OC health CARE AGENCY

MHSA Planning Advisory Committee

Review of Programs and Expenditure Plan Annual Update for FY 2024-2025

Welcome

HOUSEKEEPING

GROUP AGREEMENTS

AGENDA FOR TODAY

Todays Agenda

- Welcome and Introductions
- MHSA Program and Expenditure Plan Review
  - Prevention and Early Component
- Break
- MHSA Program and Expenditure Plan Review
  - Prevention, Innovation
- Lunch
- MHSA Program and Expenditure Plan Annual Review, Continued
  - Community Services and Supports Component
    - Workforce Education and Training
- Proposition 1 Overview
- Closing

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Announcement: Name Change

Effective March 1, 2024, Mental Health and Recovery Services will revert to the previous department name, **Behavioral Health Services.**

MHSA Program and Expenditure Plan Annual Program Review

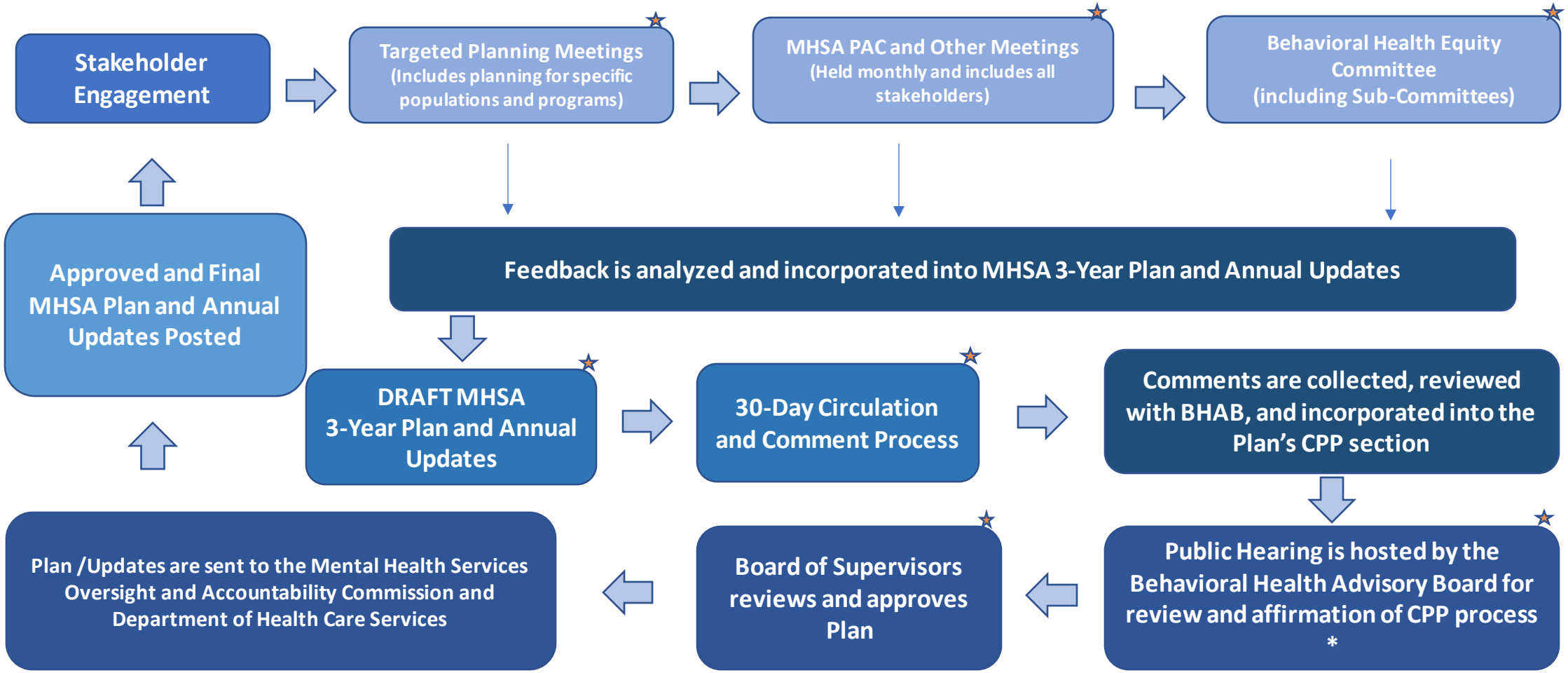
MHSA Summary

- 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.
- Requires development of Three-Year Program and Expenditure Plan and Annual Updates to the Plan.

MHSA Funding Components

Funding %	Component	Categorical Use
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 into 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, billing, 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. Broken up into State Defined Programs • 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

The MHSA Three-Year and Annual Update Process



★ Indicates opportunities for stakeholder input and feedback.

WIC §§5847(a), 5848

Prevention and Early Intervention Component

Prevention and Early Intervention: Purpose

Program services are envisioned to develop and implement strategies that stop mental illness from becoming severe and disabling, giving emphasis to improvement in timely access to services for underserved populations.

PEI programs serve all age ranges, however, 51% of services must target individuals aged 25 and under and their families.

The State defines six specific Prevention and Early Intervention Programs. Per statute, a program is defined as "a stand-alone organized and planned work, action, or approach that evidence indicates is likely to bring about positive mental health outcomes either for individuals and families with or at risk of serious mental illness or for the mental health system (WIC §3701 (b))."

These State-Defined programs areas are:

Prevention and Early Intervention

LOCAL PEI CONSTRUCT

The Orange County PEI programs operate under the State-Defined Prevention and Early Intervention reporting construct as illustrated in the following tables:

Outreach for Increasing Recognition of Signs of Mental Illness
- Behavioral Health Training Collaborative
- Mental Health and Well Being Promotion for Diverse Communities
- Early Childhood Mental Health Providers Training
- K-12 School Based Mental Health Services
- Services for TAY and Young Adults

Stigma and Discrimination Reduction
- Mental Health Community Education Events for Reducing Stigma & Discrimination

Prevention Programs
- Prevention Services and Supports for Families
- Prevention Services and Supports for Youth
- Family Support Services

Suicide Prevention
- Community Suicide Prevention Initiative
- Crisis Prevention Line
- Survivor Support Program

Access and Linkage to Treatment
- OC Links
- OC Outreach and Engagement for Homeless
- Integrated Justice Involved Services

Early Intervention
- School Based Mental Health Services
- Thrive Together OC
- OC CREW
- OC Parent Wellness Program (OCPWP)
- Community Counseling and Supportive Services
- Early Intervention Services for Older Adults
- OC4VETS

PEI: Outreach for Increasing Knowledge of Signs of Mental Illness

The goal of the Outreach to Increase Knowledge of Signs and Symptoms of Mental Illness is to:

- Increase awareness and knowledge of signs and symptoms of mental health and/or substance use issues of potential responders (such as primary care, education, law enforcement, etc.)
- Increase awareness and knowledge in families, communities, and underserved/unserved populations.

Programs

- **Behavioral Health Training Collaborative**
- **Mental Health and Wellbeing Promotion for Diverse Communities**
- **Early Childhood Mental Health Providers Training**
- **K-12 School-Based Mental Health Services**
- **Services for TAY and Young Adults**

PEI: Outreach for Increasing Knowledge of Signs of Mental Illness

Behavioral Health Training Collaborative

3 primary populations targeted:

- **Community at large** (Tier 1): General public such as parents, family members, community centers, etc.
- **Non-clinical provider** (Tier 2): A person who interacts with or provides services to those who may experience a behavioral health condition.
- **Clinical providers** (Tier 3): A direct service provider

FY 2022-2023 Results:

528 trainings

8,397 attendees

98% participant satisfaction

Types of Potential Responders:

- Community
- Child Welfare
- Behavioral Health Providers
- Medical Co-Morbidities
- Cultural/Ethnic Communities
- Individuals Working with SUD
- Homeless/At-risk
- Criminal Justice
- Families
- LGBTQI+
- Parents/Schools/Students
- Trauma Exposed Individuals

PEI: Outreach for Increasing Knowledge of Signs of Mental Illness

Early Childhood Mental Health Provider Training

Fiscal Year 2022-2023 Results:

ECMCH services were successful at enhancing social-emotional learning as measured by:

- 63% of ECE staff reported fewer children with persistent challenging behaviors.
- 37% of teachers demonstrated an increase in ability and knowledge to effectively manage children's challenging behaviors.
- 100% of children demonstrated an increase in prosocial behaviors.
- 82% of children maintained good engagement in classroom activities.

PEI: Stigma and Discrimination Reduction

Mental Health Community Education Events for Reducing Stigma & Discrimination

The goal of this program is to reduce stigma and discrimination against people living with mental illness.

The program encourages participants and their family members to attend and participate in stigma reduction activities in their community.

The program is inclusive of those living with mental health conditions and their loved ones.

Community partners who specialize in working with underserved cultural populations are involved to improve community members' access to the events.

FY22-23 Results	
Survey Questions	**n= 2,325 participants n=1,029 surveys returned**
I would be willing to talk about mental health with people I meet.	79%
I learned how to treat people who are living with a mental illness	80%
I would avoid people who are living with a mental illness.	22%
I learned how to find help for people living with a mental illness.	77%
I believe people living with a mental illness can have similar problems as I do.	85%
I believe anyone can have a mental illness at some point in their lives.	92%
I am willing to talk with someone about my mental health.	83%

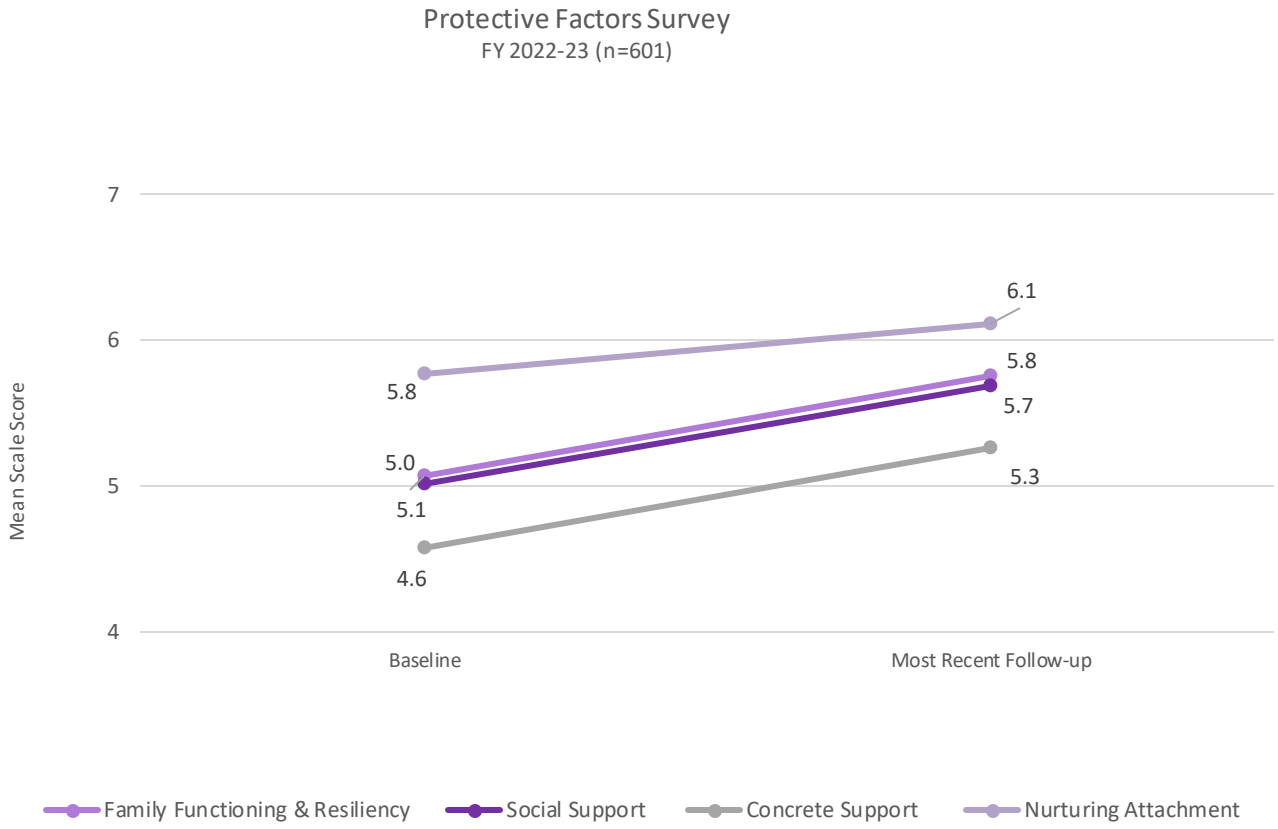
PEI: Prevention

Prevention programs work to decrease risk factors, increase protective factors, build resiliency, and work to deter mental illness from becoming severe and disabling.

OC has two programs in the state defined prevention category:

- **Prevention Services and Supports for Families**
- **Prevention Services and Supports for Youth**

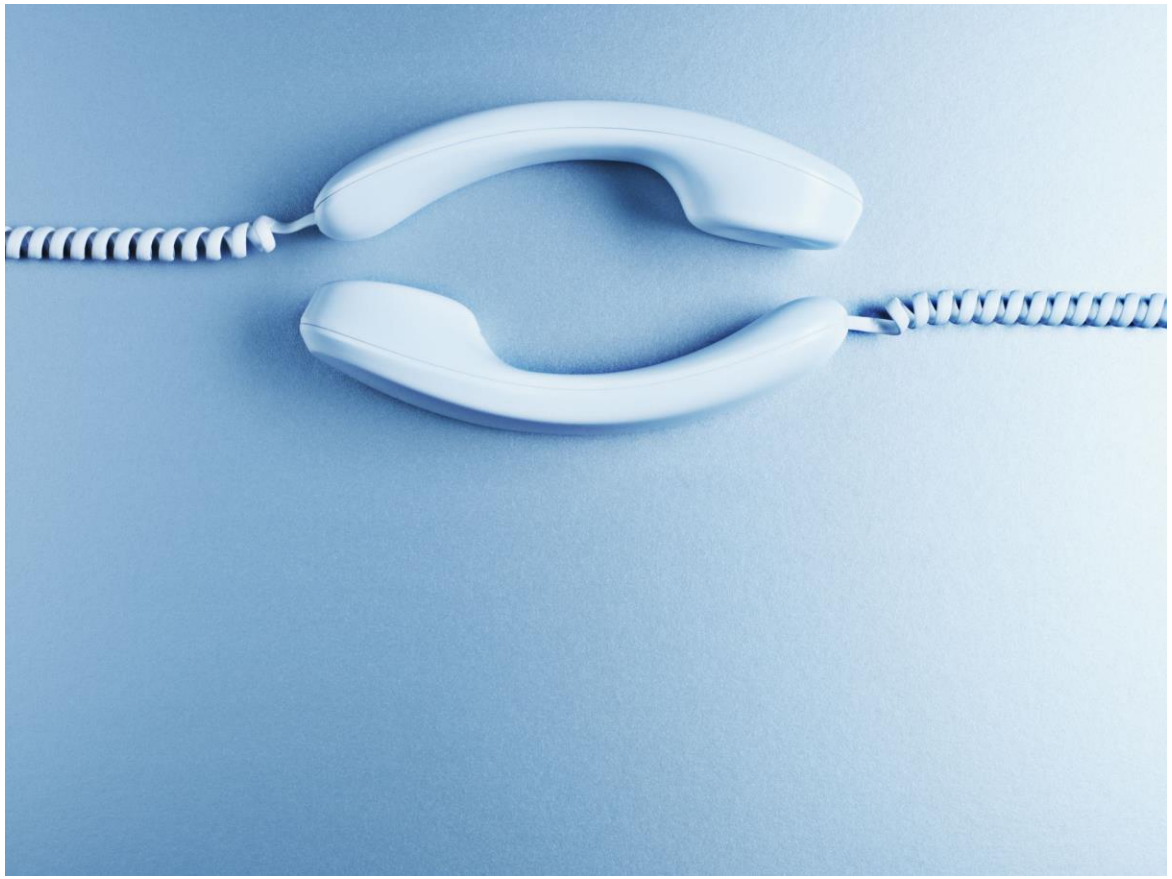
The table demonstrates improvements in family functioning and resiliency, social supports, concrete supports, and nurturing attachment for Program participants in FY 22-23



PEI: Suicide Prevention

Suicide Prevention Services include three integrated components to include:

- Community Suicide Prevention Initiative
- Crisis Prevention Line
- Survivor Support

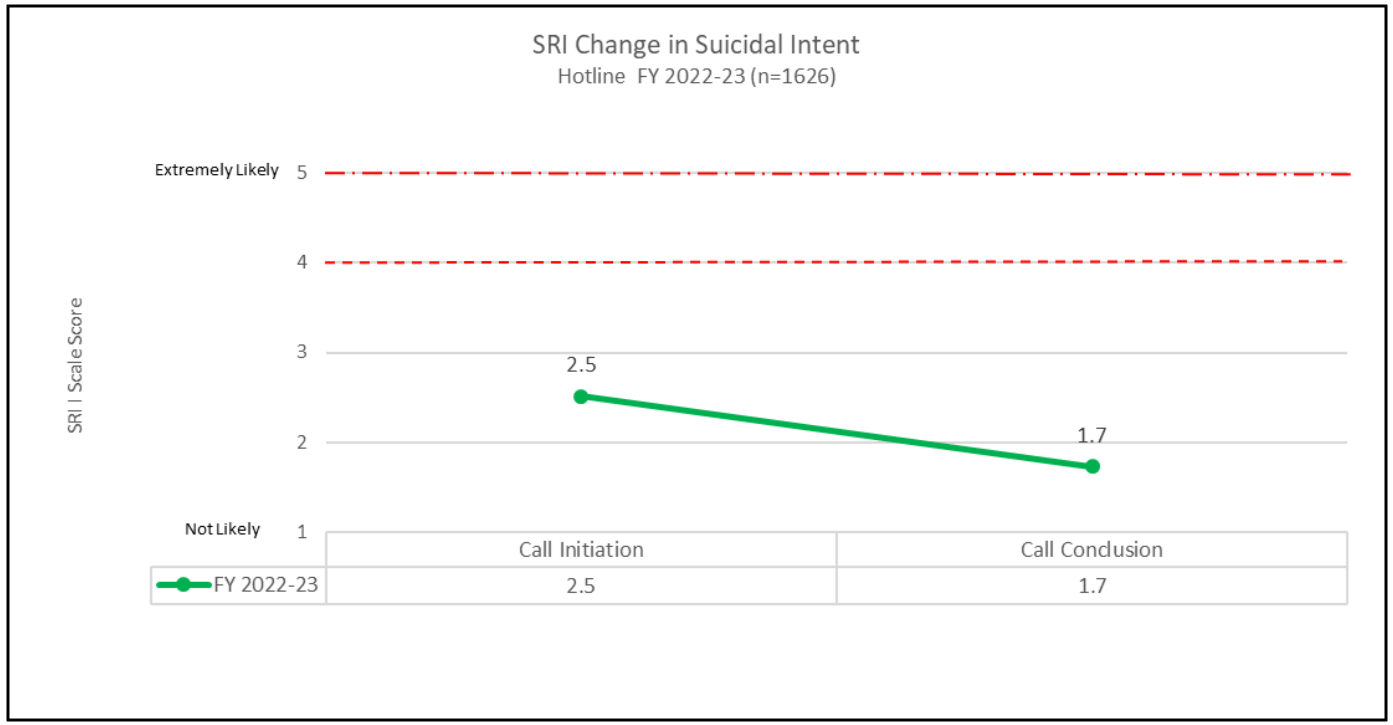


PEI: Suicide Prevention

FY 22-23

988- Suicide Intent Measure

Callers typically expressed feeling a moderate level of suicidal intent when calling 988 and talking with Crisis Prevention Line (Hotline) staff reduced the likelihood they might act upon these thoughts or feelings.

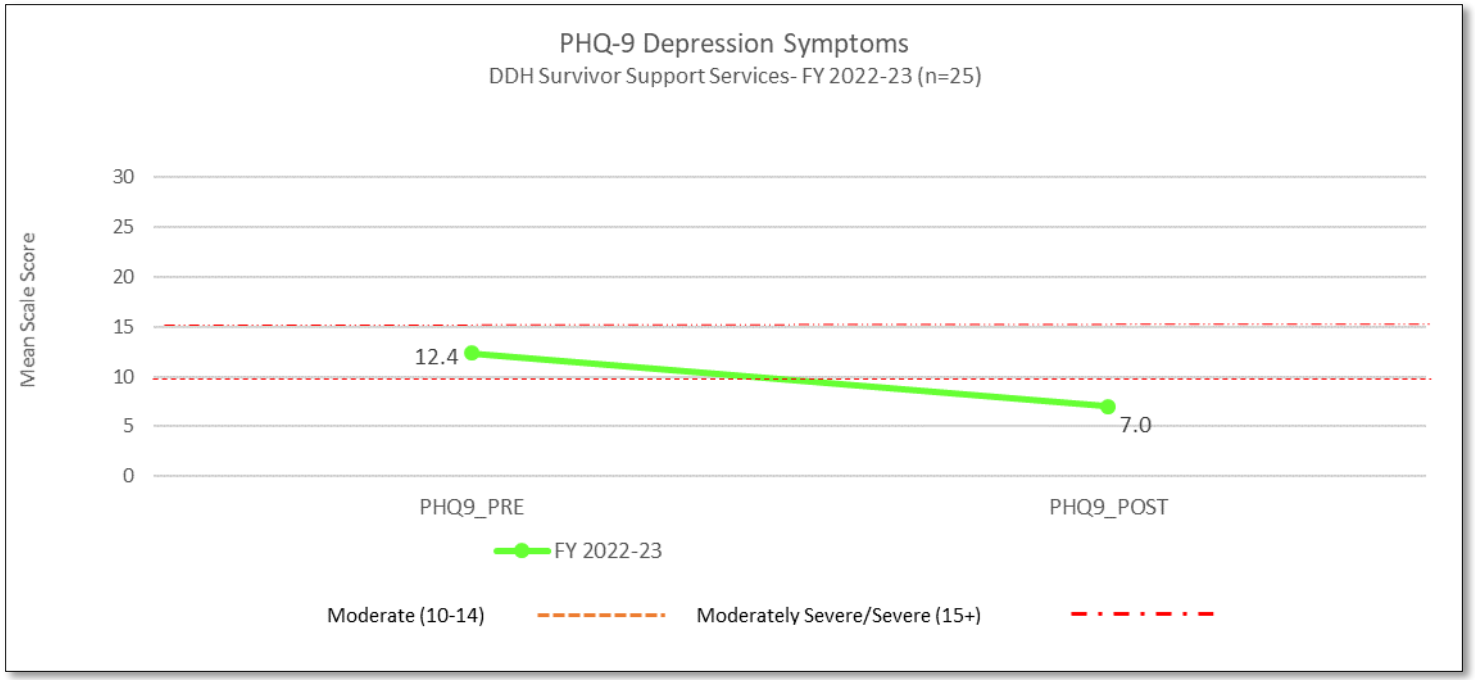


PEI: Suicide Prevention

FY 22-23

Survivor Support Services

Survivors of suicide attempts reported reductions in the severity of their depression symptoms, with average scores falling from the moderate to mild range after enrolling in specialized services.



Break Time

PEI: Access and Linkage to Treatment

The goal of the Access and Linkage to Treatment PEI programs are to:

Increase access to medically necessary care for mental illness through expanded entry points such as:

- Telephone, internet, and chat-based support
- Outreach in the community for unhoused individuals
- Re-entry points for individuals involved in the justice system

Programs

- **OC LINKS**
- **OC Outreach and Engagement**
- **Integrated Justice Involved Services**

PEI: Access and Linkage to Treatment

OC LINKS

Results FY 22/23:

- 44,678 Calls Answered
- 10,255 calls related to crisis
- 32,568 resource recommendations for behavioral health and supportive services to 28,054 of these callers.

OC Outreach and Engagement

Results FY 22/23:

- 23,289 Contacts
- 9,708 Referrals for County/Contracted programs
- 2,366 individuals linked to 3,675 offered services (38% linkage rate)

Integrated Justice Involved Services

Results FY 22/23:

- Outreach to a minimum of 1,500 individuals
  - 250 enrolled
- Over 3,600 discharge plans created for patients released from OC Jails
- 6,249 individuals served

PEI: Early Intervention

The purpose of the Early Intervention sub-component is to intervene as early as possible in the onset of a serious mental illness.

The intention is to:

- Decrease the subjective suffering associated with untreated mental illness
- Decrease likelihood that mental illness will become severe and debilitating

Programs

- School Aged Mental Health Services
- Orange County Center for Resiliency, Education and Wellness (OC CREW),
- OC Parent Wellness Program
- Community Counseling and Supports
- Early Intervention Services for Older Adults
- OC4VETS

PEI: Early Intervention

OC CREW Results FY 22/23

- Reported reductions in the severity of overall psychiatric symptoms experienced by adults and adolescents (-43% and -40%, respectively) after they enrolled in services.
- Improved functioning in clinical domains (i.e., distortions in thinking, disorganized behavior/thinking, negative symptoms) more common to psychotic disorders, with 14-59% of adults experiencing moderate-to-extremely severe symptoms upon enrollment compared to 0-14% of adults after receiving services.
- Effectively supported adolescents, with 12-54% assessed in the moderate-to-extremely severe range upon enrollment compared to 0-14% after receiving services. The one exception was an increase from 26% to 30% of adolescents who were experiencing moderate levels of disorientation.

	Adolescents		Adults	
Severity of Psychiatric Symptoms	-40%		-43%	
Functioning	Enrollment	After Svcs	Enrollment	After Svcs
	12-54%	26-30%	14-59%	0-14%

PEI: Early Intervention

Early Intervention for Older Adults Results FY 22/23:

In FY 2022-23, participants who entered the program with clinically elevated depressive or anxiety symptoms consistently reported substantial declines in their symptoms while enrolled in services.

The program provides referrals to participants for issues ranging from basic needs, medical services, housing, social support services, and higher-level mental health care (geropsychiatry).

	Baseline	Follow-Up
Depression	9.2	4.9
Anxiety	8.1	4.2

Referral and Linkage Information	
Referrals	13,418
Linkages	8,362

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Innovation

The Innovation (INN) component is designed to evaluate the effectiveness of new and/or changed practices or strategies in the field of mental health, with a primary focus on learning and process change, rather than filling a program need or gap. As such, INN strives to change some aspect of the public behavioral health system that may include system or administrative modifications.

According to the MHSA INN Project Regulations, each project must focus on mental health, identify an innovative element and clearly state the learning objectives.

Innovation

An INN project is required to contribute to learning in one or more of the following ways:

- Introduce a mental health practice or approach that is new to the overall mental health system.
- Make a change to an existing practice in the field of mental health
- Apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings.

In addition, an INN project must serve one or more of the following purposes:

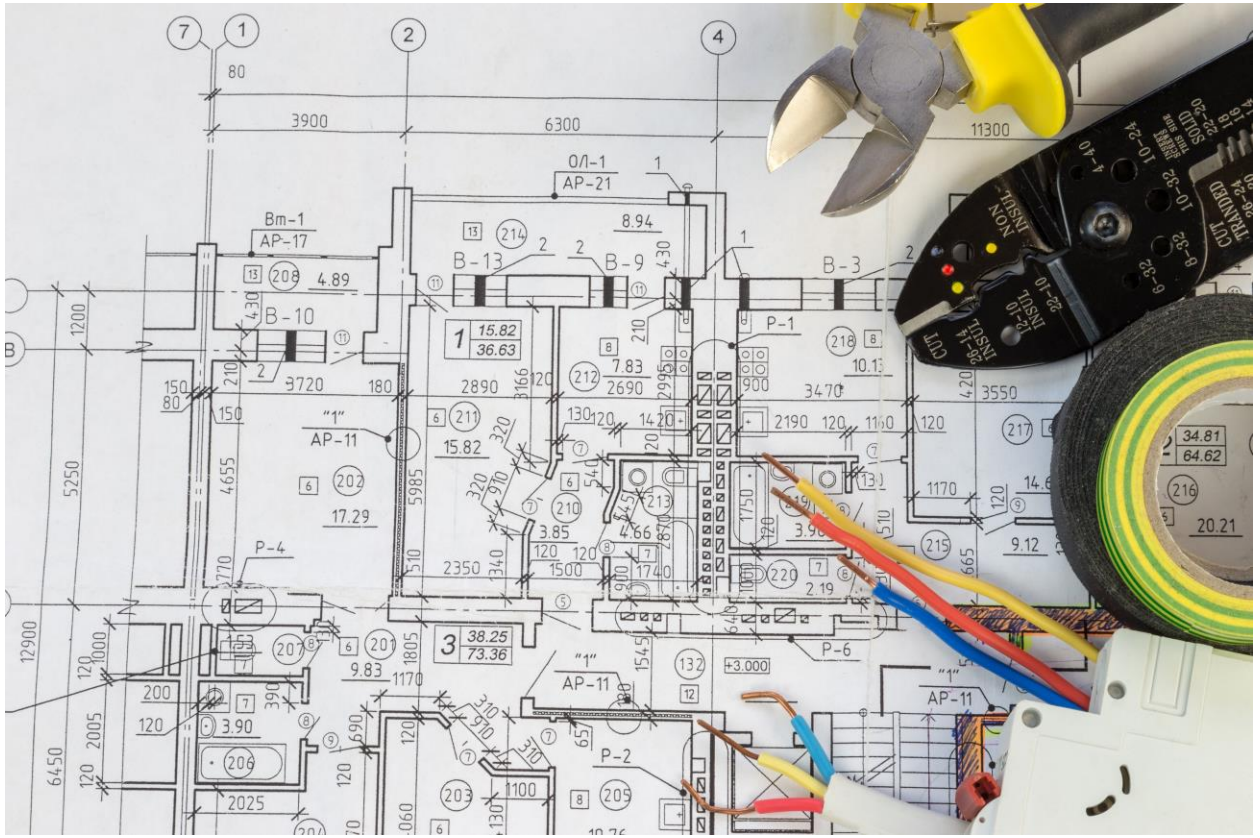
- Increase access to mental health services to underserved groups.
- Increase the quality of mental health services
- Promote interagency and community collaboration related to mental health services or supports
- Increase access to mental health services.

Programs

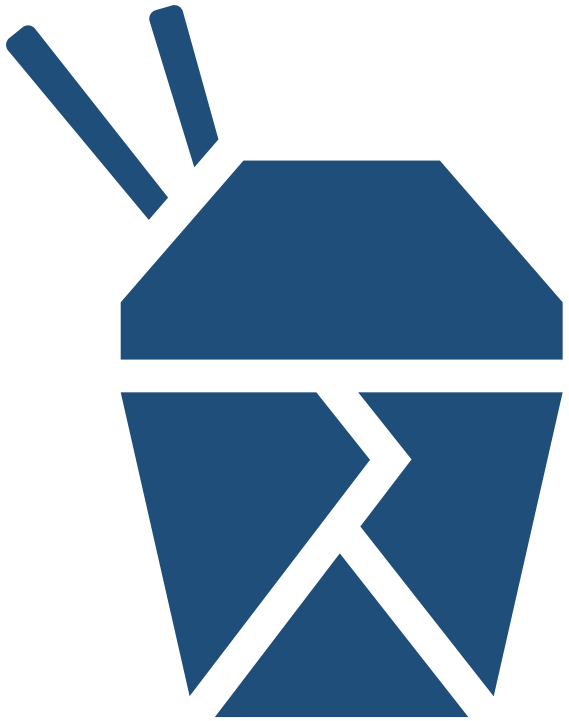
- **Statewide Early Psychosis Learning Health Care Collaborative Network**
- **Psychiatric Advanced Directives (PADS)**
- **Young Adult Court (YAC)**
- **Community program Planning**
- **Behavioral Health System Transformation**

Innovation: Prospective Projects

- Increase Community Program Planning project - $1M
- Develop Comprehensive System Redesign Project - $35M
  - Redesigning Public Behavioral Health Services
    - Full Service Partnership Reboot
    - Complex Care Management
    - Developing Capacity for Specialty Mental Health Plan Services with Diverse Communities
    - Innovative Workforce Initiatives
    - Clinic and Administrative Redesign
- PADS Part II – support technology $5M



LUNCH BREAK



Community Services & Supports

The majority of MHSA funding is directed toward the Community Services and Supports (CSS) component. The CSS component provides access to an expanded continuum of care for persons living with a serious mental illness (SMI) or serious emotional disturbance (SED). The CSS section is organized according to programs that operate with similar service responsibilities but may serve different target populations. Programs intended to provide interventions or supports during a mental health crisis are described in the Crisis System of Care section. CSS contains several Full Service Partnership (FSP) Programs, Housing and Homeless Services, Outpatient Clinical Expansion, Outreach, Engagement and Access, and Peer and Family Support sections. FSP programs provide "whatever it takes" services. Peer Support Programs are consumer driven and feature a lived experience perspective. The goal of all CSS programs is providing the necessary services and supports that help clients achieve mental health and wellness and recovery goals.

CSS: Crisis System of Care

Crisis System of Care services are a continuum community-based intervention designed to provide a variety of levels of de-escalation and relief to individuals experiencing a behavioral health crisis.

Crisis services are provided by a multidisciplinary team of trained behavioral health professionals that offer rapid response, individual assessment and community-based stabilization to individuals who are experiencing a behavioral health crisis.

Services are designed to provide relief to consumers experiencing a behavioral health crisis, reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations and law enforcement involvement.

Programs

- Mobile Crisis Assessment Team
- In Home Crisis Stabilization
- Crisis Stabilization Unit
- Crisis Residential Services
- Warmline

CSS: Crisis System of Care

In FY 2022-23, the In-Home Crisis Stabilization program met its goal of maintaining a hospitalization rate* of 25% or less during the 60 days following discharge from services

For all age groups, Crisis Residential Services met its goal of maintaining a hospitalization rate* of 25% or less during the 60 days following discharge from services

Hospitalization Rate				
	Children	TAY	Adults	Older Adults
In Home Crisis Stabilization	3%	6%	7%	8%
Crisis Residential Services	24%	12%	20%	13%

*Calculated for Medi-Cl Beneficiaries Only

CSS: Full Service Partnership

FSP programs do “whatever it takes” to support the wellness, recovery and safety of its members, with the goal that at least 80% of members remain safely in the community and do not require psychiatric hospitalization, remain out of custody, avoid arrest and/or do not experience unsheltered homelessness while enrolled in FSP services.

Target >= 80%	Children n=599	Transition Aged Youth n=1,087	Adults n=1,908	Older Adults n=347
No Unsheltered Homelessness	99%	95%	79%	84%
No Arrests	96%	90%	94%	99%
No Incarcerations	95%	86%	85%	97%
No Psychiatric Hospitalizations	90%	90%	86%	92%

CSS: Housing and Homeless Services

Housing and Emergency Shelter

Bridge Housing

CSS Housing

A one-time State allocation of $8 million in FY 2006-07 to develop permanent supportive housing for individuals living with serious mental illness who were receiving services in the Full Service Partnership programs. Funds were used to develop 34 housing units in two developments.

A one-time State allocation of $33 million in FY 2007-08 carved out of the CSS allocation (i.e., MHSA Housing Program) and used for 10 housing developments that created an additional 194 new units of PSH in Orange County.

FY 2020/21 – FY 2022/23 CSS allocation (SNHP) has created 10 additional housing developments (206 new units). Creating a total of 22 MHSA housing developments totaling 400 MHSA units.

CSS: Outpatient Clinical Expansion

Programs

- Children and Youth Expansion
- Short Term Residential Therapeutic Program
- Outpatient Recovery Center
- Older Adult Services

CSS: Outpatient Clinical Expansion

Outpatient Recovery: There are three goals of the Outpatient Recovery program:

1. Have psychiatric hospitalization rate of less than 1% whole participants are enrolled
2. Discharging at least 60% of those with known discharge dispositions into a lower level of care.
3. 30% of clients will engage in employment or volunteer work

Results:

- In FY 2022-23, the Recovery Centers were successful in meeting their target rate of hospitalization at less than 1% when discharging clients from the program, reflecting their success in helping individuals maintain recovery and remain within their communities.
  - Hospitalization rate= 0.58%
- The Recovery Centers made gains in helping link clients to community-based mental health care after discharging from the program, and fell just short of the 60% target rate:
  - Linkage to community-based care: 58.2%

CSS: Outreach, Engagement, and Access

Multi-Service Center: The goal is to provide basic needs, and referrals/linkages to various resources in the community. 678 individuals/14,783 total visits; 80/day avg

Open Access: Provide adults in need of urgent medication services within 3 business days. Link adults referred by open access to ongoing care within 30 days.

Open Access Indicator	Goal	FY 22-23 Rate	N
Linkage to medication services within 3 business days after discharge from a hospital	≥ 80%	73%	n = 328
Linkage to medication services within 3 business days of release from jail	≥ 80%	84%	n = 55
Linkage to Ongoing Care within 30 Days	≥ 80%	64%	n = 1,123

Multi-Service Center Category	# Referrals	Linkage Rate
Mental Health Services	378	48%
Substance Use Services	142	41%
Vocational Services	243	95%
Supportive Services	3,875	83%
Housing Placements	787	26%

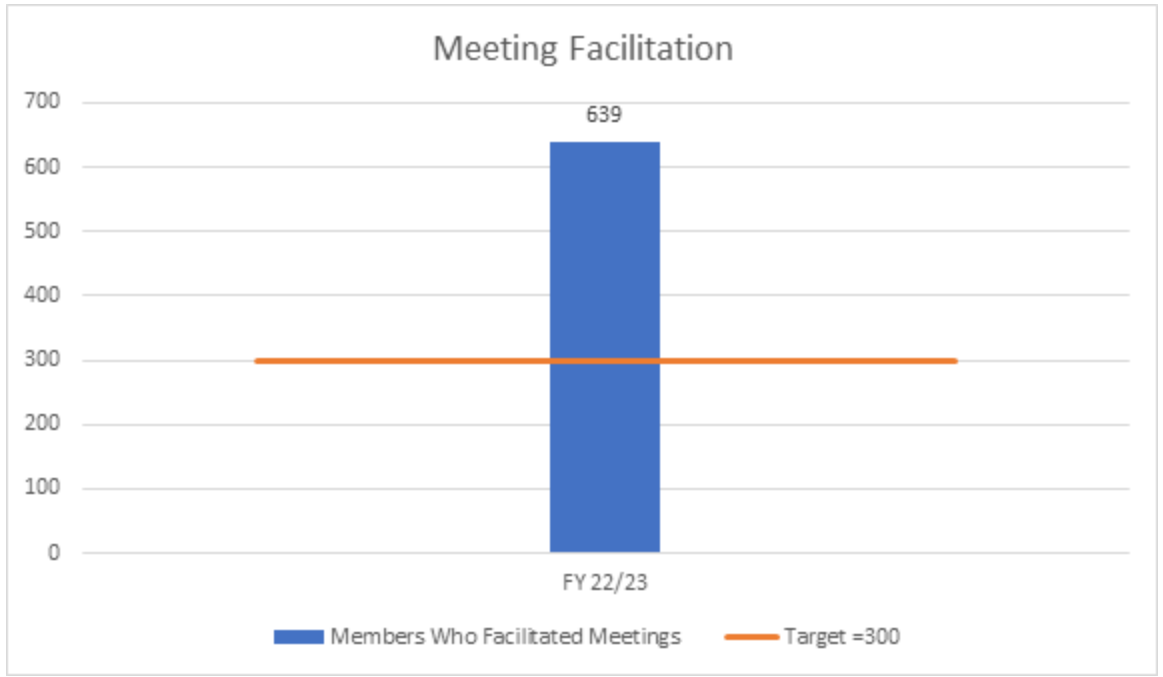
CSS: Peer and Family Support

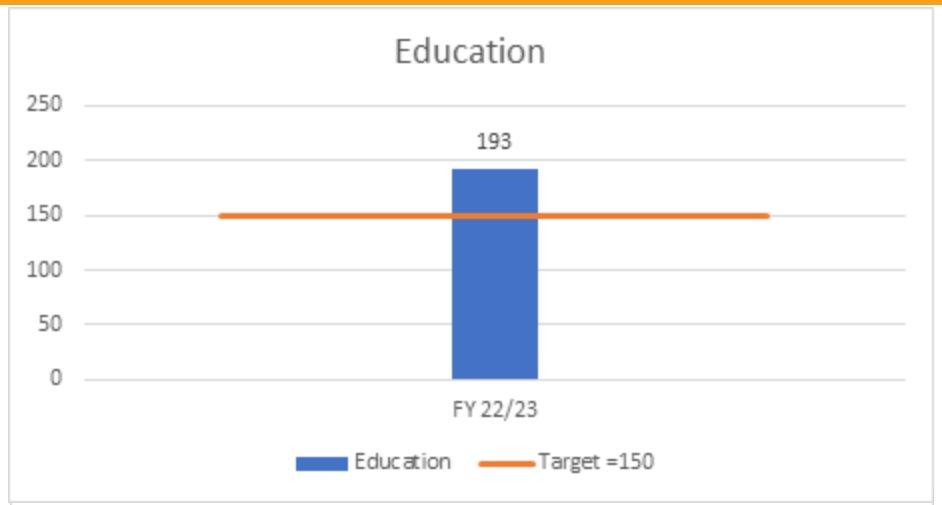
Programs

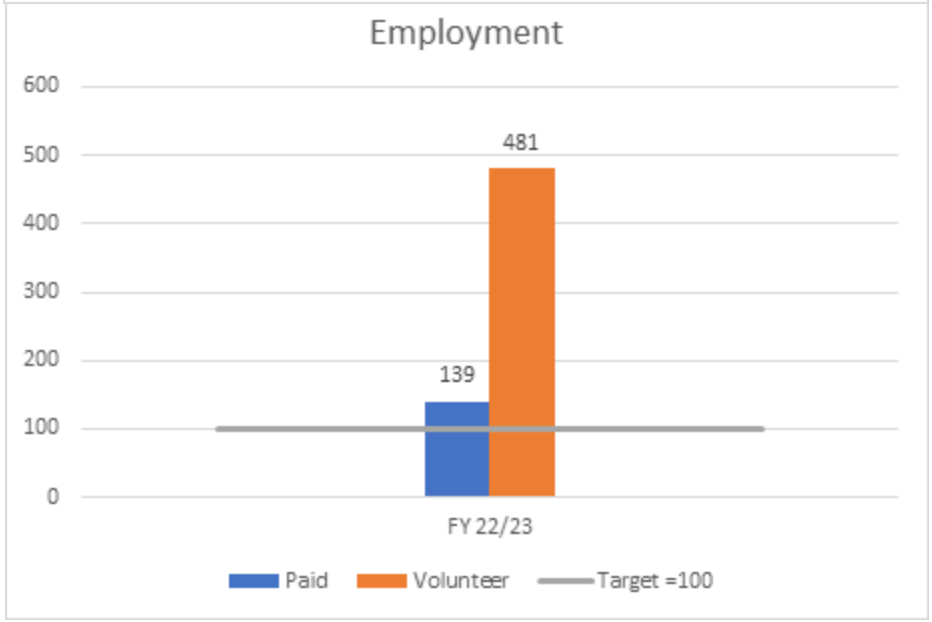
- Peer Mentor and Parent Partner Support
- Wellness Center
- Supported Employment

CSS: Peer and Family Support

Wellness Center: Wellness Centers monitor their success in supporting recovery through social inclusion and self-reliance.







Workforce Education and Training

In FY 22/23, WET offered 91 trainings to Staff and contract providers of Orange County either virtually or in-person.

Training and Technical Assistance provided 206 trainings to 8,059 attendees. Of these, 25 trainings were focused on specific evidenced-based practices and 84 trainings were CE/CME trainings.

Through the loan repayment program, Orange County approved 34 BHS staff/contract providers with the loan repayment award. Orange County also provided a $6,000 stipend to 22 graduate student interns placed in an eligible public mental health settings for one academic year.

34 MHRS staff/contract providers were awarded up to $10,000 towards their school loan with the commitment of working in BHS one year.

7 psychiatrists utilized the loan forgiveness program to total $270,000 spent towards paying down their loans.

Break Time

Proposition 1: Overview & Impacts on Behavioral Health

1.

Introduction

Governor Newsom and Legislative leaders are proposing a general obligation bond and modernization of the Mental Health Services Act (MHSA) for the March 5, 2024, ballot as Proposition 1. The Proposition promises to provide California the resources needed to build 11,150 new beds across community treatment campuses and facilities to help Californians with serious mental illness and substance use disorders get the housing and care they need.

Two bills relate to Proposition 1: Senate Bill 326 and Assembly Bill 531, focused on **four strategies** to transform California's behavioral health system through **housing with accountability and reform with results:**

1. **Services for the most in need**. Reforming the MHSA to provide services to the most seriously mentally ill and to treat substance use disorders, while continuing to invest in prevention and early intervention for children, youth, young adults, and all Californians.

2. **Accountability.** Focusing on outcomes, transparency, and equity so families and communities see real results.

3. **Behavioral health housing.** Building treatment beds and supportive housing units in community-based settings –with a dedicated number reserved for housing veterans with behavioral health challenges.

4. **Workforce**. Building up the behavioral health workforce to reflect and connect with California's diversity–helping services remain accessible.

Proposition 1 would also reduce behavioral health funding for core outpatient, crisis, prevention, outreach and engagement services in this County by over $100 million. Both bills have been signed by Governor Newsom and Proposition 1 will be voted on March 5, 2024.

Senate Bill 326

Reform

Reform public behavioral healthcare funding to prioritize services to those living with the most serious mental illnesses and to treat substance use disorders.

Expand

Expand the behavioral health workforce to reflect and connect with California's diverse populations.

Outcomes, Accountability, and Equity

Focus on outcomes, accountability, and equity. Require Behavioral Health Integrated Plans.

Assembly Bill 531

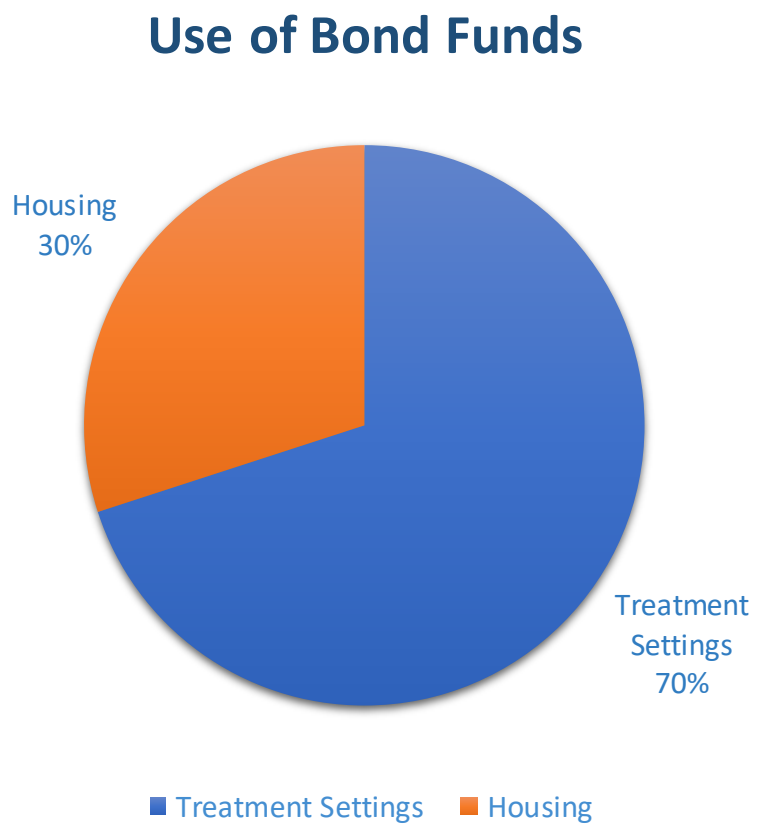
AB 531 places a $6.4 billion General Obligation Bond on the March 2024 ballot for construction of unlocked community based behavioral health treatment and residential care settings.

$4.4 Billion (70%) for grants to public or private entities for Behavioral Health treatment and residential settings.

- $1.5 billion for local governments
- $30 million tribal entities

$2.0 Billion (30%) permanent supportive housing units for veterans and persons experiencing or at risk of homelessness who have behavioral health challenges.

- $1.065 billion set aside for veterans' housing
- $922 million set aside for persons



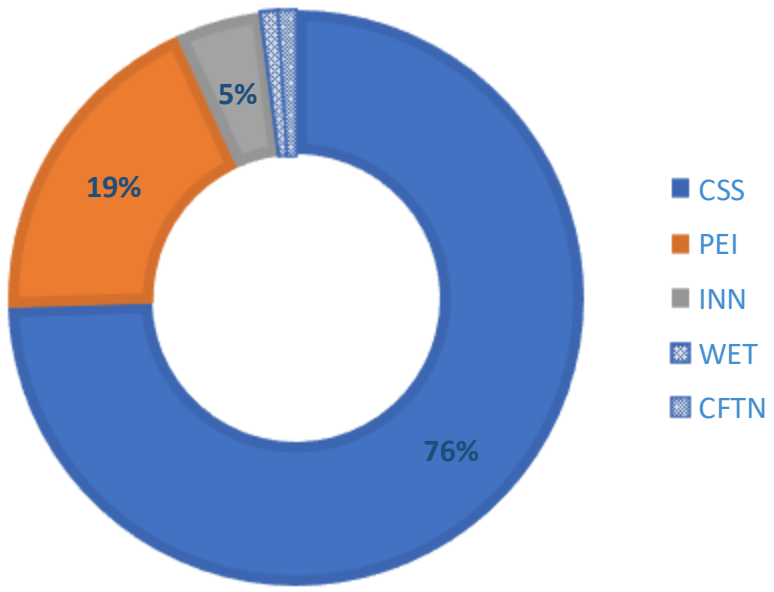
Proposition 1

SB 326	AB 531
Will change MHSA to BHSA (Behavioral Health Services Act) and will include treatment for people with substance use disorders. BHSA Plan will include **ALL Behavioral Health** programs and funds.	Also known as the Behavioral Health Infrastructure Bond Act of 2024, which directs funding to build housing and treatment beds.
Will change how counties can provide services. Counties will have to redirect MHSA funds from 5 components into 3 major "buckets": • Behavioral Health Services and Support (35%) • Full-Service Partnerships (35%) • Housing Interventions (30%)	Proposes a $6.4 billion bond to build: • 6,800 new beds for people to receive mental health care or drug or alcohol treatment at any one time. • 4,350 housing units for homeless individuals of which 2,350 are set aside for veterans experiencing homelessness.
Will direct more money to the State (10% vs. 5%) and less to Counties (90% vs. 95%). Will result in increased costs to counties to continue current programs.	The bond would provide housing to over 20% of veterans experiencing homelessness.

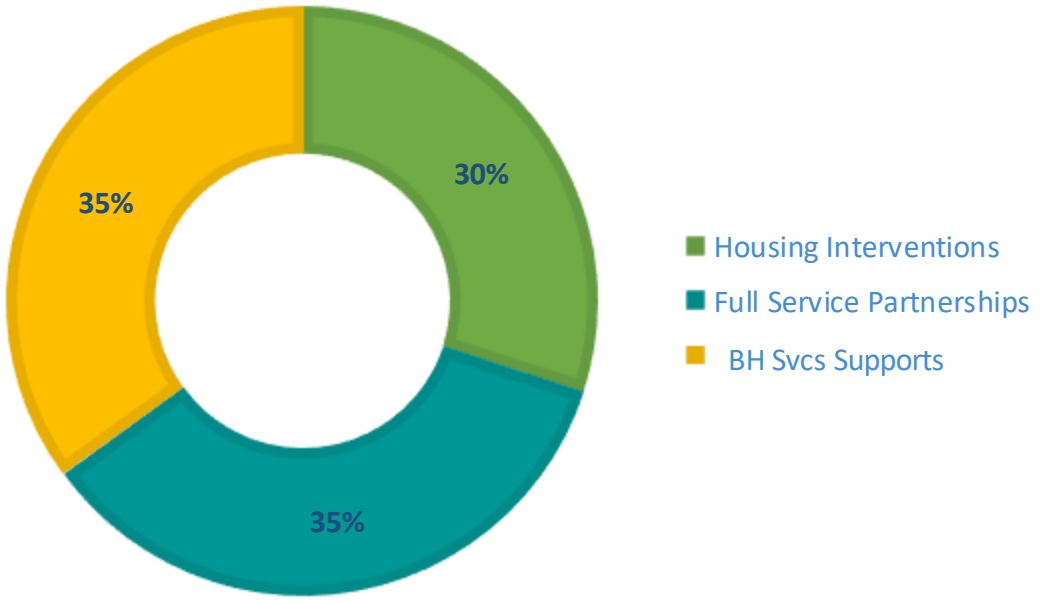
MHSA Modernization Summary

Modified from 5 Components to 3 Components

MHSA -CURRENT MODEL



BHSA - PROPOSED MODEL



MHSA Reform Impacts

FY 2026-27 Projections

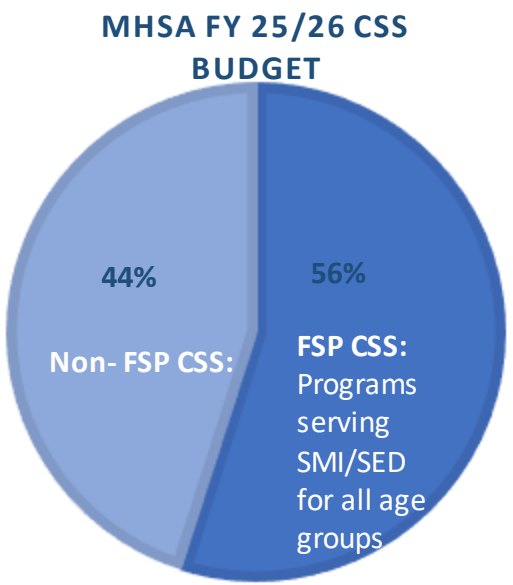
- Estimated $173,800,000 in BHSA will be available
  - Additional 5% reduction as state doubles administrative costs (from 5% to 10%) and redirects local prevention dollars for state implementation.
  - Programs and services for SUD clients will redirect mental health funds toward SUD services.
  - Significant local impacts on PEI, CSS General System Development, Workforce Education and Training, CFTN, and Innovation.
- Required to use current MHSA dollars according to their planned use.

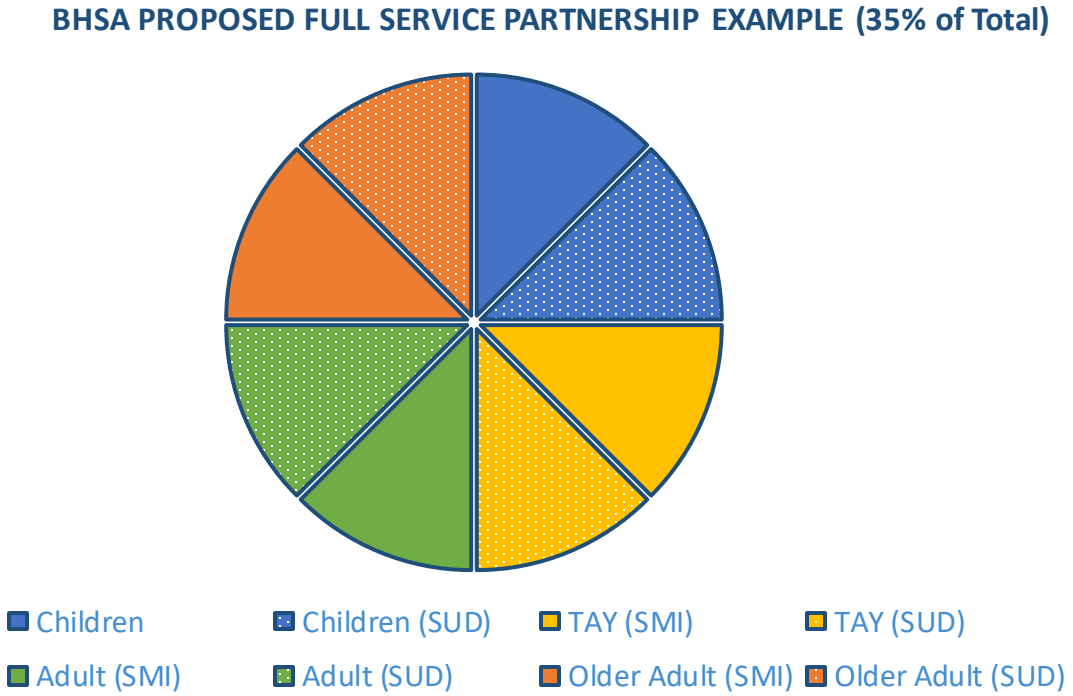
Housing Intervention

- BHSA requires counties 30% of the total BHSA fund be directed to housing interventions for individuals living with SMI/SUD.
- The majority of the funding must support housing subsidies:
  - Only 25% of the housing intervention funds can be used for capital.
  - The remaining 75% is ONLY for subsidies and cannot pay for treatment, support programs, or outreach.

Full Service Partnership

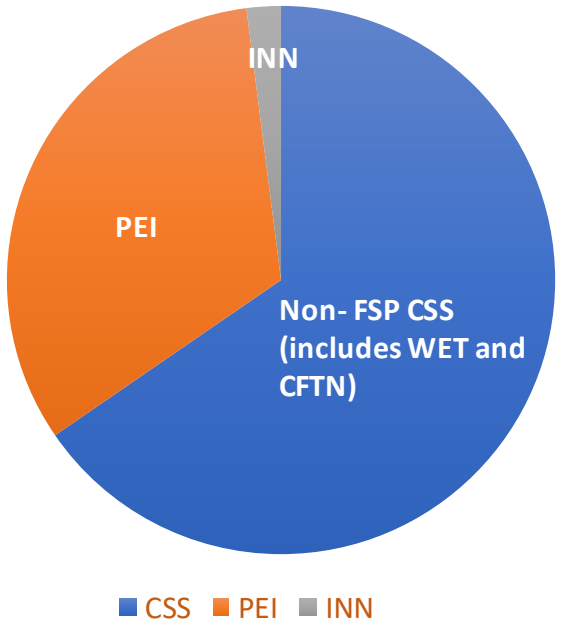
- The FY 25/26 Budget for FSP programs is currently set at $99.1M.
- BHSA requires 35% of the fund be directed toward FSPs
- In addition, BHSA requires programs for individuals living with a substance use disorder (SUD)

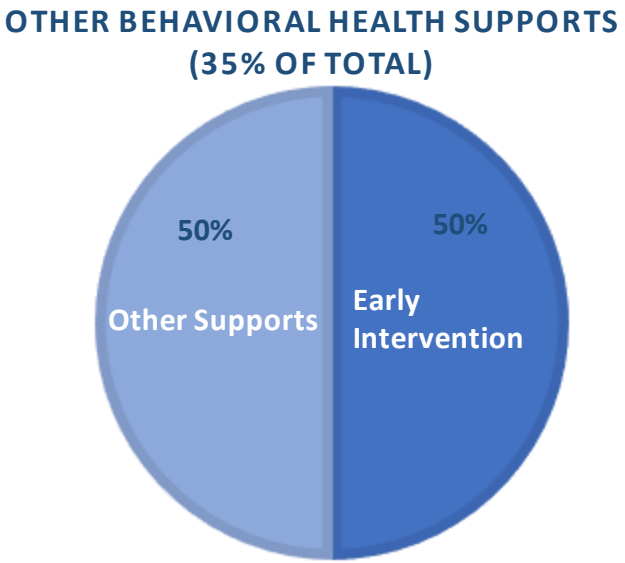




Behavioral Health Services and Supports

- BHSA requires 35% of the fund to be directed toward this category.
  - BHSS eliminates prevention and innovation programs and combines Early Intervention, CSS-GSD programs, workforce development, and capital/technology in to one bucket.
  - The 50% of the BHSS funding must be used for Early Intervention programs.
  - 51% of early intervention programs must be directed to children and youth aged 25 and younger.
  - Programs/services for SUD are required





Timeline

SB 326 (Eggman) BHSA Timeline

Detailed Timeline Related to Community Program Planning & the Transition from MHSA to BHSA

January 31, 2024
MHSA ARER for FY 2022/23 was due to state. Counties required to post ARER on public facing website.

Before June 30, 2024
Conduct the local review process, e.g., post AU document for 30 day public comment, hold public hearing at local advisory board and plan to get on BOS calendar to ensure BOS approval of **AU FY 2024/25 by June 30, 2024**. Submit document to DHCS and MHSOAC.

Starting January 1, 2025
Counties to start implementing expanded CPP process; e.g., engage expanded stakeholders; participate in MCPs and Public Health community assessments; and begin developing new Integrated Plan for **ALL BH funding sources**. Information can inform final MHSA Annual Update

Before June 30, 2025
Conduct the local CPP and local review process, e.g., post AU document for 30-day public comment, hold public hearing at local advisory board and plan to get on BOS calendar to ensure BOS approval of **AU FY 2025/26 by June 30, 2025**. Submit document to DHCS and MHSOAC.

By June 30, 2026
The county BOS **must** approve the **BHSA Three-Year Integrated Plan for FYs 2026/27- 2028/29** and counties must submit approved document to both DHCS and the BHSOAC.

July 1, 2026
Transition to new funding categories and new **BHSA Three-Year Integrated Plan FYs 2026/27- 2028/29** is in place.

June 30, 2027
Submit first **Annual Update FY 2027/28** under BHSA. The local review process re posting for 30-day public comment and public hearing are **not** required for annual updates or mid-cycle adjustments.

Between February – June 2024
Conduct the CPP process to develop the Annual Update FY 2024/25. Counties will need to continue to fund programs based on the current MHSA funding structure, e.g., 5 components. Counties to continue to educate stakeholders in CPP meetings about the forthcoming transition to BHSA. Pending where the county is in their CPP process and development of the AU document can include content noting pending transition that will take place between now and July 1, 2026.

Between March – December 2024
County BH Director, BH leadership, BHSA Coordinator, and fiscal team to finalize fiscal modeling to determine which programs and services will continue to be funded, programs that will have budgets reduced and programs that will be defunded.

January 31, 2025
MHSA ARER for FY 2023/24 due to state. Counties required to post ARER on public facing website.

Between July 2025 – June 2026
Conduct the CPP process to develop the **BHSA Three-Year Integrated Plan for FYs 2026/27- 2028/29.**

- Rural/Small counties can request an exemption from 30% to Housing and FSP EBPs
- All counties can request to transfer funds between the 3 funding categories, e.g., 7% from any one category up to 14% cumulatively

Note counties will need to build in 30 days for DHCS to approve requests outlined above prior to posting document for 30-day public comment as counties will be required to demonstrate stakeholder involvement in plan to request exemptions and/or transfers. Counties will need to complete the local review process including stakeholder engagement, post Plan document for 30-day public comment, hold public hearing with local advisory board and get on BOS calendar in order to have the Plan approved on time.

TBD 2028
Counties will submit first *County Behavioral Health Outcomes, Accountability, and Transparency Report* which replaces the ARER.

Last revised 1/24/2024

Table of Due Dates for Three-Year Integrated Plans & Annual Updates

MHSA/BHSA Document	Due Date	Notes
MHSA Three-Year Integrated Plan FYs 2023/24 – 2025/26 and Annual Update for FY 2023/24	June 30, 2023	**Last MHSA Plan with 5 funding components.** Annual Update for FY 2023/24, e.g., 1st year of the Plan, would be embedded in the Plan document in addition to reporting out for FY 2021/22 the most recent FY whereby counties closed the books, e.g., processed and verified expenditures and data related to outcomes.
Annual Update FY 2024/25 (Year 2 of Plan)	June 30, 2024	Standalone document noting any changes the county plans to make to programs and the MHSA budget outlined in the Three-Year Plan in addition to reporting out for FY 2022/23 the most recent FY whereby counties closed the books.
Annual Update FY 2025/26 (Year 3 of Plan)	June 30, 2025	Standalone document noting any changes the county plans to make to programs and the MHSA budget outlined in the Three-Year Plan in addition to reporting out for FY 2023/24 the most recent FY whereby counties closed the books. **Annual Update for the 3rd and final year of the final MHSA Three Year Plan.**
BHSA Three-Year Integrated Plan FYs 2026/27 – 2028/29 and Annual Update for FY 2026/27	June 30, 2026	**First BHSA Plan with 3 funding categories.** If done the way it is done today, the Annual Update for FY 2026/27, e.g., 1st year of the new Plan, would be embedded in the Plan document in addition to reporting out for FY 2024/25 the most recent FY whereby counties closed the books. Counties may want to do 2 separate documents; a new Three-Year Plan and an Annual Update as there will be different funding structures being reported on. CBHDA will advocate to remove the requirement for outcome reporting in Annual Updates given outcomes are included in the *County Behavioral Health Outcomes, Accountability, and Transparency Report*.
Annual Update FY 2027/28 (Year 2 of Plan)	June 30, 2027	Standalone document noting any changes the county plans to make to programs and the budget for **all BH funding sources** as outlined in the Three-Year Plan in addition to reporting out for FY 2025/26 the most recent FY whereby counties closed the books (pending result of CBHDA advocacy).
Annual Update FY 2028/29 (Year 3 of Plan)	June 30, 2028	Standalone document noting any changes the county plans to make to programs and the budget for **all BH funding sources** as outlined in the Three-Year Plan in addition to reporting out for FY 2026/27 the most recent FY whereby counties closed the books (pending result of CBHDA advocacy).
BHSA Three-Year Integrated Plan FYs 2029/30– 2031/32 and Annual Update for FY 2029/30	June 30, 2029	**2nd BHSA Plan**

Discussion

Next Steps

- Required to have MHSA Annual Update approved by BOS before June 30, 2024.
- Move existing Component programs forward:
  - Prevention and Early Intervention
  - Community Services and Supports
  - Workforce Education and Training
  - Capital Facilities and Technological Needs
  - ***Include additional Innovation Concepts in the Annual Update to streamline local approval***

- 30 Day Review and Public Comment scheduled for March 7- April 8, 2024
  - Will host a series of meetings during posting to provide the public an opportunity to review existing MHSA plan information and engage in a dialogue.
- Review of Public Comments with Behavioral Health Advisory Board (TBD)
- Public Hearing April 24, 2024, at Garden Grove Community Center from 10am – 12pm
- OC Board of Supervisor Approval (May/June 2024)
- Submission to California Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission.

Planning Advisory Post Meeting Report

1

PAC Attendees Demographic Report

2

Meeting Survey Findings Recap

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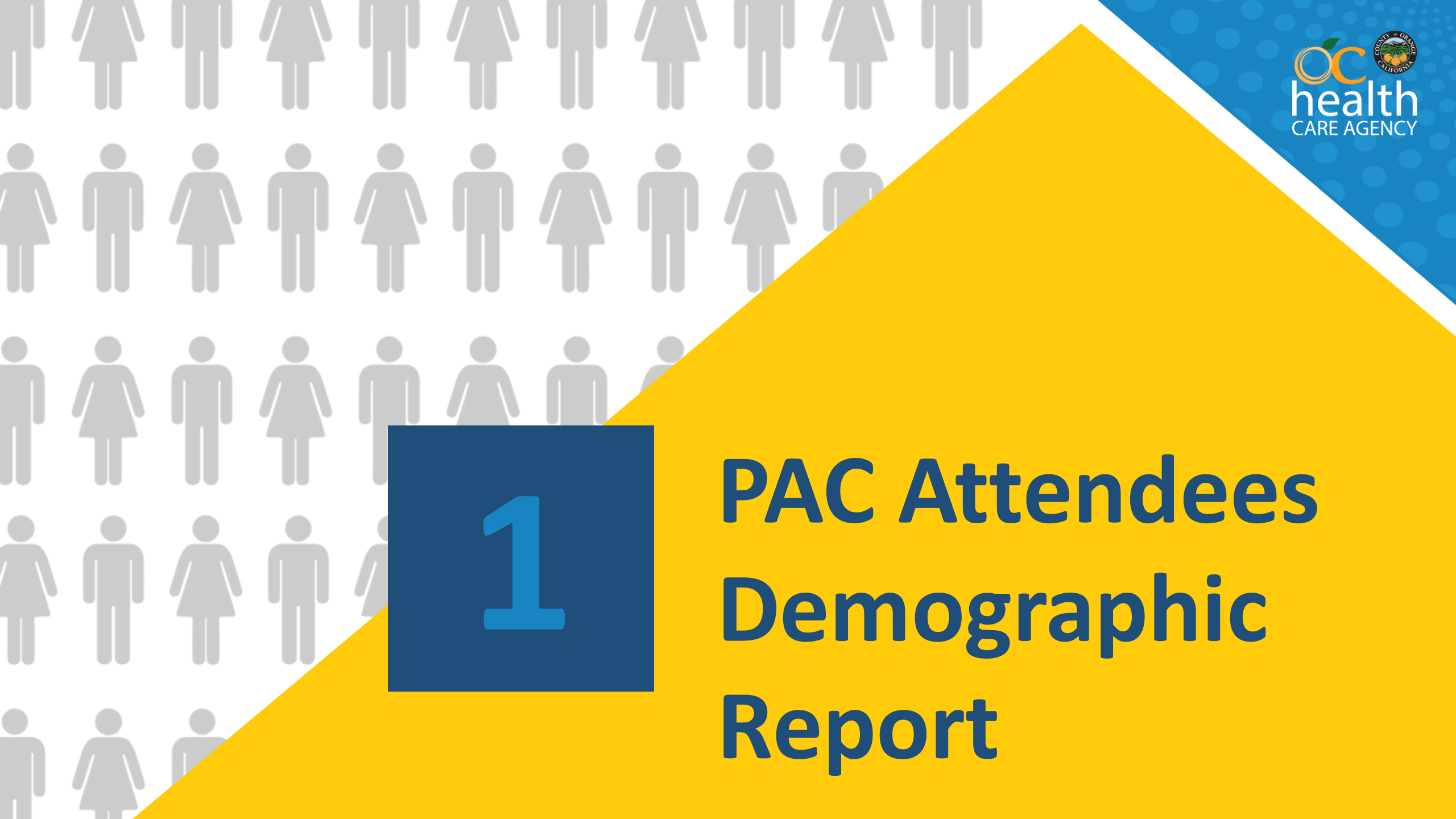
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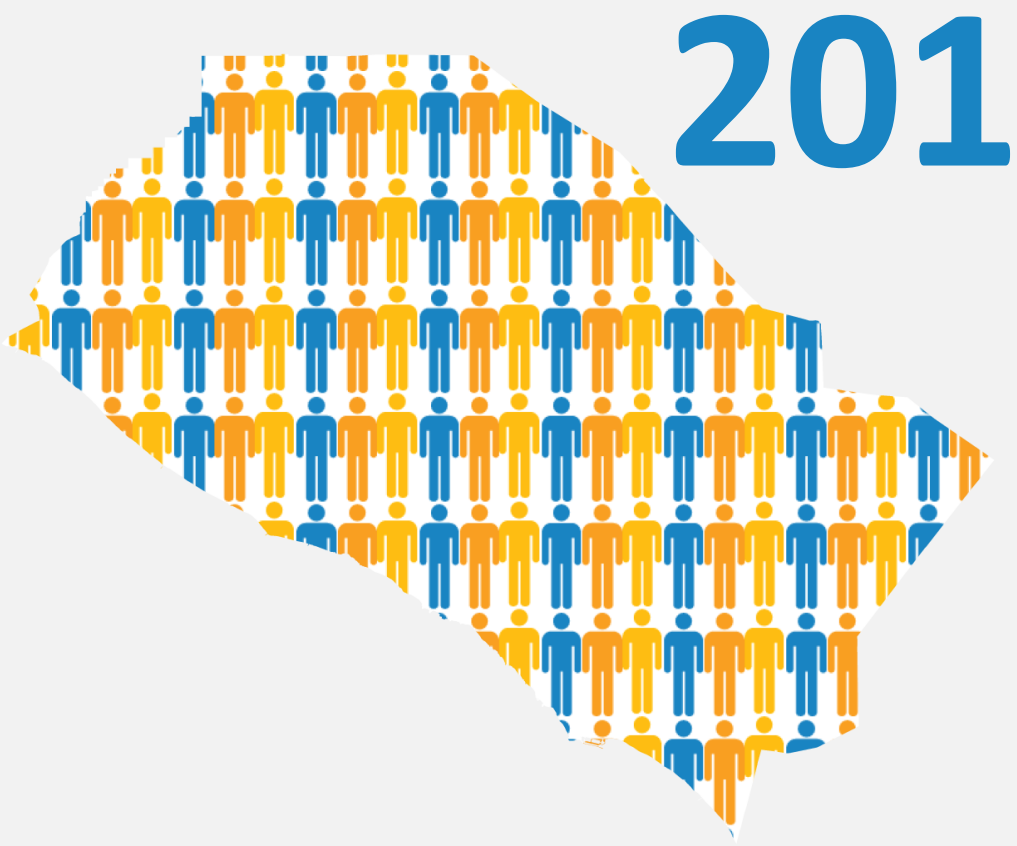
PAC Attendees Demographic Report

1 PAC Attendees Report

Demographic Surveys Completed



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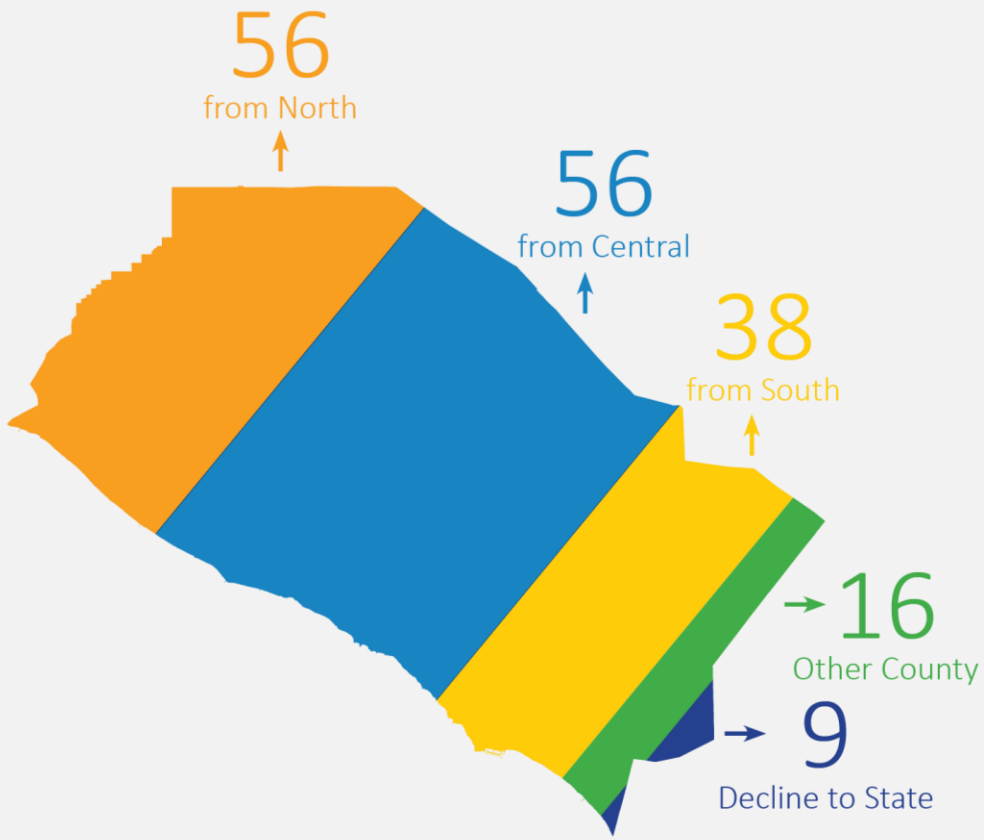
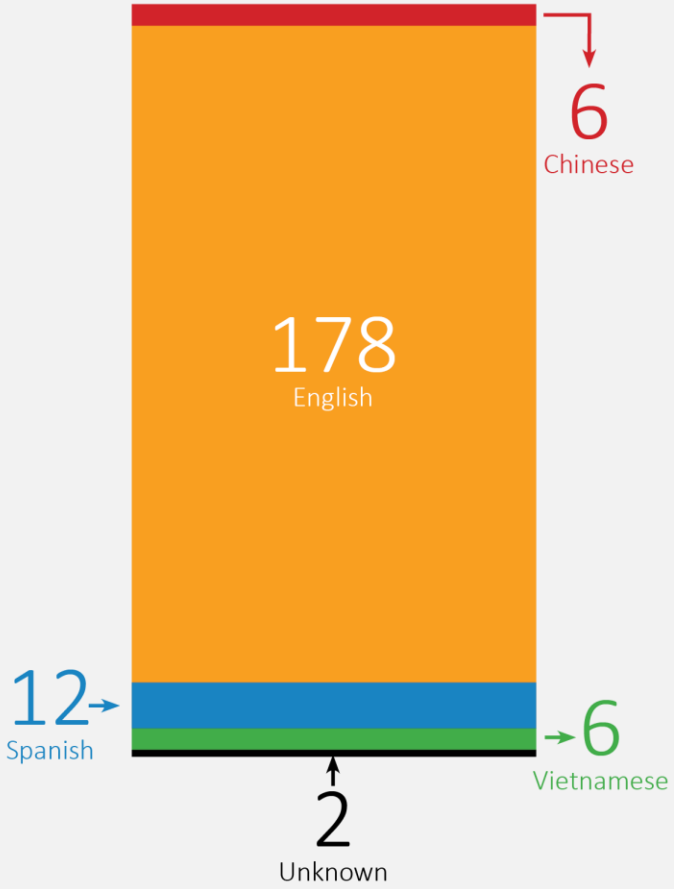
Do you live or work in OC? If yes, list the region.

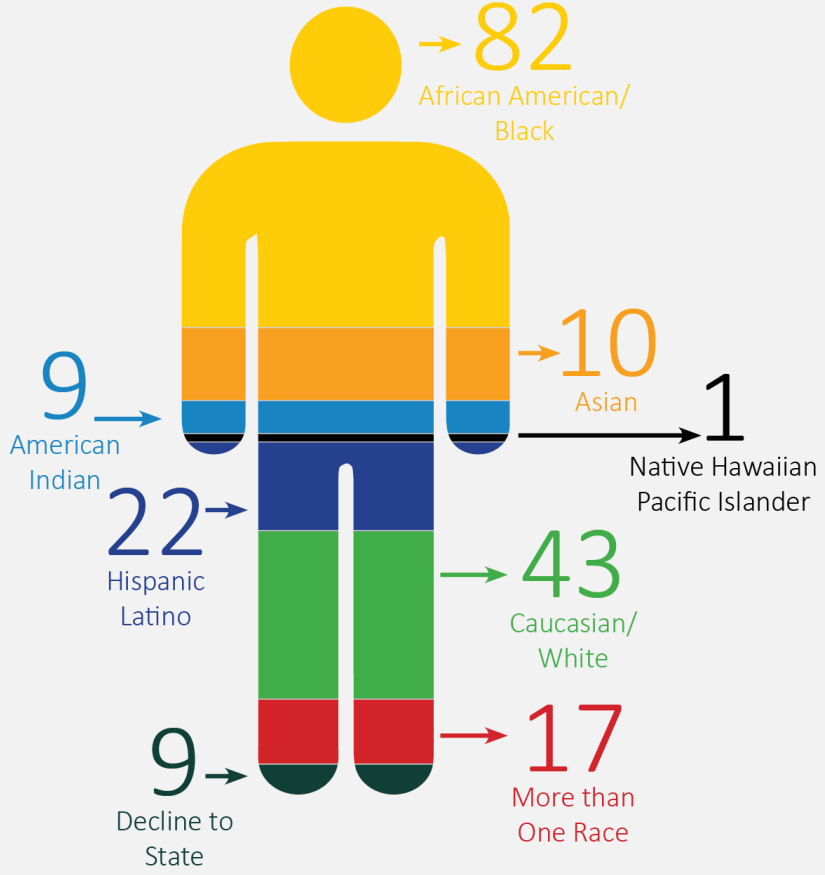


1 PAC Attendees Report

Primary Language Spoken at Home

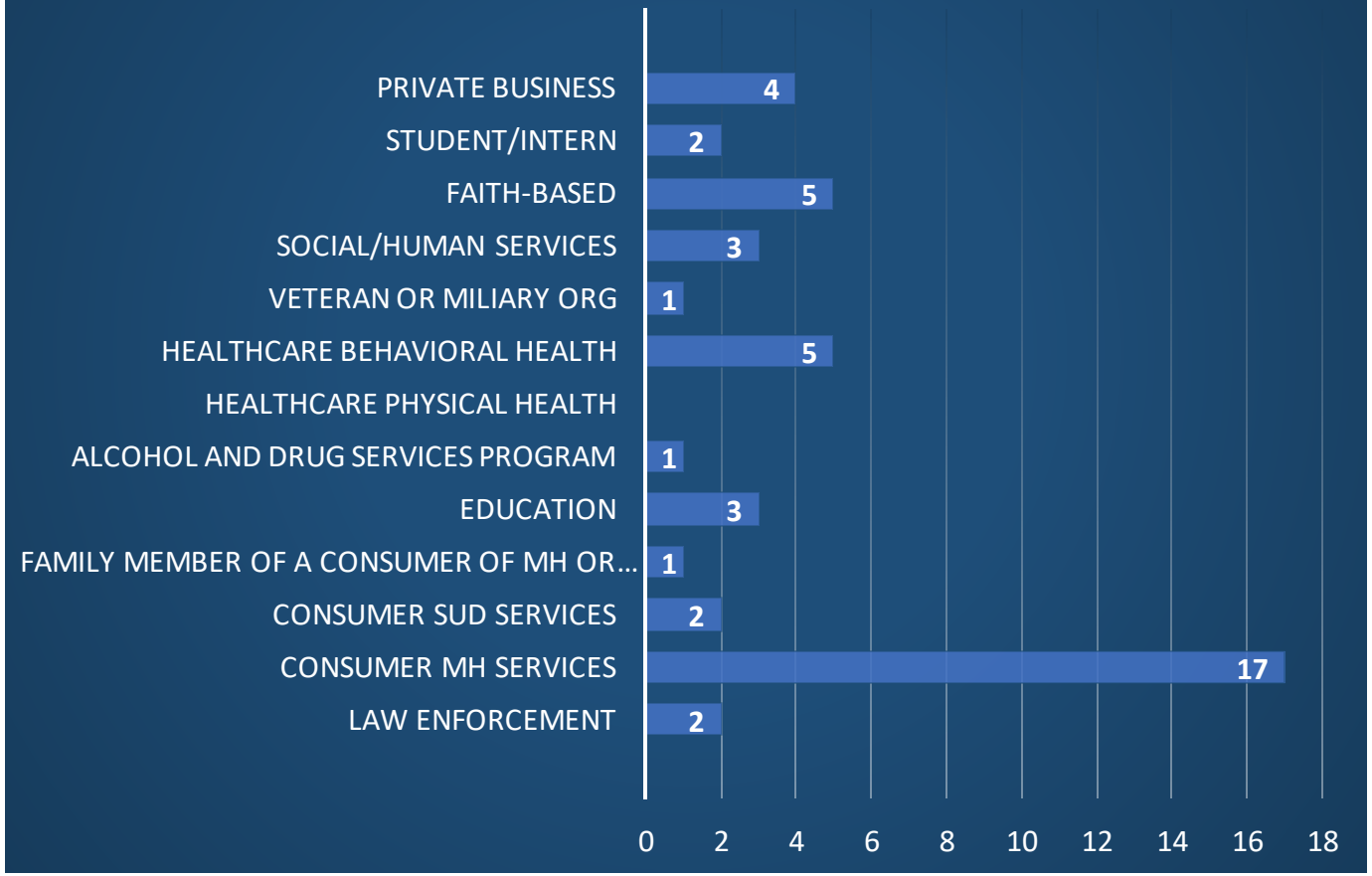


Which Category Best Describe Your Race?

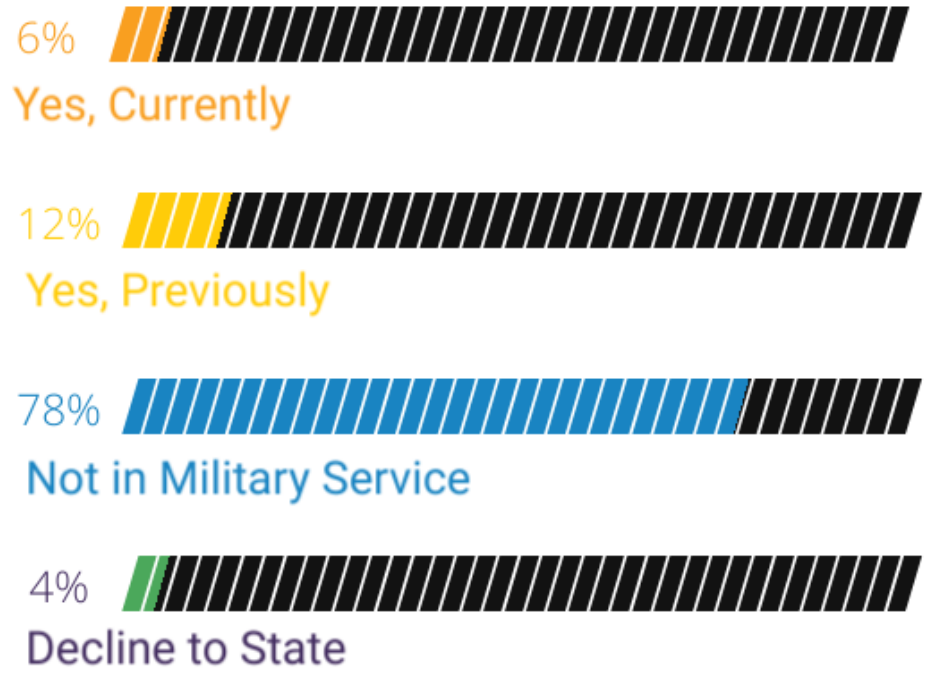


1 PAC Attendees Report

Do you work in or represent any of the following areas/fields?



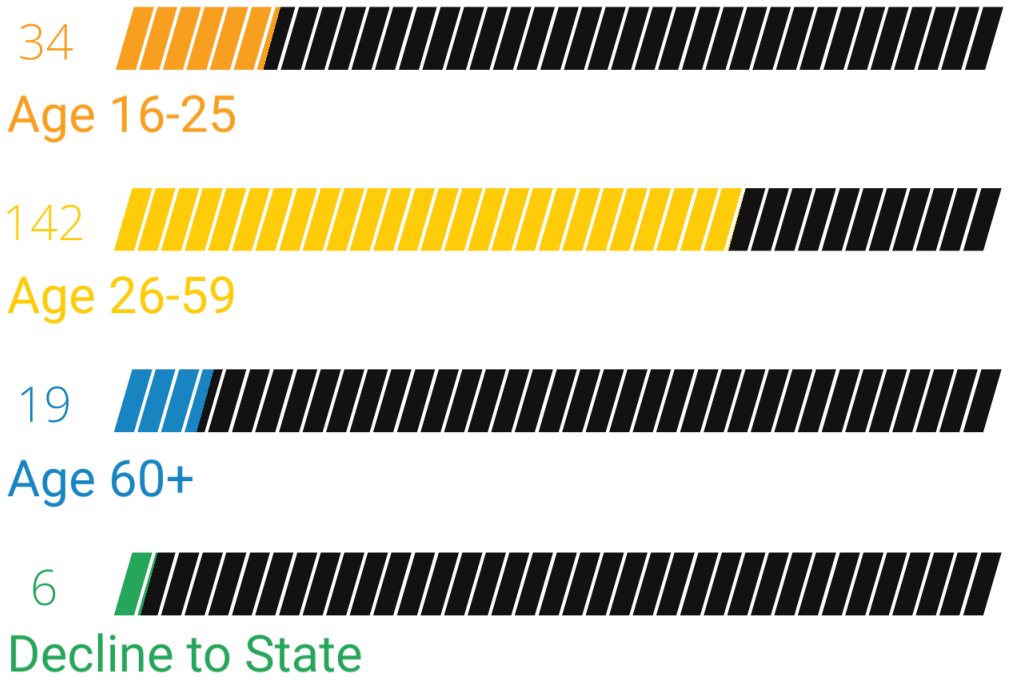
Military Service



1 PAC Attendees Report

How Do You Describe Yourself? (Gender)

What is Your Age?



2 Meeting Survey Findings Recap

2 Meeting Survey Findings Recap

Based on the feedback responses from the January PAC meeting, this is an analysis of the comments and feedback from various individuals attending a meeting or event, likely related to mental health and suicide prevention planning. Here are some observations and potential insights:

Positive Feedback:	Suggestions for Improvement:
Comments like "Excellent meeting," "I enjoyed the presentation," and "Good!!! God Bless you & Thank you!!!" indicate satisfaction and appreciation for the event.	There are suggestions for improvement, such as providing lunch at the wellness center and possibly changing incentives to Amazon gift cards.
Positive remarks on the presentation being informative suggest that the content was well-received.	Some attendees expressed a desire for more interaction and opportunities to contribute, indicating a need for more engagement during the event.

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2 Meeting Survey Findings Recap

Concerns and Insights:

Comments about the length of the meeting ("Too long") suggest that some participants may have found it overwhelming or too extensive.

There's an interesting point about the potential saturation of suicidal support ads in various places, indicating a concern about overwhelming individuals with such messaging.

Spiritual and Personal Perspectives:

Some responses touch on personal beliefs and experiences, such as faith in God to avoid suicide in the future, indicating the importance of addressing spiritual and emotional well-being in mental health discussions.

The mention of schizophrenia indicates that there may be individuals with personal experiences or interests related to specific mental health conditions.

2 Meeting Survey Findings Recap

Desire for Action:

Several comments express a desire for concrete actions to be taken based on the discussions held during the meeting, indicating a need for follow-up and implementation of plans discussed.

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Thank you for your attendance!

Please complete and turn in your surveys

For MHSA information

please call 714-834-3104 or email mhsa@ochca.com