TRI·CITY Mental Health

Founded in 1960 by the residents of Pomona, Claremont and La Verne.

MISSION: *By understanding the needs of consumers and families, Tri-City Mental Health Authority provides high quality, culturally competent behavioral health care treatment, prevention, and education in the diverse cities of Pomona, Claremont, and La Verne.*

TRI-CITY MENTAL HEALTH AUTHORITY

MENTAL HEALTH COMMISSION
REGULAR MEETING AGENDA
TUESDAY, OCTOBER 10, 2023 AT 3:30 P.M.

Meeting Location: MHSA Administration Building
2001 North Garey Avenue, Pomona, CA 91767

To join the meeting on-line clink on the following link:
https://tricitymhs-org.zoom.us/j/89307964216?pwd=brOYDM8Gb2pkUkcYVY6fLeuITG5CQfPT.6068njIDlCIR4ncj
Passcode: xm.T07sV

Public Participation. *Section 54954.3 of the Brown Act provides an opportunity for members of the public to address the Governing Board on any item of interest to the public, before or during the consideration of the item, that is within the subject matter jurisdiction of the Governing Board. Therefore, members of the public are invited to speak on any matter on or off the agenda. If the matter is an agenda item, you will be given the opportunity to address the legislative body when the matter is considered. If you wish to speak on a matter which is not on the agenda, you will be given the opportunity to do so at the Public Comment section.* ***No action shall be taken on any item not appearing on the Agenda. The Chair reserves the right to place limits on duration of comments.***

In-person participation: raise your hand when the Governing Board Chair invites the public to speak.

Online participation: you may provide audio public comment by connecting to the meeting online through the zoom link provided; and use the Raise Hand feature to request to speak.

Please note that virtual attendance is a courtesy offering and that technical difficulties shall not require that a meeting be postponed.

Written participation: you may also submit a comment by writing an email to molmos@tricitymhs.org. All email messages received by 3:30 p.m. will be shared with the Governing Board before the meeting.

Any disclosable public records related to an open session item on a regular meeting agenda and distributed by Tri-City Mental Health Authority to all or a majority of the Governing Board less than 72 hours prior to this meeting, are available for public inspection at 1717 N. Indian Hill Blvd., Suite B, in Claremont during normal business hours.

In compliance with the American Disabilities Act, any person with a disability who requires an accommodation in order to participate in a meeting should contact JPA Administrator/Clerk Mica Olmos at (909) 451-6421 at least 48 hours prior to the meeting.

Administrative Office
1717 North Indian Hill Boulevard, Suite B
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POSTING OF AGENDA

The Agenda is posted 72 hours prior to each meeting at the following Tri-City locations: Clinical Facility, 2008 N. Garey Avenue in Pomona; Wellness Center, 1403 N. Garey Avenue in Pomona; Royalty Offices, 1900 Royalty Drive #180/280 in Pomona; MHSA Office, 2001 N. Garey Avenue in Pomona; and on the Tri-City's website: http://www.tricitymhs.org

CALL TO ORDER

Chair Henderson calls the meeting to Order.

ROLL CALL

Anne Henderson – Chair	Clarence D. Cernal	Joan M. Reyes
Wray Ryback – Vice-Chair	Isabella A. Chavez	Twila L. Stephens
Carolyn Cockrell – GB Liaison	Nichole Perry	Toni L. Watson

REGULAR BUSINESS

I. APPROVAL OF MINUTES – MENTAL HEALTH COMMISSION REGULAR MEETING OF SEPTEMBER 12, 2023

II. PRESENTATION

A. "RECOVERY MOMENTS" STORY

B. MENTAL HEALTH STUDENT SERVICES ACT (MHSSA) UPDATE PRESENTED BY CHIEF CLINICAL OFFICER, LIZ RENTERIA

C. CALIFORNIA BEHAVIORAL HEALTH PLANNING COUNCIL DATA NOTEBOOK 2023 PRESENTED BY DIRECTOR OF MHSA AND ETHNIC SERVICES, DANA BARFORD

III. EXECUTIVE DIRECTOR MONTHLY REPORT

COMMISSION ITEMS AND REPORTS

Commissioners are encouraged to make brief comments or request information about mental health needs, services, facilities, or special problems that may need to be placed on a future Mental Health Commission Agenda. In addition, this is an opportunity to provide reports on their activities.

PUBLIC COMMENT

The Public may at this time speak regarding any Tri-City Mental Health Authority related issue. No action shall be taken on any item not appearing on the Agenda. The public participating on-line can make a comment by using the 'raised hand' feature. The Chair reserves the right to place limits on duration of comments.

ADJOURNMENT

The next Regular Meeting of the **Mental Health Commission** will be held on **Tuesday, November 14, 2023 at 3:30 p.m.**, in the MHSA Administrative Office, 2001 North Garey Avenue, Pomona, California.

MICAELA P. OLMOS
JPA ADMINISTRATOR/CLERK

MINUTES

REGULAR MEETING OF THE MENTAL HEALTH COMMISSION
SEPTEMBER 12, 2023 – 3:30 P.M.

The Mental Health Commission held on Tuesday, September 12, 2023 at 3:30 p.m. in the MHSA Office located at 2001 North Garey Avenue, Pomona, California.

CALL TO ORDER Chair Henderson called the meeting to order at 3:34 p.m.

ROLL CALL Roll call was taken by Chief Clinical Officer Renteria.

MENTAL HEALTH COMMISSION

PRESENT: Anne Henderson, Chair
Carolyn Cockrell, GB Member Liaison
Toni L. Watson
Nichole Perry
Joan M. Reyes
Twila L. Stephens

STAFF: Rimmi Hundal, Executive Director
Elizabeth Renteria, Chief Clinical Officer
Dana Barford, Director of MHSA & Ethnic Services
Jessica Arrellano, Administrative Assistant

ABSENT: Wray Ryback, Vice-Chair
Clarence D. Cernal
Isabella A. Chavez

REGULAR BUSINESS

I. APPROVAL OF MINUTES FROM THE JULY 11, 2023 MENTAL HEALTH COMMISSION REGULAR MEETING

Recommendation: "A motion to approve the Mental Health Commission Minutes of their Regular Meeting of July 11, 2023."

Commissioner Watson moved, and Commissioner Reyes seconded, to approve the Mental Health Commission Minutes of their Regular Meeting of July 11, 2023. The motion was carried by the following vote: AYES: Commissioner Watson, Commissioner Stephens, Commissioners Reyes, Commissioner Perry, GB Liaison Cockrell; and Chair

Henderson. NOES: None. ABSTAIN: None. ABSENT: Commissioner Cernal, Commissioner Chavez, and Vice-Chair Ryback.

II. EXECUTIVE DIRECTOR MONTHLY REPORT

Executive Director Hundal gave an update regarding Behavioral Health Reform, also known as the Mental Health Services Act (MHSA). She shared that in March of 2023 Governor Newsom's administration announced their plan for behavioral health reform; that the initiative, Senate Bill 326, is known as the modernization of the Mental Health Services Act; that it is designed to improve how California treats mental illness, substance abuse, and the homeless; that this bill will lead to at least one billion every year in local assistance for housing and residential services for people experiencing mental illness and substance abuse disorders; that it will allow MHSA funds to serve people with substance abuse disorders; that it will no longer be called Mental Health Services Act (MHSA) but Behavioral Health Services Act (BHSA). She added that over the past month, the initiative has gone through several amendments and revisions, with additional amendments to come; that Tri-City Mental Health Authority Staff has been on calls with the State; that County Behavioral Health Directors Association (CBHDA) has been lobbying for TCMHA and recommending their amendments to the State. Executive Director Hundal explained that due to the expansion to cover substance abuse disorders, the bill updates the name from MHSA to BHSA; that if the bill passes there are going to be three buckets of funding; that 30% of the funding will go for housing intervention for children and families, 35% will go for full service partnerships, which will also help with the implementation of CARE Court, 35% of the funding will support behavioral health services and supports, which includes early intervention, outreach and engagement, Workforce Education and Training (WET), Capital Facilities and Technology Needs, as well as innovative pilots that they have. She shared that the initiative is scheduled to go on the ballot on March 5th; that if it is approved, we have enough time to make the changes; that changes go into effect in 2026; that until then, services will continue as is; that staff is on the calls listening to the most up to date information; that staff is waiting for the final draft of the bill; that TCMHA will continue to provide programming and services, although structure and funding allocation may change to meet the new requirements. She assured the Commission that they will still receive an annual update each year; that they are still in their three-year plan phase; that the next two years will be business as usual; that once the bill is passed, TCMHA will host a community forum in March of 2024 to provide an update regarding the changes that will take place. Executive Director Hundal concluded by saying that whatever changes come, staff will be ready.

COMMISSION ITEMS AND REPORTS

Commissioner Reyes shared about a new bill that will be placed on the ballot regarding the shift from restitution for the State that juveniles pay when there is a crime to the State; that it is Assembly Bill 1186 and it proposes an end to youth being charged restitution fines, an amount owed by those who are found to have committed the crime and then paid to victims of the crime; that if this is something that TCMHA can weigh in on. She added another item regarding mental health and gun violence; that the link between the mentally ill and crime is very low; that a few months back, there was discussion about contacting behavioral health agencies about a Public

Service announcement that would destigmatize the link between the mentally ill and gun violence; that those who are mentally ill might be reluctant to seek care since it stigmatizes them further.

Chair Henderson mentioned that she received information about this year's Data Notebook and inquired if any other Commissioners received information about it as well. Executive Director Hundal responded that staff received information regarding the data notebook once the meeting agenda was already posted but it will be presented at next month's Mental Health Commission meeting.

PUBLIC COMMENT

There was no public comment.

PUBLIC HEARING – MENTAL HEALTH SERVICES ACT (MHSA)

Chair Henderson opened the Public Hearing for the Mental Health Services Act (MHSA). She referred to MHSA Projects Manager, Sarah Rodriguez, who is the facilitator for the Public Hearing. Director of MHSA and Ethnic Services Barford expressed her gratitude to the Commission and the community members for attending; that the public hearing is for a new innovation proposal; that the proposal is regarding the community planning process for innovations; that this was developed out of a need; that there was a desire to strengthen community engagement and stakeholder involvement which evolved into this project.

MHSA Project Manager Rodriguez introduced herself and began a land acknowledgement. She recognized that Tri-City Mental Health Authority operates on Tonga Land; that they honor the Tonga ancestors; that they are thankful for the opportunity to continue to identify ways to serve the Tonga people, support the preservation of their culture and partner with this historically underrepresented people. She continued to present about the background of the Mental Health Services Act, also known as MHSA Act; that in 2004, California voters passed the Mental Health Services Act, Proposition 63; that in 2005, the new funding began, and it was a huge overhaul for mental health services; that back in the 1960's a lot of the State hospitals closed down and it continued through the 1990's; that MHSA is funded from the Millionaires tax, which is a one percent tax that comes from anyone whose personal income exceeds a million dollars. She continued to share that MHSA funding is robust; that the funding originally accounted for 10% of California community mental health budget, which has grown to 24%, almost a quarter of all funding in California. She explained that there are five components of MHSA: Community Service Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Capital Facilities and Technological Needs (CFTN), and Workforce Training and Education (WET). MHSA Project Manager Rodriguez shared a quote, thanked the community members in attendance, and added that it is essential to involve the voice and input of community members in the creation of programs and services. She stated that the initiative is focused on stakeholder involvement and impact; that a stakeholder can be anyone who has an investment, an interest, or experience with mental and behavioral health services in the community of Claremont, La Verne, or Pomona; that stakeholder input acts as one of the pillars that determines how funds are spent; that public funds cannot be spent without public input; that every community is unique and the diverse perspectives of various individuals and cultures that live in the community are necessary. She expressed that Tri-City Mental Health Authority desires the community to be involved in the process of building something for them to serve the community.

Workforce Education and Training Supervisor Colt shared that she was recently promoted to a new position as Workforce Education and Training Supervisor; that she is still overseeing Innovation; that she started this project and continues to be a part of it; she introduced two new members on the Innovation team, Paulina, the Program Coordinator and Rachel, the Clinical Wellness Advocate. She continued to explain how the plan came to fruition; that it began with a proposed Restorative Practices for Improving Mental Health Plan, a community and stakeholder involved plan that was proposed in 2021; that the plan was denied at the State level by the Mental Health Services and Oversight Accountability Commission; that one of the reasons they did not approve it was because they did not believe that there was enough stakeholder involvement in the process. She shared that staff went back to the drawing board with work groups and held five Innovation work groups over the course of 2020-2023; that with each meeting, attendance declined; that staff was led to discuss and brainstorm how to increase stakeholder involvement to gather community input; that the process eventually led to creating the community planning process for Innovation projects. She explained that the project involves taking the Innovation funds and putting them toward the community planning process; that the community planning process is implemented ever year during the creation of the annual plan or when there is a three year update; that there are stakeholder meetings and work groups where ideas and issues in the community are brought to the forefront, which then inform new plans or projects; that Tri-City Mental Health Authority would really like to focus on getting the community involved; that they would like to hold focus groups with diverse community demographics; that they would like to develop relationships with cultural brokers; that they want to increase peer involvement. She defined peers as those who know how the services are being used, those who use the services, and those who can provide feedback on the services. She shared that for this project, there is an estimated cost of 675,000 dollars over the course of three years; that the goals for the community planning process is to increase community participation; that they have already started by sharing the flyers for the public hearing and talking about it at every outreach event and meeting that staff attends; that a lot of effort is being put forth to increase participation in the community; that they would like feedback from the target populations; that they want to know their awareness of mental health and services that TCMHA provides, the best way to reach them, the type of resources they need, any areas of concern; that they also want to gain a better understanding of the issues faced by persons with substance abuse disorders, as well as people experiencing homelessness. Workforce Education and Training Supervisor Colt referred to the new legislation, SB 326, stating that it will benefit the program if it passes. She mentioned that they also want to increase their marketing and communication through marketing materials and social media, since they know a lot of community members are on social media; that they would like to apply all the knowledge that is learned through the process to develop new ideas for the Innovation plan, the three-year plan and the annual updates. She shared the learning questions for the project that inquire about the effects of peer-led focus groups, peer involvement, longevity of peer involvement, in-person meetings, marketing strategies and more; that they would like to focus on the target populations which are African American Adults and Youth, Spanish Speaking Adults and Youth, Older Adults, People experiencing homelessness and Substance Abuse Disorders, LGBTQ+, Transitioning Adolescent Youth and Adults, Family/Loved ones of persons served by Tri-City and Law Enforcement and First Responders. She explained a breakdown of the budget for the project; that over the course of three years, the budget includes direct salaries for staff; that they like to hire peer consultants who are local to the community; that it is someone who can help build the peer base; that they will also be hiring a marketing team; that they would like to provide stipends and meals as an incentive for those who participate in the stakeholder meetings; that supplies and transportation vouchers are also included in the budget, which totals out to $675,000.

Workforce Education and Training Supervisor Colt concluded by sharing a roadmap of how the project started and where it is going; that the Restorative Practices for Mental Health was denied in June 2021; that workgroups were held from 2022-2023; that the plan was drafted at the beginning of 2023, then it was sent to the Mental Health Services Oversight Accountability Commission for technical support and make sure the project was on the right track; that they offered some input to add substance abuse disorder and homelessness to the plan; that the plan was sent to the TCMHA executive team for their review and input; that it is now coming to the Mental Health Commission for approval and it will be going to the Governing Board for approval the following week; that it will be going to MHSOAC in October and that it should be approved.

Workforce Education and Training Supervisor Colt opened it up for public comment.

Commissioner Reyes inquired about the target populations listed, specifically about adding the Asian American and Native American groups. Workforce Education and Training Supervisor Colt responded in the affirmative, stating that she will add those groups to the list. Chair Henderson added that the disabled population is also missing from the list. Workforce Education and Training Supervisor Colt responded in the affirmative, stating that she will add them as well.

Commissioner Stephens inquired about the plan that was previously denied and if this one is different.

A member of the public made a comment stating that it is possible that the community may hear about events but they may not remember and might need more support.

Another member of the public, Trent West, inquired about the $675,000 budget and if that is for the entire Innovation plan or if there are other innovation projects being funded. Director of MHSA and Ethnic Services Barford responded by saying that there are two projects that are ongoing; that they have this dollar amount for this specific project and they receive 5% on an annual basis of the MHSA funding that come to them for Innovation funding. Member of the public, Trent West, inquired about the total budget for the project, more specifically, the annual budget for innovation projects for Tri-City Mental Health Authority. Executive Director Hundal responded by saying that whatever number they get from the State, that 5% of that will always go towards Innovation, but it is difficult to give an exact dollar amount due to the fluctuating nature of the Millionaires tax. Director of MHSA and Ethnic Services Barford responded by directing Mr. West to the budget in the 2 year plan that is posted on the website. Mr. West gave suggestions to increase participation; that TCMHA should attempt to include input from caregivers; that if there is a way to reach out to them, it would be helpful to hear their feedback regarding programs for their loved ones that might need a community; that the caregivers may be more high functioning than the clients.

Director of MHSA and Ethnic Services responded by sharing that TCMHA has a close relationship with a program called Family that is designed for caregivers; that they support the program that they have the opportunity to let them know what the needs are, the needs of their clients and the person they are working with.

Mr. West inquired about where to get more information about services that are available for clients who need transportation assistance to get to appointments and etc. Workforce Education and Training Supervisor Colt responded by sharing about the Community Navigators; that there are flyers about the Community Navigators on the table.

Commissioner Perry inquired about the peers and where they are coming from. Workforce Education and Training Supervisor Colt responded by stating that peers are those who are receiving services or who have graduated from services and know Tri-City Mental Health Authority well; that it is one of the reasons they would like to work with a peer support consultant in the area; that going through the wellness center to work with peers who have received services would be the people that they want involved. She then acknowledged that everyone in the room is also a stakeholder.

Commissioner Watson moved, and Commissioner Stephens seconded, to close the Public Hearing. The motion was carried by the following vote: AYES: Commissioner Watson, Commissioner Stephens, Commissioners Reyes, Commissioner Perry, GB Liaison Cockrell; and Chair Henderson. NOES: None. ABSTAIN: None. ABSENT: Commissioner Cernal, Commissioner Chavez, and Vice-Chair Ryback.

Commissioner Watson moved, and Commissioner Reyes seconded, to approve the Community Planning Process for Innovation Projects and using the $675,000 of Mental Health Services Act Innovation Plan Funds. The motion was carried by the following vote: AYES: Commissioner Watson, Commissioner Stephens, Commissioners Reyes, Commissioner Perry, GB Liaison Cockrell; and Chair Henderson. NOES: None. ABSTAIN: None. ABSENT: Commissioner Cernal, Commissioner Chavez, and Vice-Chair Ryback.

ADJOURNMENT

At 4:17 p.m., on consensus of the Mental Health Commission its meeting of September 12, 2023 was adjourned. The next Regular Meeting of the Mental Health Commission will be held on Tuesday, October 10, 2023 at 3:30 p.m., in the MHSA Administrative Office, 2001 North Garey Avenue, Pomona, California.

_____
Micaela P. Olmos, JPA Administrator/Clerk

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by the residents

of Pomona,
Claremont and La
Verne.

PRESENTATION:
AGENDA ITEM NO. 2A- RECOVERY MOMENTS STORY

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PRESENTATION: AGENDA ITEM NO. 2B
MENTAL HEALTH STUDENT SERVICES ACT (MHSSA) UPDATE PRESENTED BY
CHIEF CLINICAL OFFICER, LIZ RENTERIA

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PRESENTATION: AGENDA ITEM NO. 2C
CALIFORNIA BEHAVIORAL HEALTH PLANNING COUNCIL DATA NOTEBOOK 2023
PRESENTED BY DIRECTOR OF MHSA AND ETHNIC SERVICES, DANA BARFORD

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California
Behavioral Health
Planning Council
ADVOCACY • EVALUATION • INCLUSION

CHAIRPERSON
Deborah Starkey

EXECUTIVE OFFICER
Jenny Bayardo

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P.O. Box 997413
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PHONE:
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MS 2706

Date: August 24, 2023

RE: 2023 Data Notebook

Dear Director of Behavioral Health Department, and
Chairperson of Behavioral Health Board/Commission,

This letter transmits the 2023 Data Notebook for local Behavioral Health Boards and Commissions to use in reporting to the California Behavioral Health Planning Council (CBHPC). Most local boards will need to partner with their behavioral health departments for information to answer the questions in the Data Notebook. This survey will fulfill the legal mandate (W.I.C. 5604.2) for the local boards/commissions to report each year to the CBHPC. We request that that you send your answers to us by **November 30, 2023**, using the enclosed 'SurveyMonkey' reporting questionnaire at this link: **https://www.surveymonkey.com/r/DP8XG65**

This year, in Part I, the Data Notebook 2023 addresses the standard yearly questions. Part II focuses on the topic of "Stakeholder Engagement in the Public Behavioral Health System."

Since 2020, we have asked each county group to submit their responses through an online survey at the link given above, instead of in a paper report as was done prior to 2020. Attached to this letter, you will receive the 2023 Data Notebook containing a report with statewide data, background information on this year's topic, and the survey questions. We have included a PDF and a Microsoft Word version of this document for your convenience.

Please note: the format of the survey questions in the Data Notebook document have been modified so that they can be displayed in the document. They may be presented differently on the SurveyMonkey website, but the text of the questions is the same.

To successfully complete the SurveyMonkey online survey:

- Use the Data Notebook document as your reference for gathering and planning your survey responses.
- Designate **one (1)** person fill out the online survey for your county to avoid duplicate responses.
- When the designated person accesses the online survey with the link, they can potentially submit a partially complete response and

California
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CHAIRPERSON
Deborah Starkey

EXECUTIVE OFFICER
Jenny Bayardo

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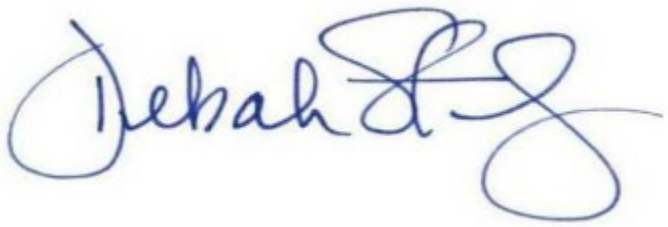
MS 2706

come back to it to finish it later. However, they must use the same computer each time to do so.

We greatly appreciate your participation in this project. If we can help with any questions, please contact DataNotebook@CBHPC.dhcs.ca.gov. If you have any questions or issues with the SurveyMonkey online survey specifically, please contact Justin Boese at Justin.Boese@cbhpc.dhcs.ca.gov.

Sincerely,

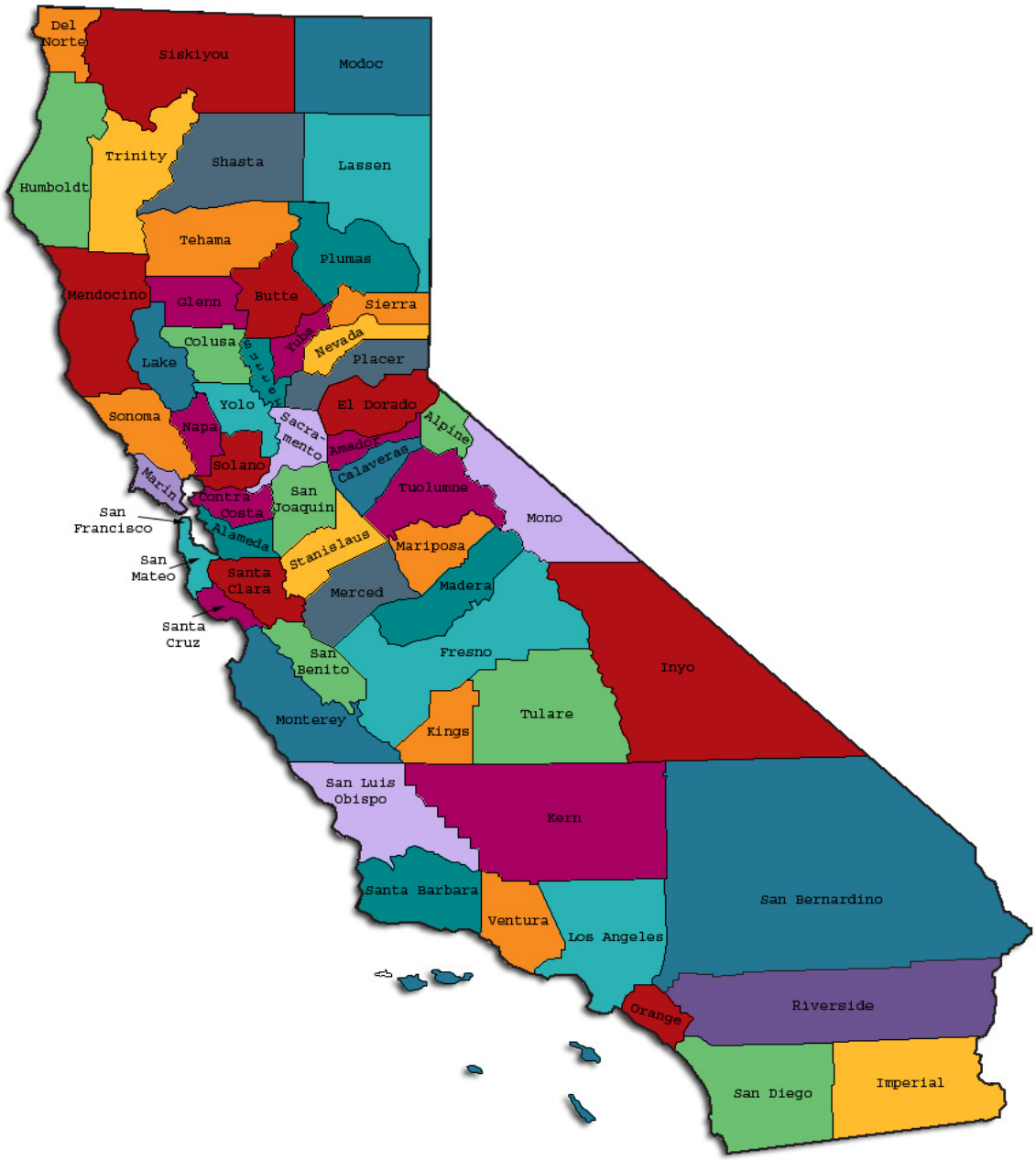


Deborah Starkey
Chairperson

DATA NOTEBOOK 2023

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS



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

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

For general information, you may contact the following email address or telephone number:
DataNotebook@CBHPC.dhcs.ca.gov
(916) 701-8211

Or, you may contact us by postal mail at:

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

For questions regarding the SurveyMonkey online survey, please contact Justin Boese at Justin.Boese@cbhpc.dhcs.ca.gov

NOTICE:

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

DO NOT RETURN THIS DOCUMENT.

Please use it for preparation purposes only.

To complete your 2023 Data Notebook, please use the following link and fill out the survey online:
https://www.surveymonkey.com/r/DP8XG65

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

Table of Contents

CBHPC 2023 Data Notebook: Introduction

What is the Data Notebook? Purpose and Goals

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

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

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

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

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

What's New This Year?

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

[1] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

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

How the Data Notebook Project Helps You

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

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

Example of Statewide Data for Specialty Mental Health and Access Rates

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

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

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[2] See the annual Overview Reports on the Data Notebook posted at the California Association of Local Mental Health Boards and Commissions, https://www.CALBHBC.org.
[3] SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For reports, see www.SAMHSA.gov.
[4] AB 470 Mental Health Services Demographics Dashboards, published by California Department of Health Care Services (DHCS) at: https://behavioralhealth-data.dhcs.ca.gov/

Table 1-A. California Children and Youth: Access Rates for Specialty Mental Health Services,[5] Fiscal Year 2021-22.

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

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

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

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

Table 1-B. California Adults and Older Adults, Access Rates for Specialty Mental Health Services, Fiscal Year 2021-22.[6]

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

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

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

CBHPC 2023 Data Notebook – Part I:

Standard Yearly Data and Questions for Counties and Local Boards

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

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

Adult Residential Care

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

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

[7] www.mhsoac.ca.gov, see MHSA Transparency Tool, under 'Data and Reports'
[8] Link to Licensed Care directory at California Department of Social Services. https://www.ccld.dss.ca.gov/carefacilitysearch/
[9] Institution for Mental Diseases (IMD) List: https://www.dhcs.ca.gov/services/MH/Pages/IMD-List.aspx

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

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

Questions:

1) **Please identify your County / Local Board or Commission.**

2) **For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Care Facility (ARF), during the last fiscal year?** (*Text response*)

3) **What is the total number of ARF bed-days paid for these individuals, during the last fiscal year?** (*Text response*)

4) **Unmet needs: how many individuals served by your county behavioral health department need this type of housing but currently are <u>not</u> living in an ARF?** (*Text response*)

5) **Does your county have any 'Institutions for Mental Disease' (IMD)?**
   a. No
   b. Yes. If Yes, how many IMDs? *(Text response*)

6) **For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during the last fiscal year?**
   In-county: (*Text response*) Out-of-county: (*Text response*)

7) **What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during the same time period?** (*Text response*)

Homelessness: Programs and Services in California Counties

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

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

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

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

[10] Link to data for yearly Point-in-Time Count:
https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2022.pdf

Table 3: State of California Estimates of Homeless Individuals Point in Time[11] Count 2022

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

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

Questions, continued:

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

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

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

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

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

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

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

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

Questions (continued):

9) **Do you think your county is doing enough to serve the foster children and youth in group care?**
    a. Yes
    b. No. If No, what is your recommendation? Please list or describe briefly. (*Text response*)

10) **Has your county received any children needing "group home" level of care from another county?**
    a. No
    b. Yes. If Yes, how many? (*Text response*)

11) **Has your county placed any children needing "group home" level of care into another county?**
    a. No
    b. Yes. If Yes, how many? (*Text response*)

CBHPC 2023 Data Notebook – Part II:

Stakeholder Engagement in the Public Mental Health System

Context and Background

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

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

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

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

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

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

Challenges and Barriers

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

Some other potential barriers include:

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

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

Key Stakeholders

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

> **Cal. Code Regs. Tit. 9, § 3200.270 - Stakeholders**
> "Stakeholders" means individuals or entities with an interest in mental health services in the State of California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness/ and/or serious emotional disturbance and/or their families.

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

> **California Code, Welfare and Institutions Code - WIC § 5848 (a)**
> Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans' organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Best Practices for Stakeholder Engagement

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

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

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

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

MHSA Community Program Planning Process

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

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

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

MHSA CPP Processes must include the following regarding stakeholder participants:

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

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

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

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

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

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

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

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

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

Resources

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

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

Part II: Data Notebook Questions

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

12. **For each of the following categories, please choose the option from the dropdown menu that best describes how often your county organizes stakeholder engagement meetings or events.**
    - **Dropdown menu options:**
        - Less than once a year
        - Annually (once a year)
        - Every 6 months
        - Quarterly (four times a year)
        - Monthly
        - More than once a month
    - **Categories:**
        - MHSA Community Planning Process (CPP)
        - MHSA 3-year plan updates
        - EQRO focus groups
        - SAMHSA-funded programs
        - Mental/Behavioral Health Board/Commission Meetings
        - County Behavioral Health co-sponsoring/partnering with other departments or agencies
        - Other (please specify):

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

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

15. **Which of the following languages did your county use to conduct stakeholder meetings or outreach during fiscal year 2021/2022, with or without the use of interpreters?** *(Check all that apply)*
    - Arabic
    - Armenian
    - Cambodian
    - Chinese
    - English
    - Farsi
    - Hindi
    - Hmong
    - Japanese
    - Korean
    - Laotian
    - Mien
    - Punjabi
    - Russian
    - Spanish
    - Tagalog
    - Thai
    - American Sign Language (ASL)
    - Other languages (please specify)

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

16. **Which of the following stakeholder groups have you collected and implemented input from within the last year?** *(Check all that apply)*
    - Adults with severe mental illness (SMI)
    - Older adults / Seniors with SMI
    - Families of children, adults and seniors with SMI
    - Individuals with developmental disabilities and/or their representatives
    - Providers of mental health and/or related services
    - Representatives of managed care plans
    - Law enforcement agencies

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

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

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

19. **Does your county have a Community Program Planning (CPP) plan in place?**
    - Yes (If yes, describe how you directly involve stakeholders in the development and implementation of this plan)
    - No

20. **Is your county supporting the CPP process in any of the following ways?** *(Please select all that apply)*
    a) Reimbursement of travel costs for stakeholders participating in in-person meetings or events.
    b) Providing refreshments or food for stakeholder participants
    c) Dedicated staff assistance to facilitate stakeholder meetings and events.
    d) Providing information and training for stakeholders on MHSA programs, regulations, and procedures.
    e) Holding meetings in physically/geographically accessible locations around the county.
    f) Utilizing language interpreting services.
    g) Holding meetings at times convenient to community stakeholders' schedules.
    h) Providing technical assistance for stakeholders participating in webinars or teleconferences.
    i) Other (please specify)
    j) None of the above

21. **Does your county provide training for staff on cultural awareness, community outreach, and stakeholder engagement? If yes, how? If no, why not?**
    - Yes (with comment)
    - No (with comment)

22. **Which of the following barriers does your county face regarding achieving meaningful and impactful engagement of stakeholders (specifically, mental health consumers and family members)?** *(Check all that apply)*
    a. General difficulty with reaching stakeholders.
    b. Difficulty conducting community outreach to racial/ethnic communities or other specific communities of interest.
    c. Difficulty reaching stakeholders with disabilities.
    d. Lack of funding or resources for stakeholder engagement efforts.
    e. Shortage of properly trained staff to support and facilitate stakeholder engagement.
    f. Difficulty adapting to virtual meetings/communications.
    g. Difficulty providing accommodations to stakeholders.
    h. Difficulty incorporating stakeholder input in the early stages of programming.
    i. Lack of "buy-in" from decision makers when it comes to implementing stakeholder input.
    j. Other (please specify)

23. **Are your behavioral health board/commission members involved in your county's stakeholder engagement and/or CPP processes? If yes, describe how.**
    a. Yes (with text comment)
    b. No

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

24. **Has the COVID-19 pandemic increased or decreased the level of stakeholder engagement and input in your county?**
    a. Increased
    b. Decreased
    c. No change

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

26. **What is one change or improvement regarding stakeholder engagement that your county would like to make within the next fiscal year?** *(Written response)*

27. **Do you have any other thoughts or comments regarding stakeholder engagement in your county or statewide?** *(Written response)*

Post-Survey Questionnaire

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

28. What process was used to complete this Data Notebook? (Please select all that apply)
   a. MH board reviewed WIC 5604.2 regarding the reporting roles of mental health boards and commissions.
   b. MH board completed majority of the Data Notebook.
   c. Data Notebook placed on agenda and discussed at board meeting.
   d. MH board work group or temporary ad hoc committee worked on it.
   e. MH board partnered with county staff or director.
   f. MH board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.
   g. Other (please specify)

29. Does your board have designated staff to support your activities?
   a. Yes (if yes, please provide their job classification)
   b. No

30. Please provide contact information for this staff member or board liaison.

31. Please provide contact information for your board’s presiding officer (chair, etc.)

32. Do you have any feedback or recommendations to improve the Data Notebook for next year?

Tri-City Mental Health Authority
MONTHLY STAFF REPORT

DATE: **October 10, 2023**

TO: **Mental Health Commission of Tri-City Mental Health Authority**

FROM: **Rimmi Hundal, Executive Director**

SUBJECT: **Executive Director's Monthly Report**

Mental Health Services Act (MHSA) Community Planning Process

The next Community meeting with take place in person and virtually. Please join us on October 17 or 19 for our MHSA Community Forum. We want to learn from clients, caregivers, and community members about how Tri-City Mental Health services and support funded by the Mental Health Services Act (MHSA) have made a difference for them, their family, and their community. We invite staff and community members alike to share their experiences and how to improve our programs. Please join us along with others in our community in making a difference in mental health services.

We will be offering two meetings with the same content for your convenience:

- (In-person) **Tuesday, October 17, 2023**
  Dinner 5:30pm - 6pm Community Forum 6pm - 7:30pm
  La Verne Community Center (3680 D St, La Verne, CA 91750)

- (Virtual) **Thursday, October 19, 2023**
  10am-11:30am
  Zoom http://tinyurl.com/3jvjvd7n

Grand Opening of Villa Esperanza

The grand opening of Villa Esperanza took place on Thursday, September 14th and was attended by the Executive Director, Director of MHSA and our Housing Department including the Housing Manager. Tri-City has made a permanent loan of Mental Health Services Act funds in the amount of $2.8 million ($2,800,000) to West Mission Housing Partners LP, for the construction and development of the Villa Esperanza Project, which restricts ten (10) rental units for Tri-City clients, as permanent supportive housing for households of extremely low income that include (or consist of) households who are homeless or at risk of homelessness, and who have a diagnosed severe mental illness. Active clients at Tri-City are eligible for referral subject to eligibility and guiding requirements of the MHSA and the Coordinated Entry Systems (CES) when referring

applicants to an available unit. With the help of Tri-City's Housing Department, 9 units have had applicants matched, approved and moved in at Villa Esperanza.

To date, Tri-City has contributed nearly 12 million dollars for the development of Permanent Supportive Housing (PSH) units and has created 72 units of permanent supportive housing in the cities of Pomona, Claremont and La Verne. Tri-City's Permanent supportive housing programs provide not only a place to live, but more importantly include myriad supportive services to assist the residents in improving their life circumstances with the goal of moving on to a permanent independent living situation.

Hispanic Heritage Month is September 15-October 15

Hispanic Heritage Month is celebrated each year from September 15 until October 15. It began as a week-long celebration in 1968 under President Johnson and was expanded to a month by President Reagan 20 years later in 1988. The month-long celebration provides more time to properly recognize the significant contributions Hispanic/Latinx Americans have made in the United States. While we celebrate Hispanic and Latinx communities beyond a month, we give extra recognition to the many contributions made to the history and culture of the United States, including important advocacy work, vibrant art, popular and traditional foods, and much more. Tri-City will be hosting a family night celebration at the wellness center.

<u>NOCHE EN FAMILIA / FAMILY NIGHT</u>

Celebrate family, culture, traditions, and community with Tri-City ¡Adelante! Latino and Hispanic Wellness Collaborative & Latino and Latina Roundtable of the San Gabriel and Pomona Valley. Join us on Friday, October 13th from 4-6 pm at the Wellness Center for an evening of fun. Free food and prizes will be raffled. Free and all ages welcome!

Tri-City Wellness Center
1403 N Garey Ave
Pomona, CA 91784