SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA) Steering Committee

Goals

The MHSA Steering Committee plays a critical role in the Community Program Planning (CPP) processes, and the development of the MHSA Three-Year Program and Expenditure Plan and Annual Updates. As informed by members, the Goals of the MHSA Steering Committee include the following:

1. Represent diverse community and stakeholder voices.
2. Support the participation of individuals living with mental health challenges, their families and direct service providers.
3. Develop meaningful and simplified input processes.
4. Include equity and inclusion in all MHSA processes and priorities.
5. Actively participate in MHSA Steering Committee meetings, workgroups and other input processes.
6. Engage in funding, planning, implementation and evaluation decisions of MHSA services and programs.
7. Review input received through CPP processes, make recommendations and prioritize programs and funding allocations.

Meetings

The MHSA Steering Committee meets four (4) times per year* and are scheduled for the first Thursday in February, May, September, and December at 3pm. All MHSA Steering Committee meetings are open to the public and will include time for public comment and means for submission of written comments.

Given that there are only 4 meetings per year, consistent attendance is very important and members who miss two meetings over the course of a year may be removed from the committee. Extenuating circumstances will be considered.

**Every three years, to support the MHSA Three-Year Plan development, there may be additional meeting(s) to allow for deeper engagement in the Community Program Planning processes.*

Workgroups

The MHSA Steering Committee will host be up to two (2) small workgroups per year focused on a specific MHSA topic that is aligned with MHSA planning needs and may require more intensive planning, improvements, evaluation and/or other recommendations (e.g. housing, full service partnerships, innovation, community program planning, etc.). The workgroups will be time-limited and made up of 10-12 participants to allow for deeper engagement.

Workgroup participation guidelines include the following:

- Participation is open to the public
- Individuals interested in participating will complete a Workgroup Participation Survey
- A selection group, made up of an MHSA Steering Committee co-chairperson, an MHSA Steering Committee member and the MHSA Manager, will review the completed surveys and select the workgroup participants
- Selection of participants will prioritize lived experience of clients and family members, cultural and stakeholder diversity and "first-come, first-serve," completion of the Participation Survey
- Workgroup participants will be required to attend all meetings and may have some "homework" in between meetings (e.g. review materials in advance, review data, research, etc.)

Composition & Membership

The MHSA Steering Committee was established as a Standing Committee of the Mental Health and Substance Abuse Recovery Commission (MHSARC), which requires the appointment of 1-2 chairperson(s) to the committee and support from the MHSA Manager.

Membership includes a broad and diverse set of stakeholders as described below.

- At least 50% representing clients/consumers and families of clients/consumers
- At least 50% representing marginalized cultural and ethnic groups including, Pacific-Islander, LGBTQ, African-American, Filipino, Latino, Chinese, Native American and others
- Maximum 2 members representing any one agency (employees or Board members)
- Minimum 1 member representing each of the following stakeholder groups:
    - Client/Consumers (youth, transition-age youth)
    - Client/Consumers (adults, older adults)
    - Families of clients/consumers
    - Providers of mental health and substance use services
    - Providers of social services
    - Cultural competence and diversity
    - Disabilities
    - Education
    - Health care
    - Law enforcement
    - Veterans and /or representatives from veterans organizations
    - Other interests (faith-based, aging and adult services, youth advocacy, etc.)

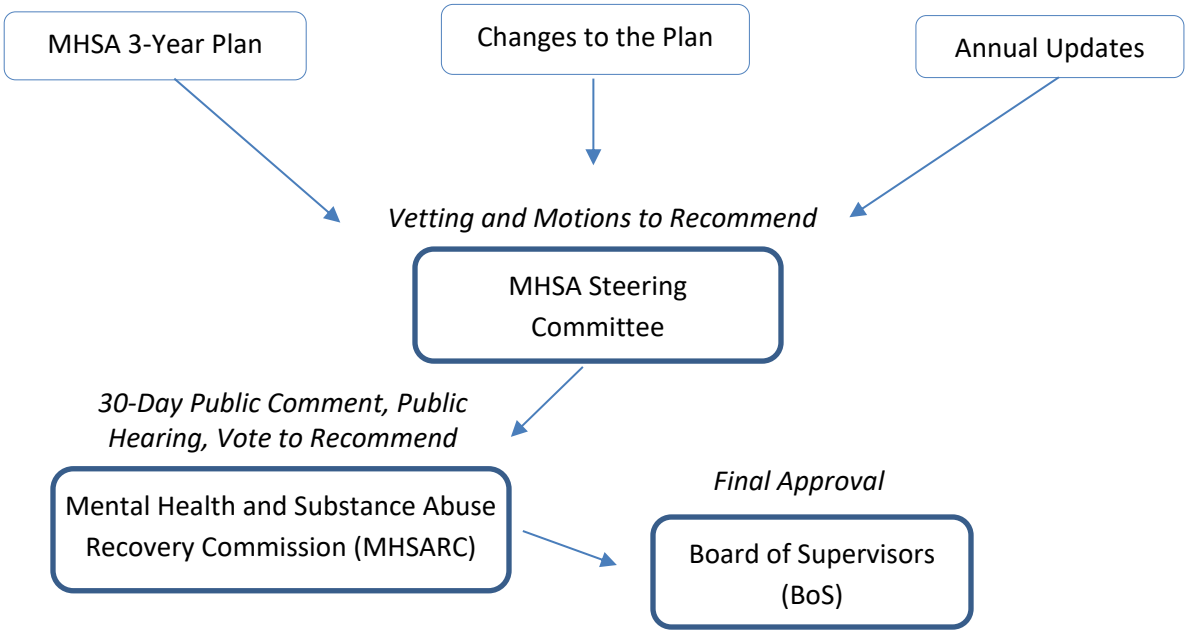
Members of the Steering Committee will be appointed by a "membership selection group" consisting of an MHSA Steering Committee member(s), a representative of the Office of Consumer and Family Affairs and/or the Office of Diversity & Equity and the MHSA Manager.

Applications will be accepted on a rolling basis and reviewed in the Spring and Fall of each year. New members will be required to attend an initial orientation, provided by the MHSA Manager.

Please visit the MHSA website www.smchealth.org/bhrs/mhsa for the MHSA Steering Committee application and the most up-to-date membership list.

MHSA Planning

The MHSA Three-Year Program and Expenditure Plan, any changes and Annual Updates must include a 30-day public comment period and a public hearing hosted by the Mental Health and Substance Abuse Recovery Commission.



Planning Timeline

- Current Three-Year Implementation: July 1, 2020 - June 30, 2023
- Annual Updates Due: June 30th of each year
- Next Three-Year Planning Begins: September 2022
- Next Three-Year MHSA Plan Due: June 30, 2023

July - August	September - January	February - April	May - June
Collect fiscal year data and reporting from MHSA funded programs	Draft MHSA Annual Update and begin Community Program Planning (CPP) processes	Presentation of the Annual Update and/or Three-Year Plan, 30-day public comment and public hearing	Approval by the Board of Supervisor and submission to the MHSOAC

For any additional questions about the the MHSA Steering Committee please contact Doris Estremera, MHSA Manager at mhsa@smcgov.org or (650) 573-2889.

Mental Health Services Act (MHSA)

MHSA Steering Committee Member Orientation

Doris Y Estremera, MPH, MHSA Manager

www.smchealth.org/mhsa

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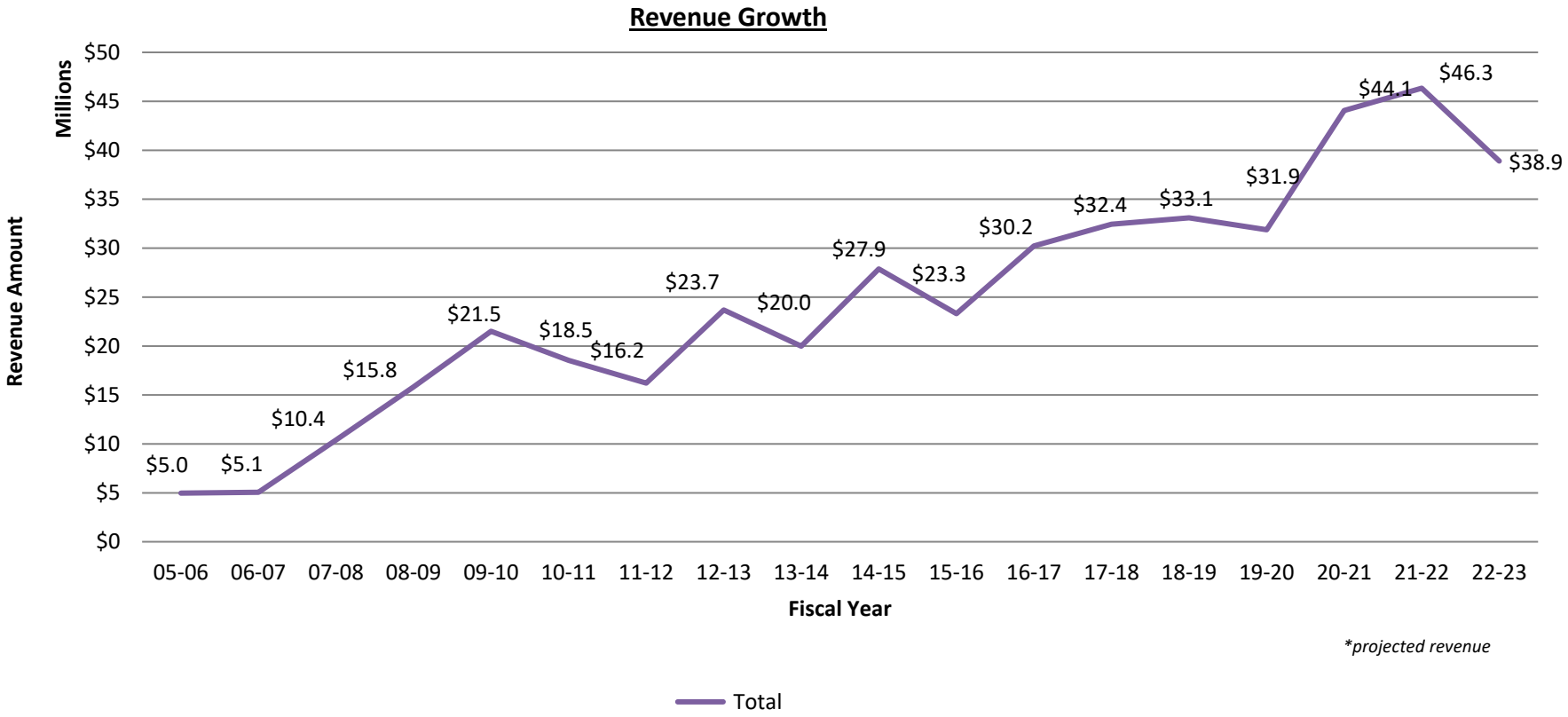
Mental Health Services Act (MHSA)

- Proposition 63 approved in 2004
- 1% tax on personal income in excess of $1M
- Emphasizes transformation of the mental health system while improving the quality of life for individuals living with mental illness.
- Principles and core values include:
  - Focus on wellness, recovery and resilience
  - Cultural and linguistic competency
  - Consumer/client and family-driven services
  - Integrated service experience
  - Community collaboration

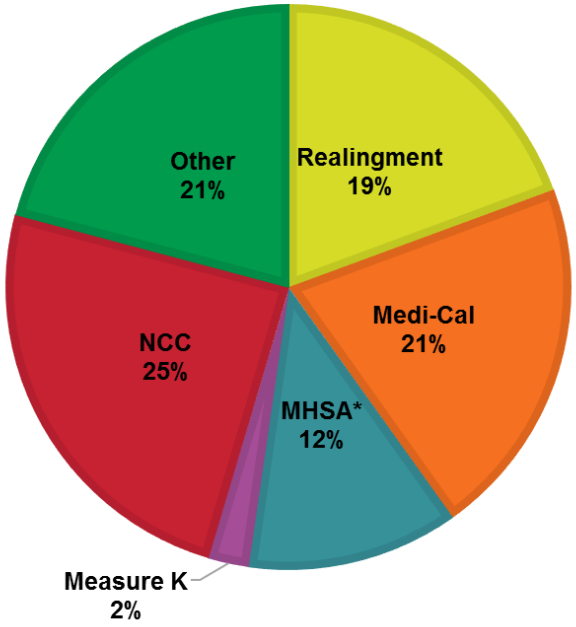
Handout: MHSA Info Sheet

San Mateo County MHSA Revenue

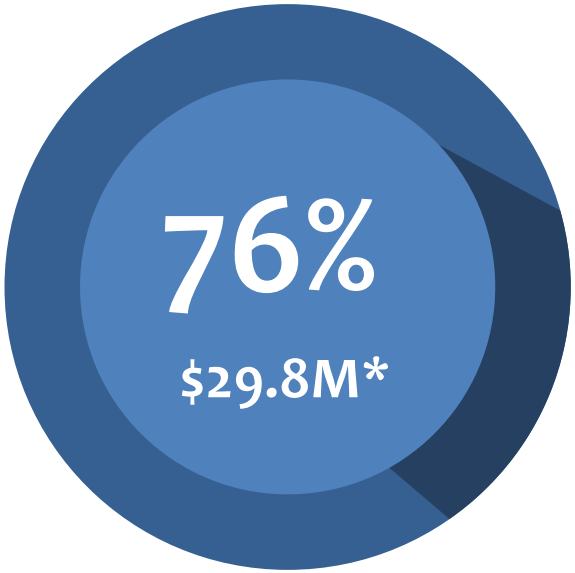


San Mateo County Approach

- Integrated funding throughout BHRS - highly leveraged
- Over 50% goes to community-based agencies
- Makes up about 15% of the BHRS budget
- Goal is system transformation efforts across the continuum of care



Average* Funding Amounts



Community Services & Supports (CSS)

Direct treatment and recovery services for individuals living with serious mental illness or serious emotional disturbance

Prevention & Early Intervention (PEI)

Interventions prior to the onset of mental illness and early onset of psychotic disorders

Innovation (INN)

New approaches and community-driven best practices

*Component amounts based on $39.2 million average MHSA revenue for San Mateo County annually in the last five years through FY 21-22

MHSA Components & Funding Allocation

Component	Categories	Funding Allocation	Reversion Period
Community Services and Supports (CSS)	Full Service Partnerships (FSP) General Systems Development (GSD) Outreach and Engagement (O&E)	76% (FSP 51% of CSS)	3 years
Prevention and Early Intervention (PEI)	Ages 0-25 Early Intervention Prevention Recognition of Signs of Mental Illness Stigma and Discrimination Access and Linkages	19% (Ages 0-25: 51% of PEI)	3 years
Innovations (INN)		5%	3 years

Handouts:

- *MHSA Components & Programs*
- *MHSA Funding Guidelines & Definitions*

Other Funding Components

Component	One-Time Allocation	Reversion Period
Workforce Education and Training (WET)*	$3,437,600 In FY 06/07- FY 07/08	10 years (expended)
Capital Facilities and Information Technology (CF/IT)*	$7,302,687 in FY 07/08	10 years(expended)
Housing	$6,762,000 in FY 07/08 Unencumbered FY 15/16	10 years (expended) 3 years (expended)

** Ongoing, up to 20% of the avg. 5-year total of MHSA funds can be allocated from CSS to WET, CF/IT and Prudent Reserve*

Component	Current Allocation	Reversion Period
Workforce Education and Training (WET)*	$500,000 annually	10 years
Capital Facilities and Information Technology (CF/IT)*	$330,000 annually	10 years
Housing	$10,000,000 one-time In FY 20/21 - 21/22	10 years 3 years

MHSA State-wide Goals (Intended Outcomes)

- Reduce the duration of untreated mental illness
- Prevent mental illness from becoming severe and disabling
- Improve timely access for underserved individuals
- Reduce stigma and discrimination
- Reduce the following seven negative outcomes that may result from untreated mental illness:
  - Suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, removal of children from their homes
- Increase number of individuals receiving public mental health services
- Reduce disparities in access to care

MHSA Outcome Reporting & Evaluation

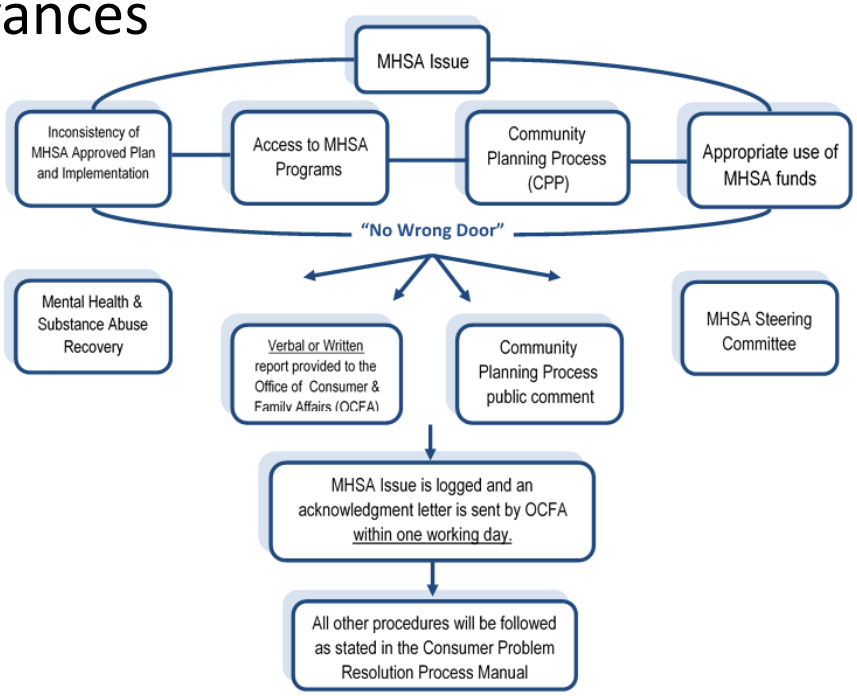
MHSA Component	Service Category	Outcome Reporting	Formal Eval/ Impact Analysis
Community Services & Supports (75%)	Full Service Partnerships (51%)	✓	✓
	General System Development	✓	
	Outreach and Engagement	✓	✓
Prevention & Early Intervention (20%)	Ages 0-25 Programs (50%)	✓	✓
	Early Intervention Programs	✓	✓
	All Ages - Office of Diversity and Equity	✓	✓
Innovations (5%)	Current Innovative Projects (2017-2020)	✓	✓
Workforce Education	Workforce Dev (Lived Experience Academy, Cultural Stipends) & Education and Training	✓	✓

State Oversight

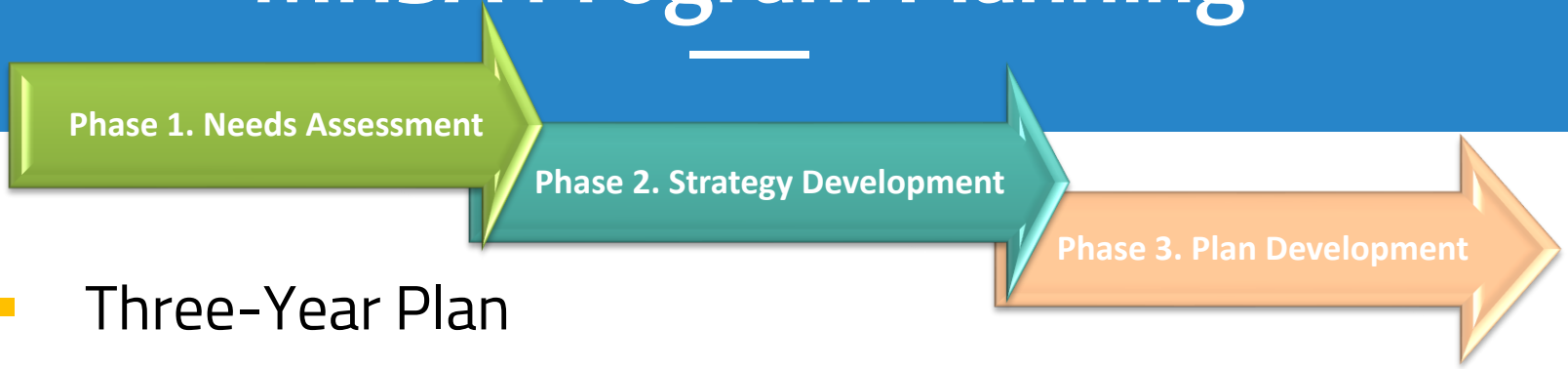
- CA State Department of Health Care Services (DHCS) contracts with County to manage implementation of MHSA
- 16-member CA State Mental Health Oversight and Accountability Commission (MHSOAC)
  - PEI and INN oversight
  - At least 2 appointees with severe mental illness, 2 family members and others

Issue Resolution Process

- Process for addressing concerns with MHSA.
- MHSA issues will be routed through the formal Office of Consumer and Family Affairs (OCFA) service/treatment grievances process.



MHSA Program Planning



- Three-Year Plan
  - Builds on previous planning process and existing programs
  - Includes description of existing programs, prioritized needs/gaps for potential funding, expenditure plans
- Community Program Planning (CPP) process
  - To engage clients, families and community
  - What's working, what needs improvement, prioritize needs, develop ideas to serve as the basis for future RFPs
  - Input Sessions, MHSA Steering Committee, MHSA Workgroups
  - 30-day public comment and public hearings at our local behavioral health commission

MHSA Program Planning (cont'd)

- Annual Updates
- Current Timeline
  - Three-Year Plan Implementation: July 1, 2020 – June 30, 2023
  - Annual Updates Due: June 30th each year
  - Next Three-Year Planning Phase begins: October 2022
  - Next Three-Year MHSA Plan Due: June 30, 2023

The MHSA Steering Committee

- Co-chaired by 1-2 member(s) of the Mental Health and Substance Abuse Commission (MHSARC)
- Oversees community engagement and input processes and the MHSA Three-Year Plan development
  - Makes recommendations for programs
  - Prioritizes needs and strategies
- Meets four times a year during implementation
  - Consistent attendance is needed

Handout: MHSA Steering Committee Roles & Responsibilities

Questions? Thank you!

smchealth.org/MHSA

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BEHAVIORAL HEALTH & RECOVERY SERVICES

Mental Health Services Act (MHSA)

Background

Proposition 63, now known as the Mental Health Services Act (MHSA), was approved by California voters in November 2004 and provided dedicated funding for behavioral health services by imposing a 1% tax on personal income over one million dollars. San Mateo County received an estimated annual average of $39.2 million, in the last five years through Fiscal Year 2021-22.

Principles and Core Values

MHSA emphasizes transformation of the behavioral health system, improving the quality of life for individuals living with behavioral health issues and increasing access for marginalized communities. MHSA planning, implementation, and evaluation incorporates the following core values and standards:

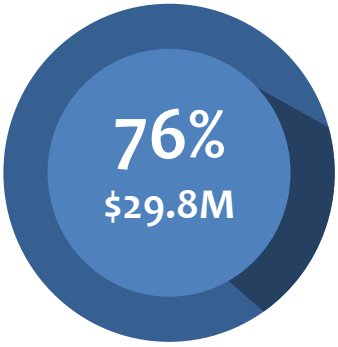
◆ Community collaboration ◆ Cultural competence ◆ Consumer and family driven services

◆ Focus on wellness, recovery, resiliency ◆ Integrated service experience

Funding Allocation

MHSA provides funding for Community Program Planning (CPP) activities, which includes stakeholder involvement in planning, implementation and evaluation. MHSA funded programs and activities are grouped into the following "Components" each one with its own set of guidelines and rules:

Community Services & Supports (CSS)



CSS provides direct treatment and recovery services to individuals of all ages living with serious mental illness or emotional disturbance.

Prevention & Early Intervention (PEI)

PEI targets individuals of all ages prior to the onset of mental illness, with the exception of early onset of psychotic disorders.

Innovation (INN)

INN funds projects to introduce new approaches or community-drive best practices that have not been proven to be effective.

San Mateo County Approach

In San Mateo County, MHSA dollars are integrated throughout the BHRS system and highly leveraged. MHSA-funded activities further BHRS' vision, mission and strategic initiatives.

Visit www.smchealth.org/mhsa for more information

Program and Expenditure Planning

Counties are required to prepare for and submit a **Three-Year MHSA Plan** and **Annual Updates.**

The MHSA Three-Year Plan is developed in collaboration with clients and families, community members, County staff, community agencies and stakeholders. The Three-Year Plan includes the following:

1. Descriptions of existing MHSA funded program under each of the required MHSA components.
2. Priorities for funding based on needs or gaps in services identified by the planning process.
3. Expenditure projections based on estimated revenues and unspent funds.

Each MHSA Three-Year Plan process builds on the previous planning process and existing funded programs. MHSA funded programs are evaluated throughout their implementation, adjustments are made as needed and outcomes shared to inform recommendations about continuing and or ending a program. All agencies funded to provide MHSA services go through a formal Request for Proposal (RFP) process to ensure an open and competitive process. To receive notification of BHRS funding opportunities, please subscribe at www.smchealth.org/rfps[1].

Stakeholder and Community Input

A **Community Program Planning (CPP)** process is used to engage clients and families experiencing mental health, drug and alcohol issues and other stakeholders, in each phase of the process.

Stakeholder input is focused on:

- Highlighting what's working well (programs, program components, efforts).
- Identifying what needs improvement, what's missing from both the CPP and services.
- Prioritizing identified needs for potential future funding.
- Developing strategy ideas to address priority needs and serve as the basis for future RFPs and/or solicitation of bids.

Input is gathered at existing community meetings, input sessions, through surveys, and as formal public comment during the required 30-Day Public Comment and Public Hearing. To receive notification of input opportunities please subscribe at www.smhealth.org/mhsa.

MHSA Planning Timeline

- Current Three-Year Implementation: July 1, 2020 - June 30, 2023
- Annual Updates Due: June 30th of each year
- Next Three-Year Planning Begins: October 2022
- Next Three-Year MHSA Plan Due: June 30, 2023

[1] RFP's can be released at any time within the Three-Year Plan implementation.

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Mental Health Services Act (MHSA) Components and Programs
Fiscal Year 2022 – 2023

Community Services and Supports (CSS)	
Full Service Partnerships (FSP)	Children and Youth • Integrated FSP - Short-term Adjunctive Youth and Family Engagement (SAYFE) • Comprehensive FSP - Turning Point • Out-of-County Foster Care FSP Transition Age Youth • Enhanced Supportive Education Services • Comprehensive FSP - Turning Point & Drop-in Centers Adult /Older Adult • Adult and Older Adult FSP's • Assisted Outpatient Treatment (Laura's Law) FSP • South County Integrated FSP Housing Supports • TAY Supported Housing • Adult and Older Adult FSP Housing Supports • Supported Housing Services • Augmented Board and Care
General System Development (GSD)	• Co-Occurring Service Providers and Recovery Supports • Co-Occurring Youth Residential • Coastside Co-Occurring Supports • Older Adult System of Integrated Services (OASIS) • Senior Peer Counseling Services (50% CSS; 50%PEI) • Pathways Court Mental Health + Co-Occurring Housing Services • Criminal Justice Restoration and Diversion • Child Welfare Partners and Pre-to-Three Programs • Puente Clinic for Intellectually Disabled Dual Diagnosis • Trauma-Informed Interventions - Neurosequential Model of Therapeutics (NMT) • Evidence Based Practices (EBP) Clinicians • School-based Mental Health • Crisis Coordination • Peer Workers and Family Partners • The Barbara A. Mouton Multicultural Wellness Center • Heart & Soul Peer Supports • The California Clubhouse • Primary Care Interface (20% CSS; 80% PEI • Infrastructure Strategies – IT, Communications, Admin, Supports • Contractor's Association
Outreach and Engagement (O&E)	• Family Assertive Support Team (FAST) • Coastside Multicultural Wellness Program – Cariño Project (80% CSS; 20% PEI) • Adult Resource Management • Housing Locator, Outreach and Maintenance • Homeless Outreach – HEAL Program • San Mateo County Pride Center (35% CSS; 65% PEI) • Ravenswood Family Health Center (40% CSS; 60%PEI)

Prevention and Early Intervention (PEI)	
Prevention & Early Intervention (Ages 0 – 25)	• Early Childhood Community Team (ECCT) • Project SUCCESS • Trauma-Informed Co-Occurring Services for Youth • Trauma-Informed Systems for 0-5 Providers • Crisis Hotline, Youth S.O.S. Team
Prevention	**Office of Diversity and Equity (ODE)** • Health Equity Initiatives • Health Ambassador Program (HAP) and HAP Youth (HAP-Y)
Recognition of Early Signs of MI	• Adult Mental Health First Aid
Stigma Discrimination and Suicide Prevention	• Digital Storytelling and Photovoice • Mental Health Awareness • San Mateo County Suicide Prevention Committee (SPC)
Early Intervention	• SMC Mental Health Assessment and Referral Team (SMART) • Primary Care Interface (80% PEI; 20% CSS) • Early Psychosis Program – (re)MIND
Access and Linkage to Treatment	• Ravenswood Family Health Center (40% CSS; 60% PEI) • North County Outreach Collaborative (NCOC) • East Palo Alto Partnership for Mental Health Outreach (EPAPMHO) • Coastside Community Engagement – Cariño Project (20% PEI; 80% CSS) • San Mateo County Pride Center (65% PEI; 35% CSS) • Senior Peer Counseling (50% CSS; 50% PEI)

Innovations (INN)
• Kapwa Kafe for Filipino/a/x Youth • PIONEERS for Native Hawaiian and Pacific Islander Youth

Other Components	
Workforce and Education Training (WET)	• Training by/for Consumers and Family Members • System Transformation and Workforce Development • Behavioral Health Career Pathways Program • Financial Incentives – Cultural Stipends, Loan Assumption
Housing	• Cedar Street Apartments in Redwood City (2009) • El Camino Apartments in South San Francisco (2010) • Delaware Pacific Apartments in San Mateo (2011) • Waverly Place Apartments in North Fair Oaks (2018) • Bradford Senior Housing in Redwood City • 2821 El Camino Real in North Fair Oaks (2019)
Capital Facilities and Information Tech	• eClinical Care (launched in 2008-09) • Client Devices

MHSA FY 22-23
Programs Budget

Community Services and Supports (CSS)			
Service Category	Program	BHRS Staff/Agency	FY 22-23 Amount
Full Service Partnership (FSP)	**Children and Youth (C/Y)**		
	Integrated SAYFE	Edgewood + MediCal match	$2,161,874
	Comprehensive C/Y "Turning Point"	Edgewood + MediCal match	$2,943,639
	Out-of-County Foster Care	Fred Finch	$235,995
	Transition Age Youth (TAY)		
	Enhanced Education (TAY)	Caminar	$204,284
	Comprehensive TAY "Turning Point"	Edgewood + MediCal match	$3,157,836
	Adult & Older Adult		
	Adult and Older Adult FSP	Telecare + MediCal match	$2,948,929
	Adult and Older Adult FSP	Caminar + MediCal match	$812,424
	Assisted Outpatient Tx (AOT) FSP	Caminar + MediCal match; BHRS	$1,713,132
	Embedded South County FSP	Mateo Lodge	$131,188
	Housing Supports		
	TAY Supported Housing	Mental Health Association	$421,607
	Telecare Adult and Older Adult FSP Housing	Telecare	$1,814,682
	Caminar FSP/AOT Housing Support Program	Caminar	$564,696
	Board and Care	Various	$2,200,000
	Adult/Older Adult Supported Housing Services	Mental Health Association	$298,992
		TOTAL FSP	**$19,609,278**
General System Development (GSD)	**Co-Occurring Integration**		
	Co-Occurring Service Integration	Various	$407,823
	Co-Occurring Residential	Advent Group Ministries	$50,000
	Recovery Support Services	VoR, StarVista (Girls Program)	$164,591
	Co-Occurring Providers	Lea Goldstein, Brian Greenberg	$31,106
	Co-Occurring Staff	BHRS Staff	$282,156
	Coastside Multicultural Wellness (80%CSS)	El Centro	$44,000
	Older Adult System of Care		
	OASIS	BHRS Staff	$1,044,408
	Senior Peer Couseling (50% CSS)	Peninsula Family Services	$176,847
	Criminal Justice Integration		
	Pathways, Court Mental Health	BHRS Staff; MHA	$190,971
	Criminal Justice Restoration and Diversion	BHRS Staff	$250,000
	Pathways, Housing Services	Life Moves	$119,600
	Juvenile Girls Program	StarVista	$64,439
	Other System Development		
	Child Welfare Partners Program; Pre-to-Three	BHRS Staff	$594,646
	Puente Clinic	BHRS Staff	$371,805
	Trauma-Informed Interventions (NMT)	Various; MHA	$211,000
	EBP Clinicians	BHRS Staff	$1,533,166
	School-based MH	BHRS Staff	$500,000
	Crisis Coordination	BHRS Staff	$76,167
	Peer and Family Partner Support		
	Peer Workers and Family Partners	BHRS Staff	$1,763,627
	OCFA Stipends	MHA; BHRS	$35,000
	Multicultural Wellness Center	One EPA	$208,272
	Peer Support	Heart and Soul	$530,071
	The California Clubhouse	California Clubhouse	$344,250
	Primary Care Integration		
	Primary Care Interface (20% CSS)	BHRS Staff	$256,887
	Total Wellness	BHRS Staff	$750,000
	Infrastructure Strategies		
	IT and Support Staff	BHRS Staff	$1,033,310

MHSA FY 22-23
Programs Budget

	Communications support	Various	$75,000
	Contractor's Association	Caminar	$111,858
	CSS Evaluations	AIR, PWA, AHDS	$152,409
	CSS Planning	RDA, J. Davila	$84,260
	CSS Admin	BHRS Staff	$954,942
		TOTAL GSD	**$12,412,611**
Outreach and Engagement (O&E)	Family Assertive Support Team (FAST)	Mateo Lodge	$325,732
	Coastside Multicultural Wellness (80%CSS)	ALAS	$316,000
	Adult Resource Management (ARM)	new priority for MHSA	$1,720,650
	Housing Locator, Outreach and Maintenance	TBD	$1,075,000
	HEAL Program - Homeless Outreach	TBD	$325,000
	SMC Pride Center (35% CSS)	StarVista	$245,000
	Ravenswood Family Health Center (40% CSS)	Ravenswood	$18,082
		TOTAL O&E	**$4,025,464**
		GRAND TOTAL CSS	**$36,047,352**
		Percent FSP (51% required)	54%
		Percent CSS of Total Budget	**76%**

Workforce Education and Training (WET)			
	WET (annual transfer from CSS)	Training Contracts, BHRS Staff	500,000

Capital Facilities and Technology Needs (CFTN)			
	CFTN (annual transfer from CSS)	Various	330,000

Prevention and Early Intervention (PEI)			
Service Category	Program	BHRS Staff/Agency	Amount
Prevention & Early Intervention Ages 0-25	Early Childhood Community Team (ECCT)	StarVista	$455,742
	Community Interventions for School Age & TAY		
	Project SUCCESS	Puente de la Costa Sur	$314,944
	Trauma-Informed Co-Occurring	Latino Commission; Puente; StarVista; YMCA	$380,000
	Trauma-Informed Systems	First5 SMC; Consultant	$150,000
	Youth Crisis Response and Prevention	StarVista	$942,039
	Early Psychosis	Felton Institute	$615,389
	Health Ambassador Program - Youth	StarVista	$257,500
	Access & Linkage to Treatment (50%)	Various	$1,175,026
	Prevention, Stigma Discrimination (50%)	BHRS Staff	$811,904
		TOTAL Ages 0-25	**$5,102,544**
Prevention	**Community Outreach, Engagement and Capacity**		
	Office of Diversity and Equity	BHRS Staff	140,565
	Health Equity Initiatives	Co-chairs; BHRS Staff	$161,274
	Health Ambassador Program	BHRS Staff	$152,476
Recognition of Early Signs of MI	Adult Mental Health First Aid	OneEPA, PCRC, StarVista, HOPE	$71,869
Stigma Discriminaiton and Suicide Prevention	Digital Storytelling and Photovoice	BHRS Staff	$62,948
	Mental Health Awareness; Be the ONE	BHRS Staff; CalMHSA	$147,321
	SMC Suicide Prevention Committee	BHRS Staff; CalMHSA	$147,321
Early Intervention	SMART	American Med Response West	$149,350

MHSA FY 22-23
Programs Budget

	Primary Care Interface (80% PEI)	BHRS Staff	$411,019
	Early Psychosis	Felton Institute	$263,738
Access & Linkage to Treatment	Ravenswood Family Health Center (60% PEI)	Ravenswood	$27,122
	North County Outreach	HealthRight 360	$116,975
	East Palo Alto Outreach	One EPA	$110,046
	Coastside Community Engagement (20%PEI)	ALAS; YLI	$44,977
	SMC Pride Center (65% PEI)	StarVista	$318,500
	Senior Peer Counseling (50% PEI)+ OA Outreach	Peninsula Family Service	$326,847
	PEI Admin	BHRS Staff + S&S	$860,917
	PEI Planning + Eval	RDA, AHDS	$272,760
		TOTAL	$3,786,024
		GRAND TOTAL PEI	**$8,888,568**
		Percent Ages 0-25 (51% required)	57%
		Percent PEI of Total Budget	**19%**

INNOVATIONS			
	Social Enterprise	Daly City Partnership	$590,251
	PIONEERS	TBD	$280,000
	Co-location of PEI in Low-income Housing	TBD	$280,000
	INN Evaluation	RDA	$87,000
		TOTAL INN	**$1,237,251**

Obligated Funds			
		FY 21-22	**FY 22-23**
	Total Reserve (Prudent + Operational)	$24,690,444	$24,690,444
	INN (5% of revenue)	$2,469,044	$2,317,234
	INN Ongoing	$6,590,881	$6,562,424
	Updated One-Time Spend Plan	$6,947,915	$1,539,000
	New One-Time Spend Plan	$11,727,000	$5,751,000
	Unencumbered Housing Funds	$97,088	$57,088
	WET Ongoing	$500,000	$500,000
	TOTAL	**$53,022,372**	**$41,417,190**

GRAND TOTAL Budget (CSS+WET+PEI+CFTN) **$45,765,920**
(OneTime+INN) **$54,350,259**

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Funding Principles

First adopted in November 2009, updated September 2018

These MHSA Funding Principles were developed to guide annual funding allocations and expansions; they also build from the County's and Health System budget balancing principles to guide MHSA reduction decisions when needed. Decisions regarding MHSA funding are based on the most current MHSA Three-Year Plan; any updates to the recommendations require MHSA Steering Committee approval and stakeholder engagement, which will include a 30-day public comment period and public hearing as required by the MHSA legislation.

Maintain MHSA required funding allocations

See attached MHSA Funding and Program Planning Guidelines document.

Sustain and strengthen existing MHSA programs

MHSA revenue should be prioritized to fully fund core services that fulfill the goals of MHSA and prevent any local or realignment dollars filling where MHSA should.

Maximize revenue sources

Billing and fiscal practices to draw down every possible dollar from other revenue sources (e.g. Medi-Cal) should be improved as relevant for MHSA funded programs.

Utilize MHSA reserves over multi-year period

MHSA reserves should be used strategically to mitigate impact to services and planned expansions during budget reductions.

Prioritize direct services to clients

Indirect services are activities not directly related to client care (e.g. program evaluation, general administration, staff training). Direct services will be prioritized as necessary to strengthen services to clients and mitigate impact during budget reductions.

Maintain prevention efforts

At minimum, 19% allocation to Prevention and Early Intervention (PEI) should be maintained and additionally the impact across the spectrum of PEI services and services that address the root causes of behavioral health issues in our communities should be prioritized.

Sustain geographic, cultural, ethnic, and/or linguistic equity.

MHSA aims to reduce disparities and fill gaps in services; reductions in budget should not impact any community group disproportionately.

Evaluate potential reduction or allocation scenarios

All funding decisions should be assessed against BHRS's Mission, Vision and Values and when relevant against County and Health System Budget Balancing Principles.

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Program Funding Guidelines – Summary

MHSA Component	Categories	Funding Allocation (% of total revenue)
Community Services and Supports (CSS)[1]	• Full Service Partnerships (FSP) • General Systems Development (GSD) • Outreach and Engagement (O&E)	76% FSP should be at least 51% of the CSS allocation
Prevention and Early Intervention (PEI)[2]	• Ages 0-25 • Early Intervention • Prevention • Recognition of Signs of Mental Illness • Stigma and Discrimination • Access and Linkages	19%* Ages 0-25 should be at least 51% of the PEI allocation
Innovations (INN)[3]	N/A	5%

* PEI expenditures may be increased given the department determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase. The justification must be included in the Three-Year Program and Expenditure Plan and/or the respective Annual Updates.

Reversion Period: Counties must expend the revenue received for each core component within 3 years (starting with the year revenue is received) or must return it to the State mental health fund.

One-time Funding Components: counties received a one-time allocation to fund strategies in Workforce Education and Training (WET)[4], Capital Facilities and Information Technology (CF/IT)[5], and Housing[6]. All one-time funding has been expended. These components can continue to be funded under CSS, as determined by the following additional funding guidelines.

- Up to 20% of the average 5-year total of MHSA funds can be allocated from CSS to the technological needs, capital facilities, human resources, and a prudent reserve.
- Assembly Bill 727 clarifies that counties can fund housing assistance, not just for FSP clients.

Three-Year Plan and Annual Updates:

- Up to 5% of total annual MHSA revenues can be allocated for annual MHSA planning efforts.
- All expenditures must be consistent with the current three-year plan or annual update developed through a Community Program Planning (CPP)[7] process.
  - Current Three-Year Plan Implementation: July 1, 2020 – June 30, 2023
  - Annual Updates Due: June 30th
  - Next Three-Year Planning Phase: January 1, 2022 – June 30, 2022
  - Next Three-Year MHSA Plan Due: June 30, 2022

Prudent Reserve (PR): Counties are required to establish and maintain a PR for revenue decreases.

- The 50% Local Prudent Reserve requirement was rescinded (Info Notice 11-05)
- Counties must establish a Prudent Reserve that does not exceed 33% of the 5-year average CSS revenue received (Info Notice 19-017).
- All other policy and guidance remains in effect (Info Notice 09-16 and 18-033).

Non-supplantation:

- Funds shall not be used to supplant any state or county funds required to be utilized to provide mental health services, that was in effect on November 2, 2004, nor cost of inflation.

Definitions

[1] **Community Services & Support (CSS)** provides direct treatment and recovery services to individuals of all ages living with serious mental illness (SMI) or serious emotional disturbance (SED):

a. **Full Service Partnership (FSP)** plans for and provides the full spectrum of services, mental health and non-mental health services and supports to advance client's goals and support their recovery, wellness and resilience.

b. **General Systems Development (GSD)** improves the mental health service delivery system. GSS may only be used for; treatment, including alternative and culturally specific; peer support; supportive services to assist with employment, housing, and/or education; wellness centers; case management to access needed medical, educational, social, vocational rehabilitative or other services; needs assessment; individual Services and Supports Plans; crisis intervention/stabilization; family education; improve the service delivery system; reducing ethnic/racial disparities.

c. **Outreach and Engagement (O&E)** is to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities. O&E funds may be used to pay for strategies to reduce ethnic/racial disparities; food, clothing, and shelter, but only when the purpose is to engage unserved individuals, and when appropriate their families, in the mental health system; and general outreach activities to entities and individuals.

[2] **Prevention & Early Intervention (PEI)** targets individuals of all ages prior to the onset of mental illness, with the exception of early onset of psychotic disorders. PEI emphasizes improving timely access to services and reducing the seven negative outcomes of untreated mental illness; suicide; incarcerations; school failure or dropout; unemployment; prolonged suffering; homelessness; and removal of children from their homes.

a. **Early Intervention** programs provide treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence. Services shall not exceed 18 months, unless the individual receiving the service is identified as experiencing first onset with psychotic features, in which case early intervention services shall not exceed 4 years.

b. **Prevention** programs reduce risk factors for developing serious mental illness and build protective factors for individuals whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members. Services may include relapse prevention and universal prevention.

c. **Outreach for Recognition of Early Signs of Mental Illness** to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

d. **Access and Linkage to Treatment** connects individuals with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including care provided by county mental health programs. Examples include screening, assessment, referral, help lines, and mobile response.

e. **Stigma and Discrimination Reduction** activities reduce negative feelings, attitudes, beliefs and/or discrimination related to mental illness or seeking services. Examples include social marketing campaigns, speakers' bureaus, targeted education and training, anti-stigma advocacy, and efforts to encourage self-acceptance.

f. **Suicide Prevention** programs are optional. Activities prevent suicide but do not focus on or have intended outcomes for specific individuals. Examples include campaigns, suicide prevention networks, capacity building, culturally specific approaches, survivor-informed models, screening, hotlines or web-based resources, training and education.

[3] **Innovation (INN)** projects are designed and implemented for a defined time period (not more than 5 years) and evaluated to introduce a new behavioral health practice or approach; make a change to an existing practice; apply a promising community-driven practice or approach that has been successful in non-behavioral health; and has not demonstrated its effectiveness (through mental health literature).

[4] **Workforce Education & Training (WET)** provides clients and families training to help others, promote wellness and other positive outcomes. Providers are able to work collaboratively to deliver client-and family-driven services, outreach to unserved and underserved populations, and provide linguistically and culturally relevant services.

[5] **Capital Facilities & Technological Needs (CF/TN)** includes facilities for the delivery of MHSA services to clients and their families or for administrative offices; support an increase in peer-support and consumer-run facilities; community-based settings; and technological infrastructure to facilitate services and supports.

[6] **Housing** is used to acquire, rehabilitate or construct permanent supportive housing for clients with serious mental illness and provide operating subsidies. This service category is part of CSS.

[7] **Community Program Planning (CPP)** process is used to develop MHSA three-year plans and updates in partnership with stakeholders to identify community issues related to mental illness, lack of services and supports; analyze the mental health needs in the community; and identify and re-evaluate priorities and strategies and includes a 30-day public comment, a public hearing by the local mental health board and local board of supervisors.

MENTAL HEALTH SERVICES ACT (MHSA) – Issue Resolution Process

I. Behavioral Health & Recovery Services (BHRS) Grievance/Appeals

BHRS consumer/clients receive client rights information upon admission to any program, which includes information on the right to a problem resolution process and how to file a grievance, appeal or request a state fair hearing after exhausting the internal problem resolution process. The Office of Consumer and Family Affairs (OFCA) is available to assist with grievances, appeals, and/or the fair hearing process. *For a complete list of Consumer Rights, call OCFA at 800.388.5189 or visit www.smchealth.org/BHRS/OCFA.*

II. MHSA Issue Resolution - Background

MHSA County Performance Contracts require that Counties adopt an Issue Resolution Process in order to resolve issues related to

1) the MHSA Community Program Planning (CPP) process;
2) consistency between approved MHSA plans and program implementation; and
3) MHSA funded programs (accessibility, appropriate use of funds, etc).

Counties are required to keep and update an Issue Resolution Log to handle client disputes and complaints. The Issue Resolution Log must include brief description of the MHSA issue, dates, and final resolution.

Specifically, CPP is defined in Title 9 California Codes and Regulations and ensures that:

- MHSA funded services are client and family driven meaning that clients and their families have the primary decision-making role in determining the services and supports that are most effective and helpful.
- The county will 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.
- Consumers and their family members will be provided training, opportunities to provide their viewpoints and experiences and granted stipends for their participation.

III. MHSA Issue Resolution Process

When an MHSA specific grievances are received by the OCFA, the coordinator will:

- Note in the Grievance/Appeal Log that it is an MHSA-specific grievance.
- Handle all issues related to treatment by MHSA funded programs.

MENTAL HEALTH SERVICES ACT (MHSA) – Issue Resolution Process

- Direct all CPP issues to the MHSA manager or appropriate staff
- If a satisfactory resolution of the CPP issue is determined, the OCFA coordinator or designee will coordinate with the MHSA Manager to provide a resolution letter.
- If a satisfactory resolution is not determined, all other procedures will be followed as stated in the Consumer Problem Resolution Process Manual.
- Where appropriate (e.g. MHSA community planning process issues) the MHSA Manager will consult a sub-committee of the MHSA Steering Committee, which shall include at least 50% consumer/client and family members to resolve the issue. Decision-makers involved in the grievance process will not have been involved in the specific grievance itself and/or in any previous level of review concerning the grievance.