our community.

2. Be prepared to share from your table!

15 Minute BREAK

MHSA PAC Overview: Meeting Frequency

- MHSA PAC will meet the 3rd Thursday of each month
  - December will be the 2nd Thursday to accommodate for holiday
- In-Person Meetings hosted quarterly from 10 a.m. – 2 p.m.:
  - August 17, 2023
  - November 16, 2023
  - February 15, 2024
  - May 16, 2024
- Virtual Meetings will be scheduled from 10 a.m. to 12 p.m.

MHSA PAC Overview: Agenda Standards

- MHSA PAC Meeting Agenda's will:
  - Include regular topical presentations.
  - Include additional topics that are developed based on previous month's PAC recommendations/discussion.
  - Provide regular policy, finance, program, implementation, or evaluation updates.
  - Include opportunities for small/large group discussion, as well as individual feedback.
  - Include time for partner announcements
  - Include the opportunity to debrief
  - Be provided, at minimum, one day prior to scheduled meetings
- In person meetings will offer:
  - Transportation and incentives to eligible community members.
  - Snacks or lunch, depending on meeting length

MHSA PAC Overview: Program Topics for FY 2023-24

Monthly program topic presentation length will vary to allow for remainder of agenda items. Topics may change.

3rd Thursday of Each Month	Tentative Topics	In-Person/ Virtual	Timeframe
July	**DARK**		
August 17, 2023	**MHSA Planning and Advisory Committee (PAC) Kick-off**: In person overview of structure and role of PAC committee; preview of upcoming fiscal year planning topics; MHSA 101 (including finance); Call to Action – roles and personal responsibilities/commitments	In-Person Training Center	10am-2pm (lunch provided)
September 21, 2023	**High Clinical Risk and Early Intervention for Psychosis:** Overview of program (population, numbers served, outcomes), partnerships, brief education on signs/symptoms, and how to refer.	Virtual	10am -12pm
October 19, 2023	**CARE Court Overview and Integration of PADS:** Learn about the OC process for CARE Court and participate in a discussion around potential integration of Psychiatric Advanced Directives (PADS) into the CARE FSP service delivery process.	Virtual	10am -12pm
November 16, 2023	**Suicide Prevention Plan Overview and Implementation Planning; Intersection of Crisis Services, CIT Steering Committee**	In-Person Training Center	10am-2pm (lunch provided)
December 14, 2023 (date moved due to holiday)	**Homeless and Housing Services: Prevention, Outreach, Engagement, and Supports**	Virtual	10am -12pm
January 18, 2024	**Infant and Early Childhood Continuum Overview and Update**	Virtual	10am -12pm
February 15, 2024	**MHSA Draft Annual Update FY 2024-25**: Comprehensive review of input utilized to drive development of the Draft Annual Update to the Plan (tentative posting March 4 – April 8, 2024 w/ PH April 24, 2024)	In-Person Training Center	10am-2pm (lunch provided)
March 21, 2024	**Child and Youth Mental Health: Collaborative Approaches in Planning for Local Impact of State Initiatives** (CYBHI and SBHIP implementation in OC)	Virtual	10am -12pm
April 18, 2024	**MHSA Policy Forum:** Overview and Discussion of Behavioral Health Modernization proposal including, proposed changes, updates	Virtual	10am -12pm
May 16, 2024	**Wellness, Resilience, and Recovery: Integrating Recovery Principles into Full Service Partnerships:** Celebration of Mental Health Awareness Month to include personal testimony and stories from individuals with lived experience presented in a Ted Talk style	In-Person Training Center	10am-1pm (lunch provided)
June 20, 2024	**CPP Review, Analysis, and Future Planning Discussion**	Virtual	10am – 12pm

LUNCH BREAK

Behavioral Health Modernization Proposal and the Mental Health Services Act:

A Summary and Comparison of MHSA to Proposed SB-326 Requirements

Michelle Smith
MHSA Senior Manager

History of Mental Health

WHEN	WHAT
1957: Short-Doyle Act	• Established current community-based treatment structure of public mental health services • Established local Mental Health Advisory boards
1968: Lanterman-Petris-Short Act	• Established due process rights of individuals facing involuntary commitment
1991: The Bronzan-McCorquodale Act	• Shifted mental health program and funding responsibilities from the state to the counties
1992: The Children's Mental Health Services Act	• Outlined a coordinated, goal-directed system of mental health care for children and their families that emphasizes an interagency approach
1996: The Adult and Older Adult Mental Health Systems of Care Act	• Outlined a recovery-oriented, outcome based mental health treatment approach for adults living with serious mental health disorders
2004: The Mental Health Services Act	• Provides increased funding for mental health programs serving individuals living with serious mental illness in California • Establishes local MHSA stakeholder process
2010: Affordable Care Act	• Addiction is now covered; expanded funds and treatment options; expanded eligibility for individuals to qualify for benefits
2022: California Advancing and Innovating Medi-Cal (CalAIM)	• Establishes whole person approaches; focus on quality and reductions in health disparities; modernization and value-based approaches, payment reform.
2023: SB-326 and AB-531	• Behavioral Health Modernization: SB-326 proposes changes to Mental Health Services Act and additional broad sweeping reform to other existing statute, with portions being enacted if approved on March 5, 2024 ballot. • AB-531: proposes a $4B general bond to establish 10,000 clinic beds and homes, if approved on March 5, 2024 ballot.

Context

- The information contained in the presentation, as related to SB-326, is PRELIMINARY information only.
- The legislative process is dynamic and is anticipated that the current bill text will be updated prior to finalization.
  - The latest version was posted 08/15/23 @ 10pm
- Generally, government employees should refrain from advocacy activities but are encouraged, locally, to provide input in the discussion to provide information from their point of view.

Mental Health Services Act Origin and SB-326 Comparison

MHSA

The Mental Health Services Act (MHSA), Proposition 63, was passed by California voters November 2004 and went into effect in January 2005.

- The MHSA provides increased funding for mental health programs across the State.
- The MHSA is funded by a 1% tax surcharge on personal income over $1 million per year.
  - The state keeps 5% for state administration and distributes 95% to Counties.
- As these taxes are paid, fluctuations impact fiscal projections and available funding.

BHSA

The Behavioral Health Services Act (MHSA), is proposed for inclusion on the March 5, 2024, California ballot and may become effective January 2025 and operational July 1, 2026.

- The BHSA provides categorical funding for mental health and ***substance use disorder*** programs across the State.
- The BHSA is funded by a 1% tax surcharge on personal income over $1 million per year.
  - The state proposes to keep ***10%*** for state administration and distribute 90% to Counties.
- As these taxes are paid, fluctuations impact fiscal projections and available funding.

Target Populations

MHSA

Individuals living with serious mental illness and/or co-occurring substance use disorders

Unserved, underserved, or inappropriately served populations

At risk of or experiencing psychiatric hospitalization, homeless, incarceration, removal from home

Trauma exposed individuals, at risk of suicide, at risk of school failure due to untreated mental illness

BHSA

Individuals living with serious mental illness and individuals living with substance use disorders

Chronically homeless, experiencing unsheltered homelessness, or at risk of homelessness

Incarcerated or at risk of being incarcerated, re-entering community from prison, jail, or correctional facility

At risk of institutionalization, conservatorship, or in the child welfare or adult protective system

(WIC §§5847(b)-(e), 5848(a), 5892(g))

Plan Requirements

MHSA

Counties receiving MHSA funds must develop a Three-Year Program and Expenditure Plan, projecting their MHSA funds and identifying how they intend to spend their MHSA funds over a three-year fiscal year period.

Each Three-Year Plan shall be developed with local stakeholders including adults and older adults living with a severe mental illness.

Plans contain a programming component and a budgetary component.

All MHSA spending shall be consistent with the Three-Year Plan or Annual Update.

(WIC §§5847(b)-(e), 5848(a), 5892(g))

BHSA

Counties receiving BHSA funds must develop an **Integrated Plan**, projecting their use of BHSA funds and identifying how they intend to spend their BHSA funds over a three-year fiscal year period.

Each Integrated Plan shall be developed with local stakeholders including adults and older adults living with a severe mental illness.

Plans contain a programming component and a budgetary component.

BHSA spending shall be consistent with the Integrated Plan, Amendments, or Annual Update.

The MHSA Three-Year Plan Requirements
vs.
The BHSA Integrated Plan Requirements

MHSA: Three Year Plans

- Description of the Community Program Planning process
- Prevention and Early Intervention program
- Community Services and Supports program
- An Innovation program
- A program for Technological Needs and Capital Facilities (if sustained)
- Identification of personnel shortages and training/education needs (if sustained)
- Establishment and maintenance of a prudent reserve
- Estimated expenditures for each component
- Certification that MHRS's plan complies with all MHSA statutes and regulations, including stakeholder participation, non-supplantation requirements, and prudent reserve requirements.

BHSA: Integrated Plans - **Must include SUD services**

- Description of the Community Program Planning process
- Full Service Partnership program
- Housing Intervention program
- Behavioral Health Supports program
- Population Based Prevention program
- Estimated expenditures for each categorical funding component
- Prudent Reserve
- Certification that MHRS' plan complies with all BHSA statutes and regulations.
- **Inclusion of all funding for all public behavioral health programs, including a description and expenditures for all substance use and specialty mental health programs (i.e., mental health block grant, realignment funds, PATH grant, Opioid Settlement, SAPG, etc.)**

MHSA Funding vs. BHSA Funding Regulations

- MHSA funds cannot be used to supplant funding for existing programs.
- MHSA funds shall be kept in a local Mental Health Services fund and shall be invested but can not be commingled with other MHRS funds.
- Interest earned on the MHSA money held in the local Mental Health Services fund shall be invested in MHSA programs/expenditures in future years.
- These funds may not be loaned to the state General Fund, or any other fund of the state, or a county general fund, or any other county fund for any purpose other than those authorized by Section 5892.
- Annual MHSA revenues must be spent within the 3-year, 5-year (specific to Innovation), or 10-year timeframe, as required per guidelines.
- Must maintain a prudent reserve (up to 33% of the 5 year average of CSS funds).

- BHSA funds cannot be used to supplant funding for existing programs.
- BHSA funds shall be kept in a local Mental Health Services fund and shall be invested but can not be commingled with other MHRS funds.
- Interest earned on the BHSA money held in the local Mental Health Services fund shall be invested in BHSA programs/expenditures in future years.
- These funds may not be loaned to the state General Fund, or any other fund of the state, or a county general fund, or any other county fund for any purpose other than those authorized by Section 5892.
- Annual BHSA revenues must be spent within the 3-year timeframe.
- Must maintain a prudent reserve (**up to 20% of the 5 year average of all BHSA funds**).

MHSA Funding Components

76%	**Community Services and Supports**	CSS funds are intended for direct treatment and recovery services to individuals living with serious mental illness or serious emotional disturbance. • A minimum of 51% must be used for Full Service Partnership (FSP) services • General System Development (GSD) is used to build a continuum and fill gaps in services • Outreach and engagement for identifying and getting people in to the right level of care • Ability to transfer up to 20% of money from CSS to pay for Workforce programs/activities, pay for technology required for administration and data, and create places where services can be delivered (WET/CFTN)
19%	**Prevention and Early Intervention**	Programs and services intended to prevent mental illness from becoming severe and disabling. Can include individual, group, and community interventions. • Outreach for increasing recognition of early signs of mental illness • Stigma and Discrimination Reduction • Suicide Prevention • Access and Linkage to Treatment • Prevention • Early Intervention
5%	**Innovation**	Short-term projects intended to test an approach or practice that will improve public behavioral health services

Proposed BHSA Funding Components

35%	**Behavioral Health Supports**	• Includes programs that provide supports for substance use disorder programs and mental health programs. Can include investments in Capital Facilities and Technological Needs, Workforce Education and Training, and contributions to prudent reserve. • Outreach and Engagement is an allowable service • 51% shall be used for Early Intervention • At least 51% of Early Intervention shall be used to serve individuals who are 25 years of age or younger.
30%	**Housing Interventions**	Housing interventions for individuals with serious mental illness/serious emotional disturbance (SED) and/or substance use disorder and experiencing chronic homelessness, homelessness, or at-risk of homelessness (using the federal HUD definition) • At least 50% must be geared toward chronically homeless, with a focus on individual in encampments • Includes rental subsidies, operating subsidies, shared housing, family housing for children and youth, non-federal share for Medi-Cal services, and other housing supports, as defined by DHCS. • May not use BHSA to pay for housing services or supports that are covered benefits under managed care plans • DHCS will establish criteria and a process for using funds to build housing
35%	**Full-Service Partnerships**	• Optimize use of Medi-Cal to leverage funds and include SUD population FSP • Must implement ACT/FACT model to fidelity

Table Discussion

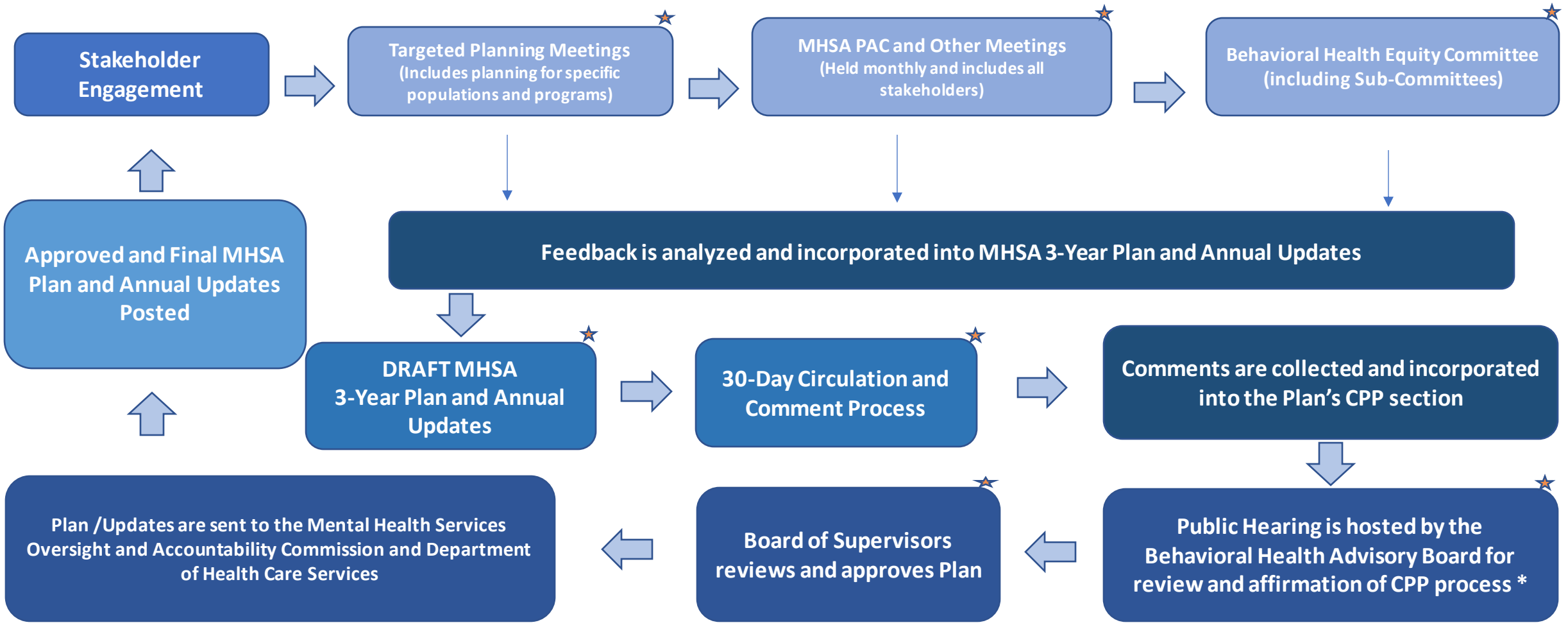
Consider the information that was presented and the potential changes to MHSA

1. What are your preliminary thoughts about the high-level changes to the MHSA?
2. In thinking about friends, family, clients how could this affect them?
3. How do you think the required inclusion of the SUD population will affect programs and services?

Please take 5-7 minutes in your group to discuss and identify a person to report out.

Community Program Planning to Develop the MHSA/BHSA Plan

The MHSA Three-Year and Annual Update Process



WIC §§5847(a), 5848

★ Indicates opportunities for stakeholder input and feedback.

The MHSA/BHSA Community Planning Process (CPP)

Identifies community issues related to untreated serious mental illness resulting from lack of community services and supports, including any equity issues identified during the implementation of the Mental Health Services Act (unserved/underserved).

Analyzes the behavioral health needs of specialty mental health population

Identifies and evaluates/re-evaluates priorities and strategies to meet changing mental health needs.

Identifies issues related to prevalence of serious mental illness and substance use disorder and requires Plan(s) to fund programs to address prevalence.

Analyzes the behavioral health needs of specialty mental health population and those living with substance use disorders (SUD).

Identifies and evaluates/re-evaluates priorities and strategies to meet changing mental health/SUD needs.

9 CCR §§3200.070, 3300(a)

Who are the MHSA/BHSA Stakeholders?

MHSA Stakeholders:

- Adults and Seniors with severe mental illness
- Families of children, adults and seniors with sever mental illness
- Providers of services
- Law enforcement agencies
- Education
- Social Services agencies
- Veterans
- Representatives from veterans organizations
- Providers of Alcohol and Drug Services
- Health care organizations
- Other important interests

BHSA Stakeholders:

- Adults and older adults with serious mental illness or in recovery from a substance use disorder
- Families of children, adults, and older adults with serious mental illness or with a substance use disorder
- Youths or youth mental health or substance use disorder organizations
- Providers of mental health services and substance use disorder treatment services
- Public safety partners
- Education agencies
- Higher education partners
- Early childhood organizations
- Local health jurisdictions
- County social services and child welfare agencies
- Labor representative organizations
- Veterans
- Representatives from veterans organizations
- Health care organizations
- Health care service plans, including Medi-Cal managed care plans
- Disability insurers
- Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
- The five most populous cities in counties with a population greater than 200,000
- Area agencies on aging
- Independent living centers
- Continuums of care
- Regional centers

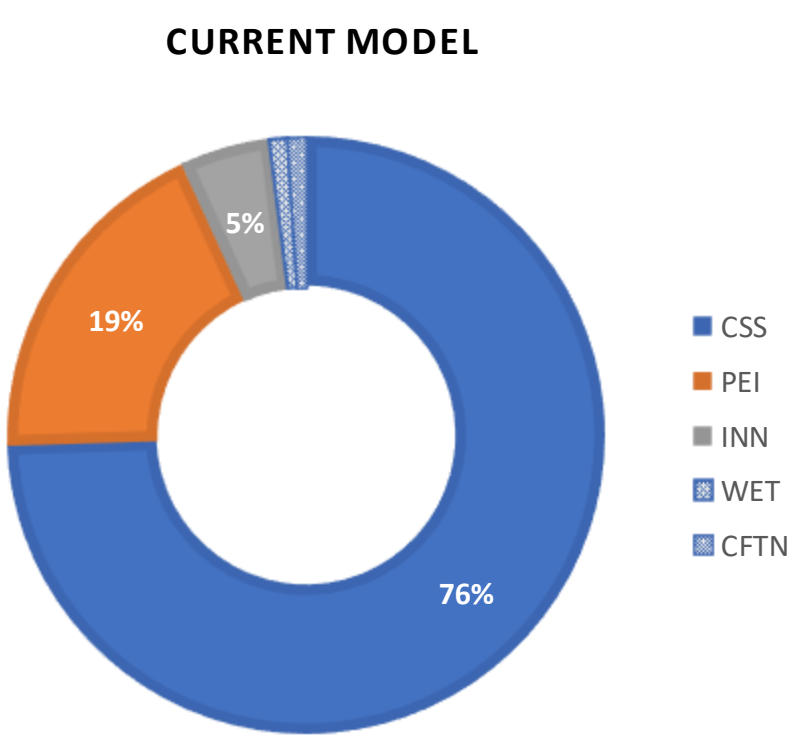
Table Discussion

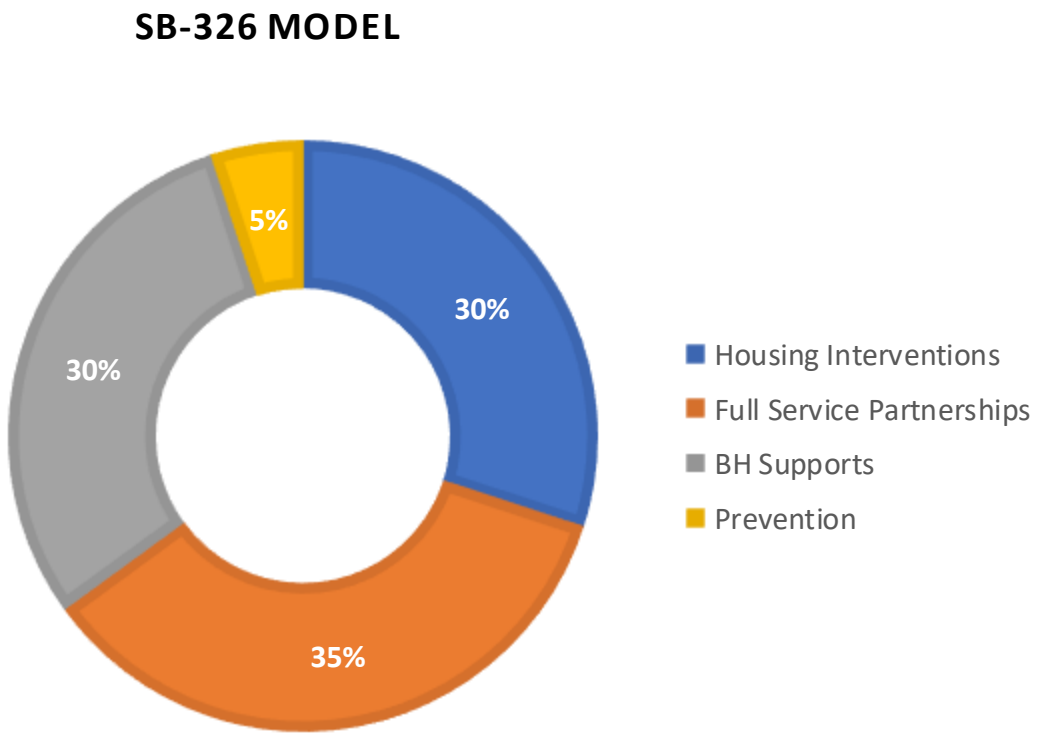
Consider the information that was presented and the potential changes to MHSA

1. When you think of the expanded group of stakeholders proposed in SB-326, can you think of any benefits, deficits, opportunities, or unintentional consequences?
2. What do you think about possibly having to design programs based on prevalence of a disease?

Please take 10 minutes in your group to discuss and identify a person to report out.

Components of MHSA and BHSA

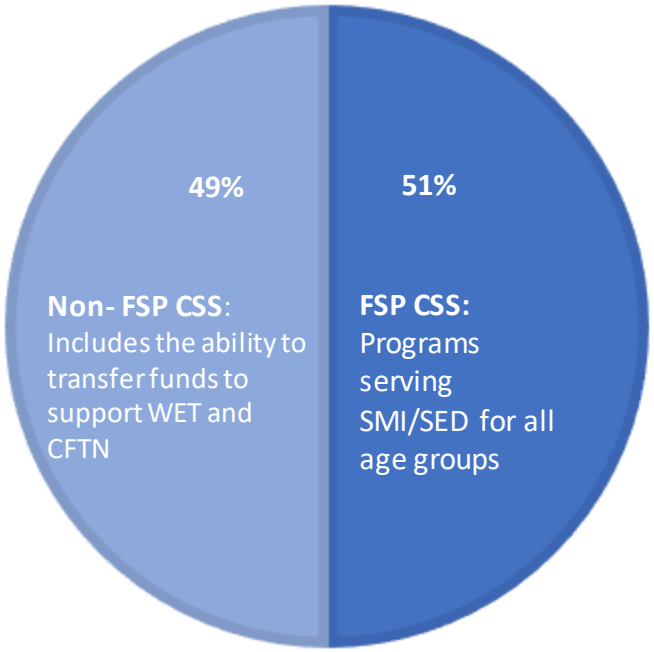




Full Service Partnership Model

(not based on actual models)

CURRENT CSS DISTRIBUTION

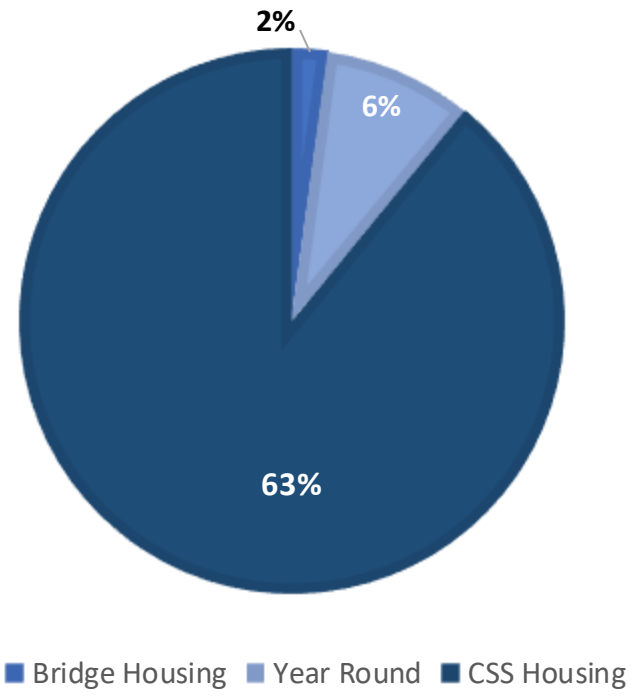


PROPOSED FULL SERVICE PARTNERSHIP EXAMPLE (35% of Total)

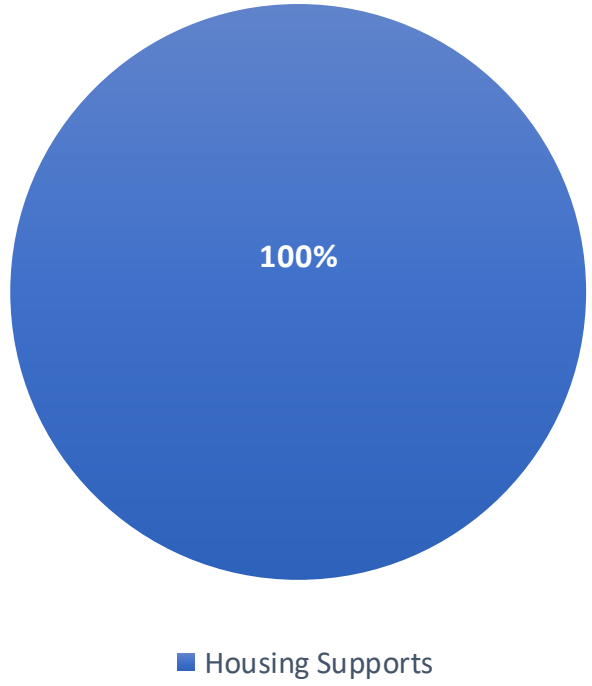
Housing Intervention Model

(not based on actual models)

CURRENT CSS HOUSING INVESTMENT



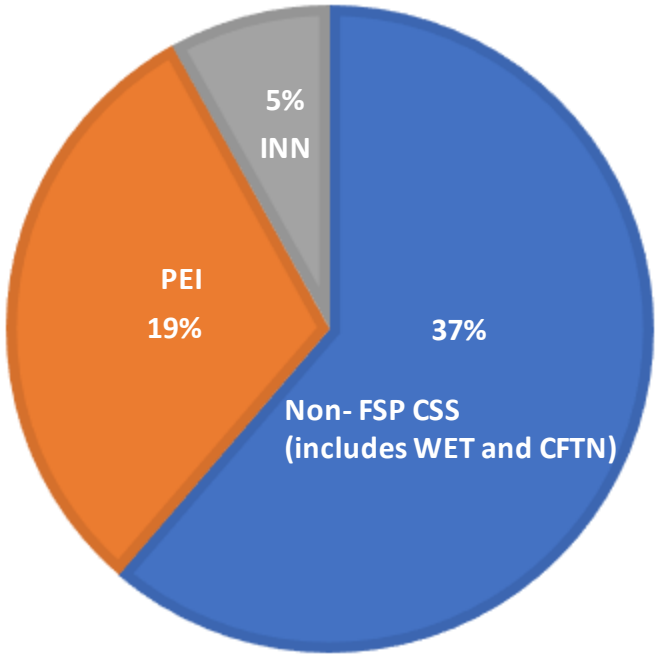
HOUSING INTERVENTIONS (30% of Total)



Other Behavioral Health Supports Model

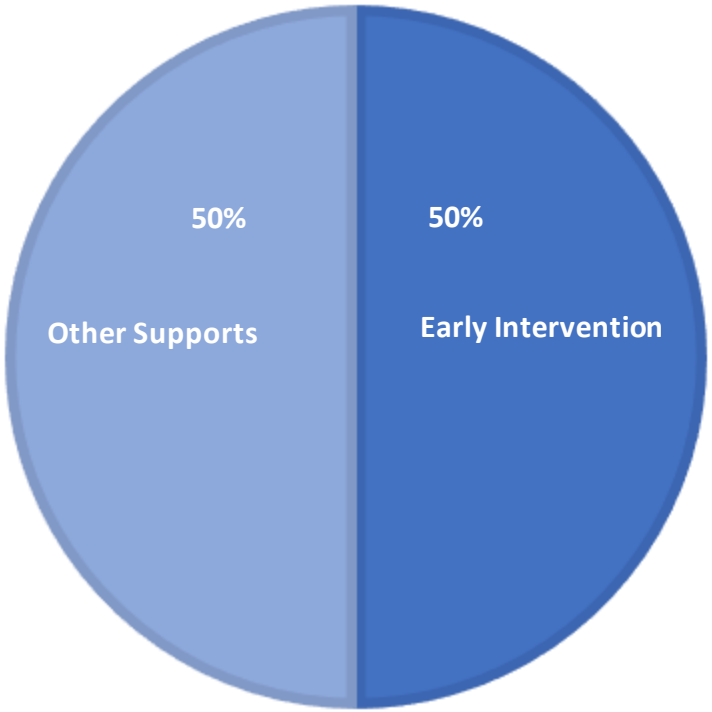
(not based on actual models)

REDISTRIBUTION TO OTHER BEHAVIORAL HEALTH SUPPORTS CATEGORY



Note: Currently, PEI is combined into one categorical funding pot. BHSA will deconstruct this paradigm to separate Prevention from Early Intervention

OTHER BEHAVIORAL HEALTH SUPPORTS (35% OF TOTAL)



State Analysis Information

- Mental Health Services Act: Revenue Volatility and the Governor's Proposal to Reduce Allowable County Reserves
- Mental Health Services Act: Proposed Change in Mental Health Services Oversight and Accountability Commission's Role
- Mental Health Services Act: Proposed Restructuring of the MHSA Funding Categories and Impacts on County Spending

Timeline

Legislative and Voting Process

- September 14, 2023: Last day for either the senate or assembly to pass a bill
- October 14, 2023: Last day for the Governor to sign or veto bills passed by the Legislature
- October 26, 2023: Last day for propositions to qualify to appear on the ballot
- November 3, 2023: Last day for the Proposition Ballot Label and Title Summary

If approved, this initiative will go before the voters on the March 5, 2024, Statewide Primary Election

- If approved by voters, Governor signs bill and BHSA takes affect January 1, 2025
- By July 1, 2025, the department shall adopt any regulations necessary to implement
- The goal is for the BHSA to be operative on July 1, 2026

Group Discussion

Please take 5-10 minutes to discuss your thoughts, concerns, opportunities, and ideas for how we will get through this change together.

MHSA Finance

MHSA Finance

- MHSA revenue is based on a 1% tax surcharge on personal income, making it difficult to predict from year to year

- To mitigate the risk to programs providing vital services, the MHSA regulations require that counties maintain a "Prudent Reserve," at a minimum level of 5% and a maximum level of 33%, of the average amount of CSS money received over the previous 5 fiscal years.
  - BHSA proposes to change this to a maximum of 20% of the total BHSA funds

- In general, MHSA dollars must be spent within 3 fiscal years (Jul-June) or they get sent back to the state and redistributed.

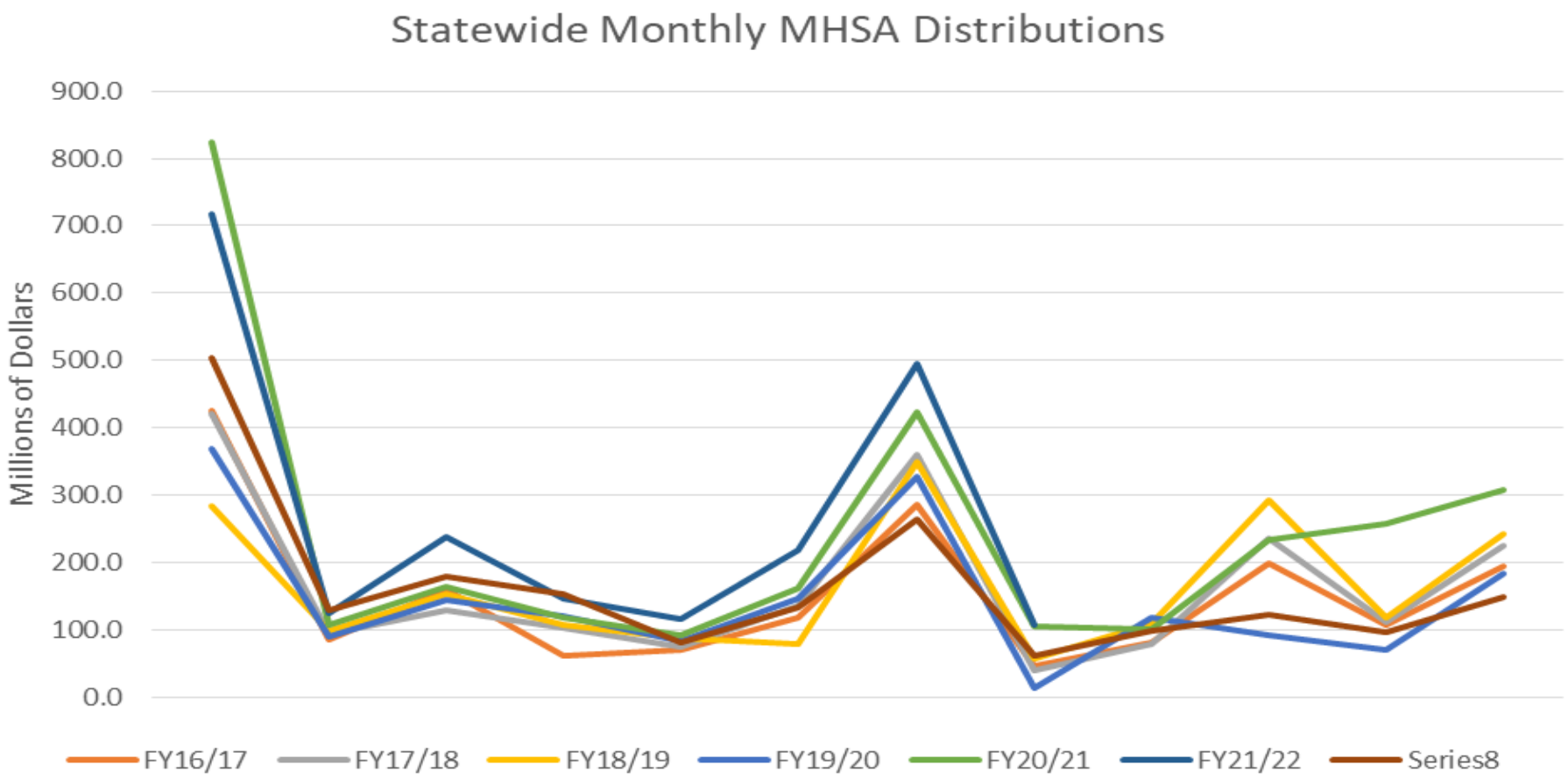
MHSA Non-Supplant

Welfare and Institutions Code Section 5891(a) specifies that MHSA funds cannot be used to supplant existing resources

California Code of Regulations Section 3410 specifies that MHSA funds cannot be used to supplant funds required to be used for services and/or supports that were in existence in FY2004-05

DMH Policy Letter 05-08 identifies the aggregate funding amount for each county that must be spent in order to comply with the non-supplant policy

Statewide MHSA Projected Revenue



Annual MHSA Projected Revenue

Orange County
MHSA Estimated Component Funding
(Millions of Dollars)

	Fiscal Year				
	Actual	Estimated			
	21/22	22/23	23/24	24/25	25/26
CSS	$188.1	$121.7	$253.1	$203.4	$132.1
PEI	$47.0	$30.4	$63.3	$50.9	$33.0
Innovation	$12.4	$8.0	$16.7	$13.4	$8.7
Total	$247.5	$160.2	$333.0	$267.7	$173.8

Group Discussion

Is there additional information related to MHSA you would like covered at a future MHSA-PAC Meeting?

Debrief

- Group Announcements
- Next Steps
- Surveys