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.

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.

Prioritize 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.

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.

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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 in which 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.

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, 2017 – June 30, 2020
  - Annual Updates Due: December 2018, December 2019, December 2020
  - Next Three-Year Planning Phase: January 2020 – June 2020
  - Next Three-Year MHSA Plan Due: December 2020

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 may fund to a level determined appropriate and that does not exceed 33% of the counties' largest annual distribution (Info Notice 18-033).
- All other policy and guidance remains in effect (Info Notice 09-16).

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.

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 7 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 the highest quality and cost-effective 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.