Draft MHAB Comments on MHSA (Draft) MHSA Plan FY23-26

Overarching recommendations and comments

1. The Mental Health Services Act was intended to provide funding to people suffering from the most serious, disabling and persistent forms of mental illness. (See Welfare & Institutions Code sec. 5600.3(b).) It appears that many of the programs funded in the Three-Year Plan do not address the needs of the most seriously mentally ill (SMI) people in our County.

2. It is unclear how the County decides what programs to fund or how they understand what it would take to fill the unmet needs for the SMI. We recommend that the County conduct a needs assessment to better understand the gaps and what it would take to fill the unmet needs for the SMI. This should include the continuum of care to support this population's complex needs from acute facilities, crisis programs, step down facilities and ongoing support programs.

3. The Prevention, Education and Intervention (PEI) portfolio should be reviewed and scrubbed to focus investments on programs that address the specific stated goals and avoid being spread too thin and being ineffective. The Mental Health Services Oversight & Accountability Commission (MHSOAC) established priorities for the use of County's Prevention and Early Intervention funds. There are Six priority focus areas listed as well as desired outcomes. "PEI programs focus on reducing seven negative outcomes that may result from untreated mental illness: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes." This provides good guidance on what our County programs and portfolios should focus on in the PEI area. When looking at the ensemble of our portfolio many don't appear to be specifically focused on these desired outcomes.

4. It is unclear how the County manages the programs to ensure that the goals and outcomes are consistent with meeting the defined needs. There appears to be a disconnect between the goals and stated accomplishments for a fair number of programs, particularly in the PEI section. The County should consider implementing more rigorous metrics and accountability for delivering on MH aspects of the program goals.

5. Nearly every Full-Service Partnership program mentioned a shortage of housing and staff (clinical case managers, therapists etc.) to treat those in their programs. Could funds be redirected to meeting these needs?

6. The Draft Plan makes it clear that for those individuals who are able to engage and participate in an FSP, their chances of being hospitalized and/or arrested in the future is reduced. Clearly FSPs can work for those who engage and are amenable to

treatment. We don't see anything in the Draft Plan that funds programs aimed at the population who, by virtue of their mental illness, is not able to engage in a Full-Service Partnership.

7. The MHSA Three-Year Plan should anticipate the new direction coming from Sacramento and include funding specifically targeted to treat "homeless persons who are mentally ill." (See Welfare & Institutions Code sec. 5600.3(b)(4)(A).). This would mean funding permanent supportive housing programs. It would also mean ensuring that we have adequate acute treatment facilities to stabilize people prior to them being ready to thrive in supported housing options.

8. Given the changes to MHSA funding that are proposed by the Governor, we suggest reconsidering starting any new programs that are not aligned with the proposed changes.

9. The cities have firsthand in the field experience dealing with the homeless and calls to the police for 5150's. The MHSA Director should seek input from city councils and mayors on what their communities need to meet treatment of mental illness needs.

10. While cultural competence and responsiveness was listed as a guiding principle, the Plan does not highlight how ACBH is emphasizing this.

Process comments

1. The MHAB was not given adequate time to provide meaningful feedback within the public comment period. The MHSA plan should have been made public prior to April 1, so that the MHAB could hear the MHSA presentation, ask questions and provide written feedback by April 30.

2. The MHSA plan is over 700 pages, which is far too lengthy and cumbersome for the public to review and digest, especially in such a short period of time. Allowing for only a 30-day window to comment sends the message that the comments are not going to be taken that seriously and will not meaningfully change the draft document. If the plan cannot be significantly shortened, it should, at a minimum, include an in-depth Executive Summary which covers all of the plan's most significant points. The Executive Summary is only 4 pages long.

3. We are not sure the stakeholder process hears the voices of those who are suffering the most in our county. People who are in and out of John George and who traverse the endless cycle of John George - Jail - Homeless encampments are not represented in the stakeholder process.

Comments by category section

Community Services and Supports (CSS)

1. The county should consider doing an assessment to find out how many FSP programs and slots are needed to meet the needs. Are the current 1,045 slots enough? If not, how many are needed? Can funds from other MHSA be applied to meeting this critical need?

2. State law is clear that the MHSA can fund short-term acute inpatient treatment for clients who are in Full-Service Partnerships (FSPs). (See 9 Cal. Code of Reg. 3620(k).) Every year in our county many FSP clients require treatment and stabilization in an acute and/or sub-acute hospital setting. It appears that there is nothing in the Three-Year Plan which funds medically necessary treatment in an acute or sub-acute setting for FSP clients.

3. Nearly every FSP program mentions the shortage of housing and staff (clinical case managers, therapist etc.) to treat those in their programs – could funds be redirected to meeting these needs?

4. The plan should provide funding for the expansion of the Safe Landing Project at Santa Rita Jail so that it: 1) can be located in a permanent structure, rather than in a trailer; and 2) have a presence within the jail, so inmates can be connected to Project services prior to the time they exit the jail.

Prevention and Early Intervention (PEI)

1. Under California law, PEI is supposed to pay for "downstream" RELAPSE prevention for people who already have a severe mental illness. Welfare and Institutions Code section 5840(c) states: "[The PEI program] shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illness and assisting people in quickly regaining productive lives." We don't see anything in the PEI funding "bucket" of the 3-year plan that is aimed at preventing relapse and deterioration for people who are already suffering from serious and persistent mental illness.

2. On page 380 the priorities are stated for the PEI portfolio. The PEI portfolio should be reviewed and scrubbed to focus investments on programs that address these specific goals and avoid being spread too thin and being ineffective. The Mental Health Services Oversight & Accountability Commission (MHSOAC) established priorities for the use of County's Prevention and Early Intervention funds. There are Six priority focus areas listed as well as desired outcomes. "PEI programs focus on reducing seven negative outcomes that may result from untreated mental illness: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes." This provides good guidance on what our County programs and

portfolios should focus on in the PEI area. When looking at the ensemble of our portfolio many don't appear to be specifically focused on these desired outcomes.

3. The plan provides funding for a very large number of programs countywide. Although each of the programs may be worthwhile, many are not focused on providing mental health services or treating mental illness. Many of the programs cite community engagement, social events and general wellness activities as their goal and accomplishment but it is not clear the extent to which mentally ill individuals are actually connected to mental health services. instead of providing or connecting people to MH services.

4. There seems to be a disconnect between the program description and examples of successes and accomplishments for the year for quite a few programs in PEI. For example, citing community engagement social events and general wellness activities instead of providing or connecting people to MH services. Purposeful Metrics and accountability for delivering on MH aspects of the program goals should be developed and implemented.

5. The following PEI programs are of particular concern in that they lack focus on serving MI needs and either the program description and/or the accomplishment examples cite general community service rather than MI and MH needs. We are concerned that focus is on being generally helpful to the community but is not focused on preventing SMI or severe outcomes as MHSA focus states. In addition, it is unclear how or if some of these programs connect people to MH services. PEI programs: PEI 7, PEI 8, PEI 17B, PEI 19, PEI 20A, PEI 20B, PEI 20E, PEI 27, PEI 28. These programs should be re-evaluated and refined before funding.

6. Concern that quite a few programs mention staff fatigue and lack of capacity to execute.

Innovations – any specific comments on innovations section?

1. There should be greater rationale, and strategy applied to funding priority areas in allocation of these funds. We are concerned that simply allocating $80,000 per entity may leave strategically important areas underfunded to accomplish their goals. It would be good to provide the rationale of why $80,000 per entity was selected and how many entities are expected to be funded, given the intention to commit $10M. This is a lot of funds that are spread out so thinly, so it is unclear how this is intended to help boost the CBOs to address the five eligible funding areas.

Workforce, Education, and Training (WET)

1. It would be good to know what ACBH will do after the needs assessment is conducted. It does not seem sufficient to just include that a needs assessment will be done. How will the needs assessment inform priorities? Will there be any commitments to address some of the priority needs? Will the findings be shared with the public?

2. While this section only focuses on changes from the previous plan, it would be good to share how the proposed psychiatry training partnership are add-ons to the existing training programs. It would be good to list out what are the current ones, to show how ACBH is investing in the different roles within a robust mental health team (e.g., licensed mental health professionals, peer counselors, case managers, psychiatrist).

3. Are there any efforts to address the severe mental health workforce shortages, including providing seed funding for CBOs to grow their own pipeline programs? Is there any emphasis on bilingual/ bicultural professionals, given ACBH's commitment to cultural competency and responsiveness?

<u>Capital facilities and technology needs (CFTN)</u>

1. CF2 Respite Bed Expansion. This seems like an important project that is focused on previously unmet needs - It seems like funding is ending – are needs currently met? – is more funding still needed to meet the needs?

2. CF5: African American Wellness Hub. While there is general support for the concept, there were Serious concerns expressed by MHSA SG. These concerns should be addressed before funding.

    - For a $19 million dollar investment there should be a well-defined program. The vision sounded more like a community center that could refer people to services rather than provide them on site.

    - Did not focus on the needs of mentally ill.

    - Lack of clarity on what the 'wellness hub Program' was.

    - Plans did not include having a psychiatrist and therapist on site, which stakeholders viewed as essential.

    - A Question was raised – could you rent space and refine program to best meet needs before buying a building? A building should not be procured without well-defined needs and programing developed to meet those needs.

- It was mentioned that there are community listening sessions planned for April – suggested that the questions posed to the community be focused on mental illness/health treatment needs and not just a blank slate of what is wanted in a 'wellness hub'.

- Concern raised that the building that is currently being pursued would need extensive renovations including the addition of an elevator.