Health, Housing & Community Services
Mental Health Commission

To: Mental Health Commissioners
From: Jamie Works-Wright, Commission Secretary
Date: April 13, 2023

Documents Pertaining to 4/20/23 Agenda items:

Health, Housing & Community Service Department
Mental Health Commission

Berkeley/ Albany Mental Health Commission

Regular Meeting
Thursday, April 20, 2023

Time: 7:00 p.m. - 9:00 p.m.

Location: South Berkeley Senior Center
2939 Ellis St. Berkeley, Conference Room A

Teleconference Location
2475 Prince St, Berkeley, CA 94705

AGENDA

1. **Roll Call (1 min)**

2. **Preliminary Matters (5 min)**
   a. Action Item: Approval of the April 20, 2023 agenda
   b. Public Comment (non-agenda items)
   c. Action Item: Approval of the March 16, 2023 minutes

3. **Bridge to SCU and SCU Update – Dr. Lisa Warhuus, Director Health, Housing & Community Services (15 min)**

4. **Mental Health Manager's Report and Caseload Statistics – Jeff Buell (15 min)**
   a. MHC Manager Report
   b. Caseload Statistic March 2023
   c. RBA supplement

5. **Write a letter to council about trying to fill MHC vacancies (10 Min)**

6. **Annual Report Update – Judy Appel (15 Min)**

7. **Governor's proposed changes to funding of mental health programs – Edward Opton (15 Min)**

8. **Update on the Care First, Jails Last resolution: summary of meeting with Berkeley Police Department and options going forward (15 Min)**

9. **Subcommittee Reports (20 min)**

   a. **Diversion Subcommittee**
   b. **Youth Subcommittee**
   c. **Membership Subcommittee**

d. **Evaluation Subcommittee**

10. Adjournment

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Contact person: Jamie Works-Wright, Mental Health Commission Secretary (510) 981-7721 or Jworks-wright@cityofberkeley.info

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SB 343 Disclaimer

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Department of Health,
Housing & Community Services
Mental Health Commission

Berkeley/Albany Mental Health Commission
Drafted Minutes

7:00 pm
Zoom Webinar

Regular Meeting
March 16, 2023

Members of the Public Present:
Staff Present: Jeff Buell, Lisa Warhuus, Jamie Works-Wright

1) **Call to Order at 7:09 pm**
Commissioners Present: Margaret Fine, Kate Harrison, Monica Jones, Edward Opton, Andrea Prichett (7:35), Glenn Turner **Absent:** Judy Appel, Mary Lee Kimber-Smith,

2) **Preliminary Matters**
   a) **Approval of the March 16, 2023 agenda**
   M/S/C (Harrison, Fine) Motion to add May is Mental Health Month to come after the subcommittee reports
   PASSED
   Ayes: Fine, Harrison, Jones, Opton, Turner **Noes:** None; **Abstentions:** None; **Absent:** Appel, Kimber-Smith, Prichett,

   M/S/C (Fine, Opton) Motion to approve agenda with the new additions
   PASSED
   Ayes: Fine, Harrison, Jones, Opton, Turner **Noes:** None; **Abstentions:** None; **Absent:** Appel, Kimber-Smith, Prichett,

   b) **Public Comment-** 2 public comment

   c) **Approval of the February 23, 2023 Minutes**
   M/S/C (Turner, Opton) Motion to approve the minutes
   PASSED
   Ayes: Fine, Jones, Opton, Turner **Noes:** None; **Abstentions:** Harrison; **Absent:** Appel, Prichett, Kimber-Smith

3. **Bridge to SCU and SCU Update – Dr. Lisa Warhuus, Director Health, Housing & Community Services**
   No Motion Made

4. **Mental Health Manager report and Caseload statistics – Jeff Buell**
   No motion Made

5. **Subcommittee Reports**
   a. **Diversion Subcommittee – Mary-Lee Kimber Smith**
   b. **Youth Subcommittee – Monica Jones**
   c. **Membership Subcommittee**
   d. **Site Visit Subcommittee – discussion to renew**
   e. **Evaluation Subcommittee**
   f. **Crisis Stabilization Subcommittee**

6. **May is Menta Health Month BMH division update – Jamie**

7. **Update: Law enforcement arrest regarding people with dementia – Edward Opton**
   Did not get to item

8. **Update: Access to 988 for Berkeley People – Edward Opton**
   Did not get to item

9. **Adjournment – 9:00 PM**

Minutes submitted by: _____
Jamie Works-Wright, Commission Secretary

Health Housing and
Community Services Department
Mental Health Division

MEMORANDUM

To: Mental Health Commission
From: Jeffrey Buell, Mental Health Division Manager
Date: 4/11/2023
Subject: Mental Health Manager Report

Mental Health Services Report

Please find the attached report on Mental Health Services for March 2023.

Information Requested by MHC

The MHC Chair and vice Chair have not submitted questions for this period.

Mental Health Division Updates

The Mental Health Division has several areas of updates at this time:

A) MHSA projections from the State of California were shared with fiscal this last year. Current estimates indicate that while there may be a marginal single year increase for the coming fiscal year (FY24-25), rates are expected to follow a pattern of steady decrease in successive years.
B) Governor Newsom has indicated plans to change standing legislation, including the Mental Health Services Act. Some of these proposed changes include provision of MHSA services to individuals with SUD needs (without needing a co-occurring MH diagnosis); utilizing up to a billion a year of MHSA funds for housing and treatment facilities; and providing services and housing to the neediest individuals. This would need to go on the ballot in November 2024 and then if it passes, it would be phased in, beginning July 2025. The proposed funding changes would impact jurisdictions that receive MHSA funding, including the City of Berkeley, resulting in large future reductions of current funding levels for our local jurisdiction.
C) With the current fiscal forecast from the state now available, the Division structural reorganization (with the purpose to right-size the workload and better

offer support for future expansion by creating two new programs to reallocate existing teams) tentatively continues and may require different funding streams to remain viable. Several key positions are being recruited during this current fiscal year for transition, planning, and implementation. Interviews have been completed for the program supervisors of the two new programs. With future MHSA funding reductions possibly on the horizon, the planned mental health expansion will be approached cautiously and prudently.

D) RDA is the contractor who was engaged to support the Division in developing Results Based Accountability (RBA) data collection strategies and dashboards for the Division. RDA is in the final stages of this process, and will be presenting the final data dashboards with initial baseline information to BMH leadership this month (attached to this report). The plan has been to hire a permanent staff position for the Division to continue this data gathering and analysis moving forward.

Berkeley Mental Health Caseload Statistics for March 2023

Adult Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Previous 12 Months	Fiscal Year 2023 (July '22-June '23) Demographics as of March 2023
Adult, Older Adult and TAY Full Service Partnership (AFSP) (Highest level outpatient clinical case management and treatment)	1-10 for clinical staff.	5 Clinicians, 1 Clinical Supervisor	54	$9,887	Clients: 59 API: 1 Black or African-American: 32 Hispanic or Latino: 1 White: 25 American Indian: 0 Other/Unknown: 0 Male: 32 Female: 25 Missing Gender ID: 1 Prefer Not to Answer Gen ID: 1 Multiple Gender ID: 0 Heterosexual: 45 Unknown: 6 Missing Sex Orient: 0 Bisexual: 1 Queer: 1 Prefer Not to Answer Sex Orient: 3 Multiple Sex Orient: 2 Gay: 0 Questioning: 1 Lesbian: 0
Adult FSP Psychiatry (March Stats)	1-100	.5 FTE	47		
AFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)				$2,037,600	
Homeless Full-Service Partnership (HFSP) (Highest level outpatient clinical case management and treatment)	1-8 for clinical staff	5 Clinicians, 0 Clinical Supervisor	38	$7,133	Clients: 39 API: 2 Black or African-American: 23 Hispanic or Latino: 1 Other/Unknown: 0 White: 13 Male: 26

Berkeley Mental Health Caseload Statistics for March 2023

					Female: 11 Missing Gender ID: 1 Unknown: 1 Prefer No to Answer: 0 Multiple Gender Identities: 0 Heterosexual: 31 Missing Sex Orient: 1 Bisexual: 3 Unknown: 2 Gay: 1 Questioning: 1 Multiple Sex Orient: 0 Prefer Not to Answer: 0 Lesbian: 0
HFPS Psychiatry (March Stats)	1-100	.0 FTE	24		
HFSP FY22 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			TBD		
Comprehensive Community Treatment (CCT) **(High level outpatient clinical case management and treatment)**	1-20	6 Clinicians 1 Team Lead 1 Clinical Supervisor	153	$2,780	Clients: 171 American Indian: 2 API: 17 Black or African-American: 66 Hispanic or Latino: 7 Other/Unknown: 4 White: 75 Male: 85 Female: 77 Multiple Gender Identities: 2 Missing Gender ID: 1 Non-Conforming Gender ID: 2 Prefer Not to Answer Gender ID: 1 Female to Male: 1 Queer Gender ID: 1 Unknown: 1 Heterosexual Sex Orient: 127 Unknown: 17 Missing Sexual Orient: 3 Bisexual Sex Orient: 3

Berkeley Mental Health Caseload Statistics for March 2023

					Lesbian Sex Orient: 5 Gay Sex Orient: 4 Prefer Not to Answer Sex Orient: 8 Multiple Sexual Orient: 1 Queer Sexual Orient: 2 Other Sexual Orient: 1
CCT Psychiatry (March Stats)	1-200	0.75 FTE	120		
CCT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$2,617,010		
Focus on Independence Team (FIT) (Lower level of care, only for individuals previously on FSP or CCT)	1-20 Team Lead, 1-50 Post Masters Clinical 1-30 Non-Degreed Clinical	1 Licensed Clinician 1 CHW Sp./ Non-Degreed Clinical, 1 Clinical Supervisor	88	$1,429	Clients: 92 API: 7 Black or African American: 33 Hispanic or Latino: 5 Other/Unknown: 0 White: 47 Male: 52 Female: 38 Intersex: 1 Missing Gender ID: 1 Other Gender ID: 0 Heterosexual: 80 Unknown: 6 Missing Sexual Orient: 1 Prefer Not to Answer Sexual Orient: 3 Gay: 1 Multiple Sexual Orient: 1 Questioning: 0
FIT Psychiatry (March Stats)	1-200	.25	81		
FIT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$900,451		

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Family, Youth and Children's Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Last 12 months	Fiscal Year 2023 (July '22-June '23) Demographics as of March 2023
Children's Full-Service Partnership (CFSP)	1-8	1 Senior Behavioral Health Clinician, 1 Clinician	10	$6,735	Clients: 11 American Indian: 0 API: 0 Black or African-American: 5 Hispanic or Latino: 6 Other/Unknown: 0 White: 0 Female: 4 Male: 5 Missing Gender ID: 1 Unknown: 1 Non-Conforming Gender ID: 0 Heterosexual: 6 Missing Sexual Orient: 1 Unknown: 4 Gay: 0 Other Sexual Orient: 0 Questioning Sexual Orient: 0
CFSP Psychiatry (March Stats)	1-100	0	4		
CFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$489,235		
Early and Periodic Screening, Diagnostic and Treatment Prevention (EPSDT) /Educationally Related Mental Health Services (ERMHS)	1-20	1.5 Clinicians, 1 Clinical Supervisor	43	$2,234	Clients: 59 American Indian: 6 API: 3 Black or African-American: 23 Hispanic or Latino: 12 Other/Unknown: 1 White: 14 Female: 23 Male: 22 Missing Gender ID: 5 Unknown: 4 Multiple Gender ID: 3 Non-Conforming Gender ID: 2

					Female to Male: 0 Other Gender ID: 0 Heterosexual: 24 Unknown: 20 Missing Sexual Orient: 5 Gay: 4 Multiple Sexual Orient: 3 Bisexual: 2 Prefer Not to Answer: 1 Other Sexual Orient: 0 Queer Sexual Orient: 0 Questioning Sexual Orient: 0
ERMHS/EPSDT Psychiatry (March Stats)	1-100	0	11		
EPSDT/ERMHS FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$1,062,409		
High School Health Center and Berkeley Technological Academy (HSHC)	1-6 Clinician (majority of time spent on crisis counseling)	3.5 Clinicians, 1 Clinical Supervisor	Drop-in: 17 Externally referred: 20 Ongoing tx:75 Groups: 6 Offered/ 4 Conducted		N/A
HSHC FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$396,106		

Crisis and ACCESS Services	Staff Ratio	Clinical Staff Positions Filled	Total # of Clients/Incidents	MCT Incidents Detail	Calendar Year 2022 (Jan '22- Dec '22) Demographics – From Mobile Crisis Incident Log (through March 2023)
Mobile Crisis (MCT)	N/A	2 Clinicians filled at this time	• 108 - Incidents • 21- 5150 Evals • 4 - 5150 Evals leading to involuntary transport	• 80 - Incidents: Location - Phone • 16 - Incidents: Location - Field • 5 - Incidents: Location - Home	Clients: 191 API: 7 Black or African-American: 29 White: 59 Hispanic or Latino: 5 Other/Unknown: 91 Female: 84 Male: 89 Transgender: 0 Unknown: 18
MCT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$771,623		
Transitional Outreach Team (TOT)	N/A	.5 Licensed Clinician, (TOT and CAT have been recently merged)	• 4 – Incident(s)	N/A	Clients: 15 API: 0 Black or African-American: 2 White: 8 Hispanic or Latino: 2 Other/Unknown: 3 Female: 8 Male: 5 Transgender: 0 Unknown: 2
TOT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$272,323		
Community Assessment Team (CAT)	N/A	3 Non-Licensed Clinicians, .5 Licensed Clinician, 0 Clinical Supervisor	• 118 - Incidents	N/A	Clients: 166 API: 5 Black or African-American: 31 White: 33 Hispanic or Latino: 3 Other/Unknown: 94 Female: 60 Male: 73 Transgender: 1 Unknown: 32

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CAT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)	$735,075

Not reflected in above chart is Early Childhood Consultation, Wellness and Recovery Programming, or Family Support.
In demographics, other/unknown is used both when a client indicates that they are multi-racial and when demographic info is not known.

*Average System Costs come from Yellowfin, and per ACBH include all costs to mental health programs, sub-acute residential programs, hospitals, and jail mental health costs.

Berkeley Mental Health Division-level Measures

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # of clients served (ALL) 2. # of unduplicated clients served (ALL but MCT, CAT/TOT)	3. Responsiveness of service (e.g. x days following qualifying event) (FSPs, CCT, FIT, CAT/TOT only) 4. Consistency of service (e.g. % clients who had met targeted frequency of services) (FSPs, CCT, FIT only) 5. Equity of services (e.g. client demographics compared to MediCal population) (FSPs, CCT, FIT only) 6. Customer service (% of clients who were satisfied with services) (ALL but Wellness)**	7. % of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units in the last 12 months compared to the 12 months before enrollment (FSPs, CCT, FIT only) 8. % of clients with a decrease in hospitalizations/hospitalization days (FSPs, CCT, FIT only) 9. % of clients with a decrease in incarceration days (FSPs, CCT, FIT only) 10. % clients who had a primary care visit in the last year (FSPs, CCT, FIT only) 11. % of clients who moved out of homelessness (i.e. homeless at intake, placed into housing) (ALL but MCT, CAT, and Wellness)**

*Please note: demographic data will be reported at the division level, where available

**Data not available for baseline reporting period, will include in future rounds of reporting

Data Development Agenda – measures the team is interested in reporting on but for which reliable data are not available

1. % clients who feel they received culturally/racially responsive care
2. % of clients meeting treatment goals
3. % of community members eligible for BMH services that BMH serves
4. Timeliness of service (e.g., x days following a referral)
5. # of new clients opened for ongoing services

Adult Full Service Partnership (FSP)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. Average # of days in FSP per client 4. Average # of service hours per client per month 5. Average # of services per client per month	6. % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program 7. % of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month 8. % of clients with no service gap of over 30 days 9. % of discharges from hospitalization or subacute who had a follow up visit with FSP staff within 7 and within 30 calendar days 10. #/% of clients closed, by reason closed 11. #/% of clients transferred to another level of care 12. % of clients who were satisfied with services**	13. % of clients who had a reduction in jail days in the last 12 months compared to the 12 months before enrollment 14. % of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units in the last 12 months compared to the 12 months before enrollment 15. % of clients with a decrease in hospitalizations/hospitalization days 16. % of clients with a primary care visit in the last 12 months 17. % of clients who moved out of homelessness**

*Please note: demographic data will be reported at the program level, where available

**Data not available for baseline reporting period, will include in future rounds of reporting

Data Development Agenda – measures the team is interested in reporting on but for which reliable data are not available

1. % of clients who have a billable contact with FSP staff within 7 calendar days:
    a. Following discharge (from a hospital, crisis residential or release from jail)
    b. After assignment to the team
2. Client-to-staff ratio
3. % staff retention year-to-year
4. Average # of contacts per month per client

Comprehensive Community Treatment (CCT)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. Average # of service hours per client per month 4. Average # of services per client per month	5. % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program 6. % of clients with no service gap of over 90 days 7. % of discharges from hospitalization or subacute who had a follow up visit with staff within 7 and within 30 calendar days 8. #/% of clients closed, by reason closed 9. #/% of clients transferred to another level of care 10. % of clients who were satisfied with services**	11. % of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units in the last 12 months compared to the 12 months before enrollment 12. % of clients with a decrease in hospitalizations/hospitalization days 13. % of clients who had a reduction in jail days in the last 12 months compared to the 12 months before enrollment 14. % of clients with a primary care visit in the last 12 months

*Please note: demographic data will be reported at the program level, where available

**Data not available for baseline reporting period, will include in future rounds of reporting

Data Development Agenda – measures the team is interested in reporting on but for which reliable data are not available

1. % of clients who have a billable contact with FSP staff within 7 calendar days:
   a. Following discharge (from a hospital, crisis residential or release from jail)
   b. After assignment to the team
2. % of clients who drop out of service within the first 6 months following enrollment
3. % of clients who had a decrease in days spent in psychiatric hospital settings comparing most recent 12 months in the program to the 12 months prior to enrollment
4. Average # of contacts per month per client
5. "Other" reason for client being closed
6. No-shows/missed contacts

Focus on Independence Team (FIT)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. Average # of service hours per client per month 4. Average # of services per client per month	5. % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program 6. % of clients with no service gap of over 90 days 7. % of discharges from hospitalization or subacute who had a follow up visit with staff within 7 and within 30 calendar days 8. #/% of clients closed, by reason closed 9. #/% of clients transferred to another level of care 10. % of clients who were satisfied with services**	11. % of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units in the last 12 months compared to the 12 months before enrollment 12. % of clients with a decrease in hospitalizations/hospitalization days 13. % of clients with a primary care visit in the last 12 months

*Please note: demographic data will be reported at the program level, where available

**Data not available for baseline reporting period, will include in future rounds of reporting

Data Development Agenda – measures the team is interested in reporting on but for which reliable data are not available

1. % of appointments kept by clients
2. % of clients who engage in leisure activities
3. Average # of contacts per month per client
4. "Other" reason for client being closed
5. No-shows/missed contacts

High School Health Center (HSHC)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. # of services provided by service type	4. % clients screened for depression, trauma, and substance use 5. % clients contacted within a week following a referral to the HSHC 6. % of school population served 7. % of clients satisfied with services, as measured by % of clients who agree with the following: HSHC staff… a. Treat me with respect b. Listen carefully to what I have to say c. Make me feel like there's an adult at school who cares about me	8. % of clients able to receive needed care, as measured by % of clients who agree with the following: The HSHC… a. Is easy to get help from when I need it b. Helps me to meet many of my health needs

*Please note: demographic data will be reported at the program level, where available

Data Development Agenda – measures the team is interested in reporting on but for which reliable data are not available

1. Responsiveness of service (e.g. x days following qualifying event)
2. % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program

Educationally Related Mental Health Services (ERMHS)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. # of individual therapy hours provided 4. # of collateral hours per client	5. % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program 6. % of clients with at least one session per month** 7. % of clients who had collateral sessions 8. % of clients who were satisfied with services**	9. Of clients who were discharged from the program, #/% who met mental health goals

*Please note: demographic data will be reported at the program level, where available

**Data not available for baseline reporting period, will include in future rounds of reporting

Data Development Agenda – measures the team is interested in reporting on but for which reliable data are not available

1. #/% of IEP meetings clinicians attended per client - Unavailable currently, as there is no code exclusively for IEP meetings.
2. Disaggregate data by BUSD school
3. Responsiveness of service (e.g. x days following qualifying event)
4. % of clients with no gap in therapy sessions over 21 days

Early and Periodic Screening Diagnosis and Treatment (EPSDT)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. # of individual therapy hours provided 4. # of collateral hours per client	5. % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program 6. % of clients with at least three sessions per month** 7. % of clients who had collateral sessions 8. % of clients or family members who participate in the survey**	9. Of clients who were discharged from the program, #/% who met mental health goals

*Please note: demographic data will be reported at the program level, where available

**Data not available for baseline reporting period, will include in future rounds of reporting

Data Development Agenda – measures the team is interested in reporting on but for which reliable data are not available

1. % of clients who receive two or more visits within 30 days of their episode opening date
2. % of clients who receive four or more visits within 60 days of their episode opening date
3. Responsiveness of service (e.g. x days following qualifying event)
4. % of clients with no gap in therapy sessions over 21 days

Children's Full Service Partnership (CFSP)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. Average # of days in FSP per client 4. Average # of service hours per client per month 5. Average # of services per client per month	6. % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program 7. % of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month 8. % of discharges from hospitalization or subacute who had a follow up visit with CFSP staff within 7 business days 9. % of clients with no service gap of over 30 days 10. #/% of clients closed, by reason closed 11. % of clients or family members who participate in the survey**	12. % of clients with a primary care visit in the last 12 months 13. % of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units in the last 12 months compared to the 12 months before enrollment** 14. % of clients with a decrease in hospitalizations/hospitalization days

*Please note: demographic data will be reported at the program level, where available

**Data not available for baseline reporting period, will include in future rounds of reporting

<u>Data Development Agenda</u> – measures the team is interested in reporting on but for which reliable data are not available

1. Spending: # of Flex Funds spent on a family per year, based on tenure in program
2. Service provision: % of clients who received unscheduled service contacts due to low engagement or necessity/acuity of family needs
3. Staff training:
    a. % of staff trained in WRAP
    b. % of staff who are skilled to implement trauma-informed interventions
4. Staff satisfaction: % of staff who report that they have the tools/resources necessary to do their jobs

5. Client satisfaction, specifically in regards to measuring racially responsive care
    a. #/% of clients/families who report high quality, racially responsive care on the annual Consumer Perception Survey
6. Client/family outcomes:
    a. # of clients/families who can navigate systems better to address their needs
    b. # of clients with improved school attendance and increased engagement in class/school
    c. % of clients with improved family relations (communication and stability, problem solving, support)
7. Client-to-staff ratio
8. % staff retention year-to-year
9. % of clients who schedule a meeting with FSP team within 14 calendar days of referral
10. % of clients who are referred to other primary services (therapy, TBS, etc.,) within 5 calendar days of agreement in a family team or a provider meeting
11. % of new clients who receive a face-to-face visit within 7 calendar days of the episode opening date
12. % of clients/families discharged from services within 9-12 months because of improved life circumstances

Mobile Crisis Team (MCT)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of client contacts made, by a. Field contacts b. Phone contacts 3. # of crisis services referrals made to the MCT, by referring party (i.e. BPD, BFD, BMH, community, etc.) 4. # of 5150 evaluations conducted	5. % of 5150 evaluations that did not result in transportation to a receiving facility for further evaluation 6. % of clients who were satisfied with services**	7. #/% of repeat interventions

*Please note: demographic data will be reported at the program level, where available

**Data not available for baseline reporting period, will include in future rounds of reporting

Data Development Agenda – measures the team is interested in reporting on but for which reliable data are not available

1. Response times: average response time, by call type
2. Receiving facilities data:
    a. #/% evaluations upheld at receiving facility

Crisis Assessment and Triage/Transitional Outreach Team (CAT/TOT)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of documented contacts	3. % of clients who receive a visit (phone contact with client or hospital service provider) in the 24 hours after hospitalization 4. % of MCT contacts who had a CAT attempt to contact 5. % of clients who were satisfied with services**	None available at this time**

*Please note: demographic data will be reported at the program level, where available

**Data not available for baseline reporting period, will include in future rounds of reporting

Data Development Agenda – measures the team is interested in reporting on but for which reliable data are not available

1. #/% of calls to CAT line that receive crisis intervention support that does not involve the police: crisis referral to non-MCT, crisis support, de-escalation support
2. % of clients who receive a follow-up call for a no-show screening, intake or appointment
3. #/% of no-show clients for whom there is inter-system coordination to engage
4. #/% of clients and families who receive connection to grief counseling and other services
5. % of clients connected to a service team within 7 calendar days
6. % of clients assessed or referred on the same day as inquiry

Homeless FSP (HFSP)

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served 2. # of new clients opened for ongoing services 3. Average # of days in FSP per client 4. Average # of service hours per client per month 5. Average # of services per client per month	6. % of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program 7. % of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month 8. % of discharges from hospitalization who had a follow up visit with HFSP staff within 7 and within 30 calendar days 9. % of clients with no service gap of over 30 days 10. #/% of clients closed, by reason closed 11. % of clients who were satisfied with services**	12. #/% of clients housed** 13. #/% of clients who gained or maintained housing since enrollment** 14. % of clients who had a reduction in jail days in the last 12 months compared to the 12 months before enrollment 15. % of clients with a primary care visit in the last 12 months 16. % of clients who had a reduction in psychiatric emergency services/inpatient/crisis stabilization units in the last 12 months compared to the 12 months before enrollment 17. % of clients with a decrease in hospitalizations/hospitalization days 18. % of clients with an increase in the number of days in community living compared to 12-month period before enrollment**

*Please note: demographic data will be reported at the program level, where available

**Data not available for baseline reporting period, will include in future rounds of reporting

Data Development Agenda – measures the team is interested in reporting on but for which reliable data are not available

1. Client satisfaction with services
2. Client engagement in interpersonal activities

3. Client income (incl. entitlements)
4. Change in violence (e.g. # of violent interactions reported) experienced by the client
5. Change in educational or workforce training status of client
6. Client-to-staff ratio
7. % staff retention year-to-year
8. % of clients and/or their caregivers who have consented to participate in services and have received one or more face-to-face visits within 7 calendar days of their HFSP referral
9. #/% of clients who maintained housing at 6 months from housing placement date

Medical Services

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # clients served	2. % of appointments kept per year	3. % clients connected to a primary care provider

*Please note: demographic data will be reported at the program level, where available

Data Development Agenda – measures the team is interested in reporting on but for which reliable data are not available

1. Average service hours per patient per year, with a demographic breakdown and adjusted for client panel
2. #/% of patients who report improvement in their quality of life
3. Reduction in number of hospitalization days per patient
4. Consistency of service (e.g. % clients who had met targeted frequency of services)
5. Responsiveness of service (e.g. x days following qualifying event)
6. % clients who had a primary care visit in the last year
7. # of new clients opened for ongoing services
8. % of clients who had a meeting with a psychiatrist every x months
9. % decrease of days incarcerated per client
10. % decrease of incarceration events per client
11. #/% of clients re-hospitalized within 1 month of inpatient discharge

Wellness Services

Process Measures How much did we do?	Quality Measures How well did we do it?	Impact Measures Is anyone better off?
1. # participants served 2. # of different groups convened per year 3. # of group events held per year 4. # of participants who meet the requirements for "Telling Your Story" *(MHSA PEI requirement)*	5. #/% of participants who return for group events	6. #/% of participants who reported feeling less shame about their experiences and challenges 7. #/% of participants who reported recognizing progress in their recovery

Data Development Agenda – measures the team is interested in reporting on but for which reliable data are not available

1. Advance directives data:
    a. #/% of participants with an advance directive completed
    b. #/% participants able to advocate for themselves with service providers
2. Equity of services (e.g. client demographics compared to MediCal population)
3. % of clients who were satisfied with services

BMH RBA Report FY 2022

Adult Full Service Partnership (FSP)

Reporting Period: July 2021-June 2022 (Baseline)

Process Outcomes ("How much did we do?")

75

Clients Served

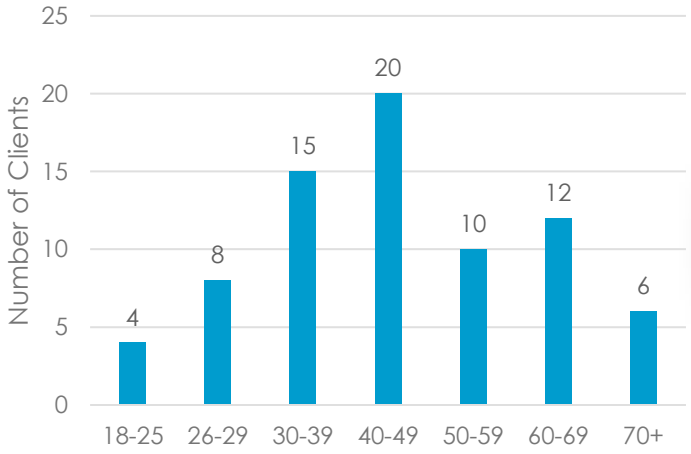
11

New Clients

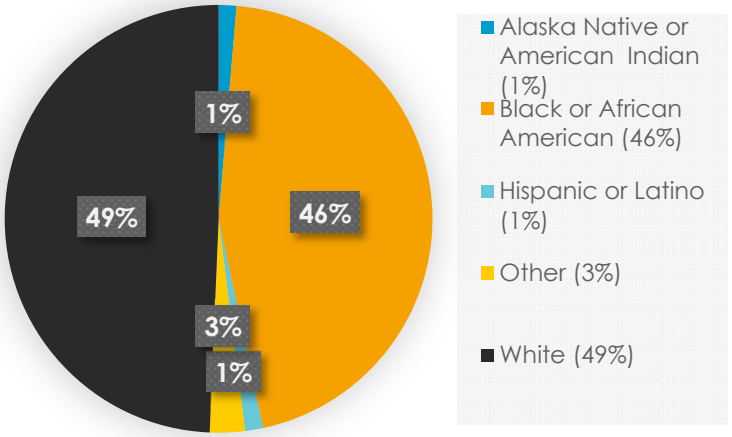
represents 10 clients

Program Description: The Full-Service Partnership (FSP) team provides services to clients who are considered the highest need within our adult mental health service system. The FSP team is based on an Assertive Community Treatment Model which involves low staff-to-client ratios at approximately 10:1 and a focus on providing care as a team rather than individual case load assignments. Services are primarily provided in the community rather than in an office setting.

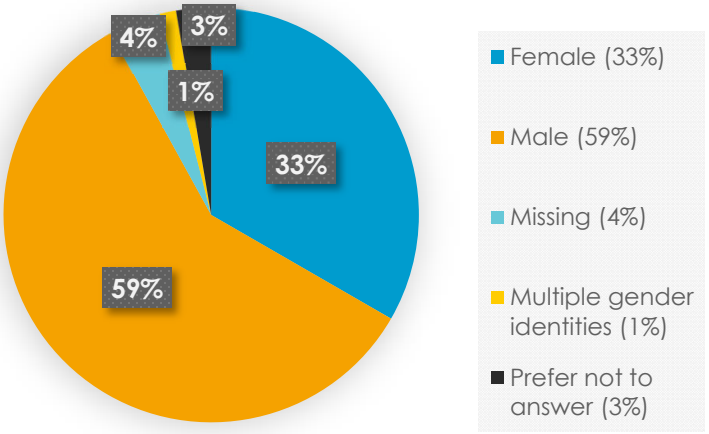
Demographics (Age)



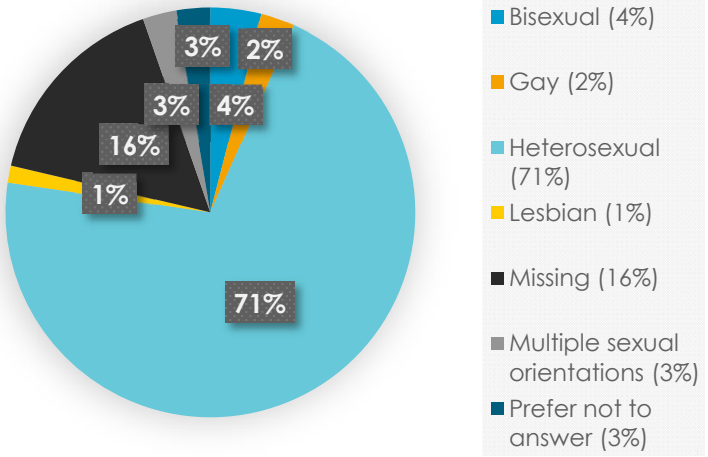
Demographics (Race)



Demographics (Gender Identity)



Demographics (Sexual Orientation)



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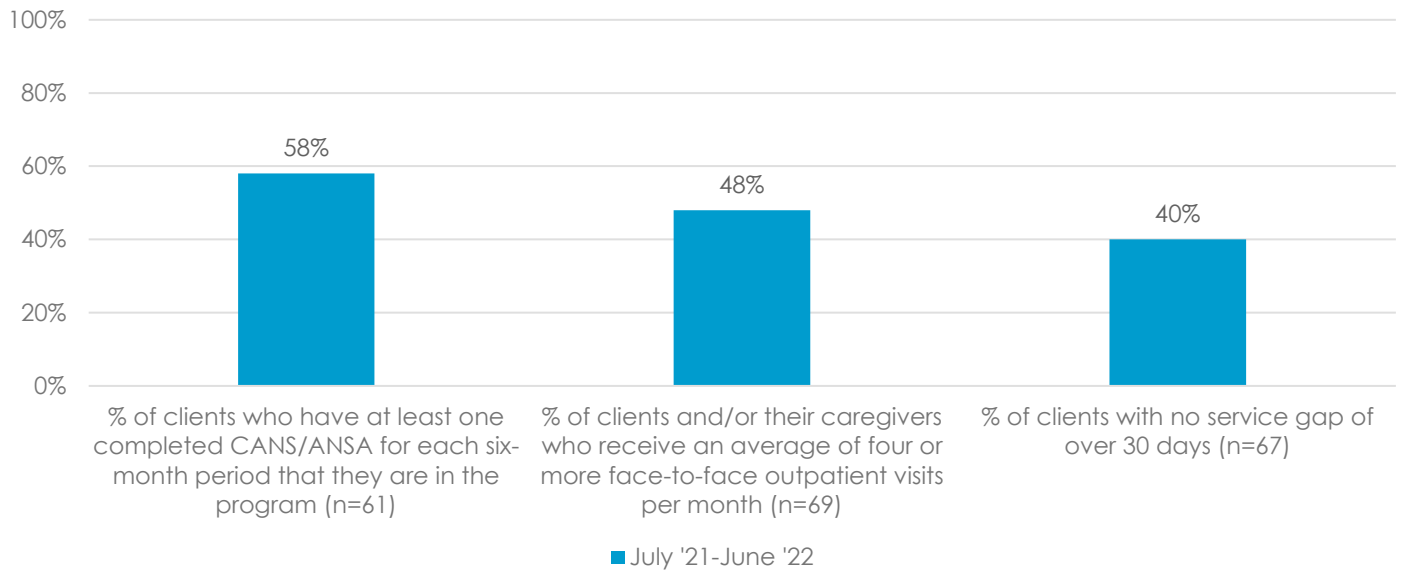
The average client served in 2021-2022:

- remained in the FSP program for **1,231 days**
- received **5.17 hrs** of services per month
- received **4.53 services** per month

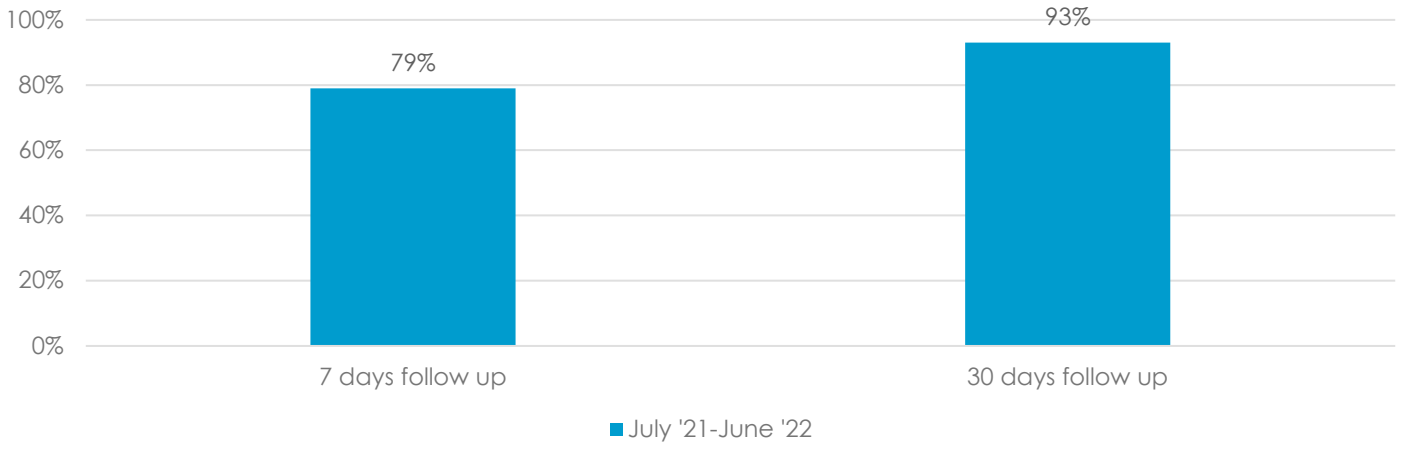
Quality Outcomes ("How well did we do it?")

Service Consistency



Hospital Follow Up Consistency

% of discharges from hospitalization or subacute who received FSP follow up within 7 and 30 days (n=28)



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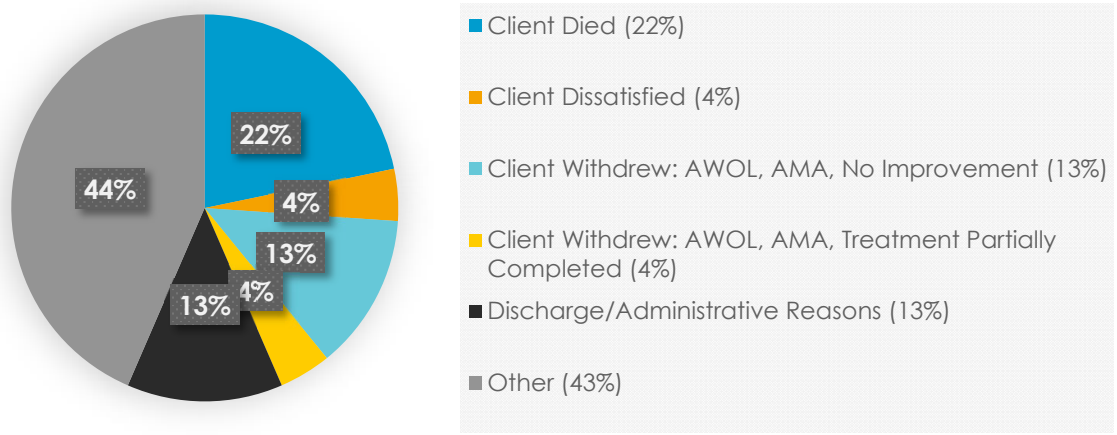
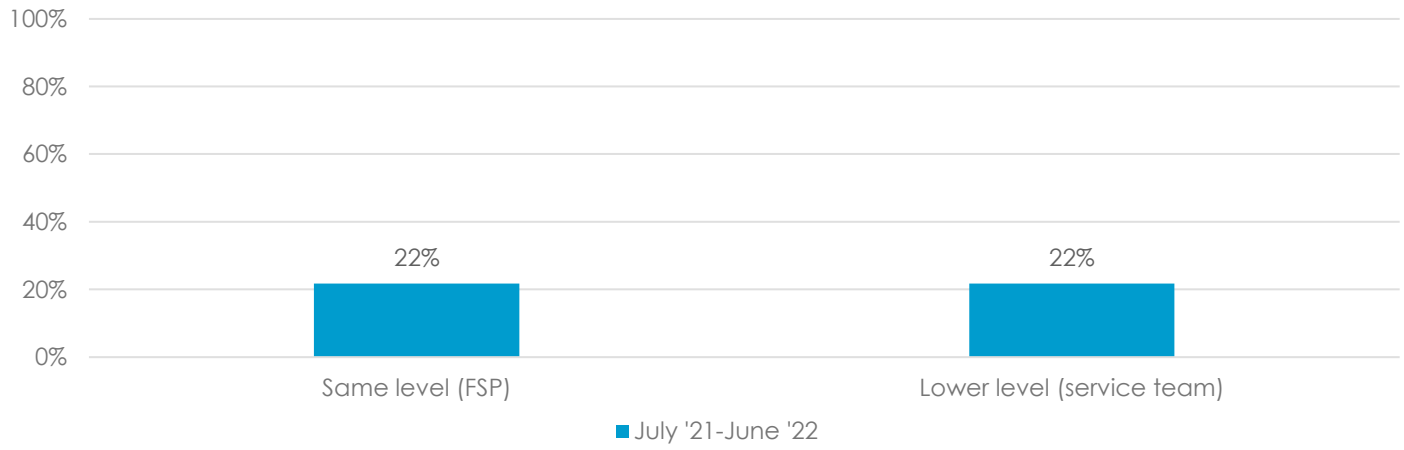
Clients Closed by Reason Closed (n=23)



Clients Transferred to Another Program, by Level of Care (n=23)



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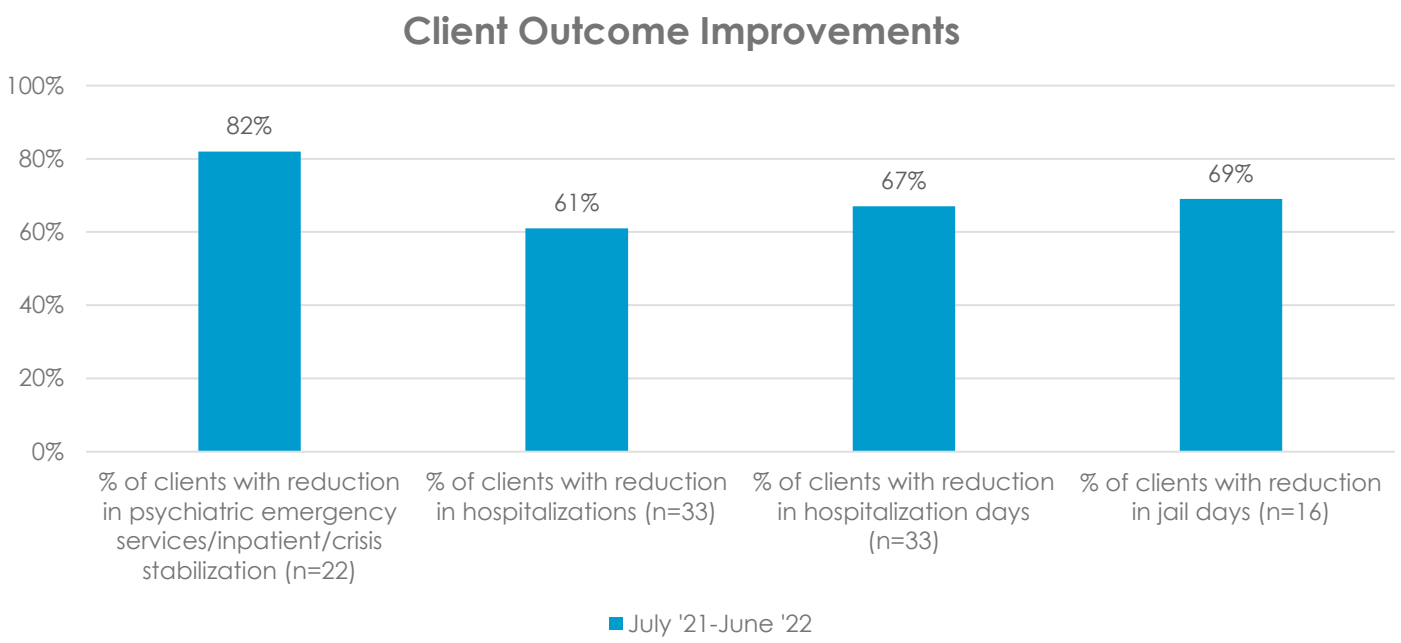
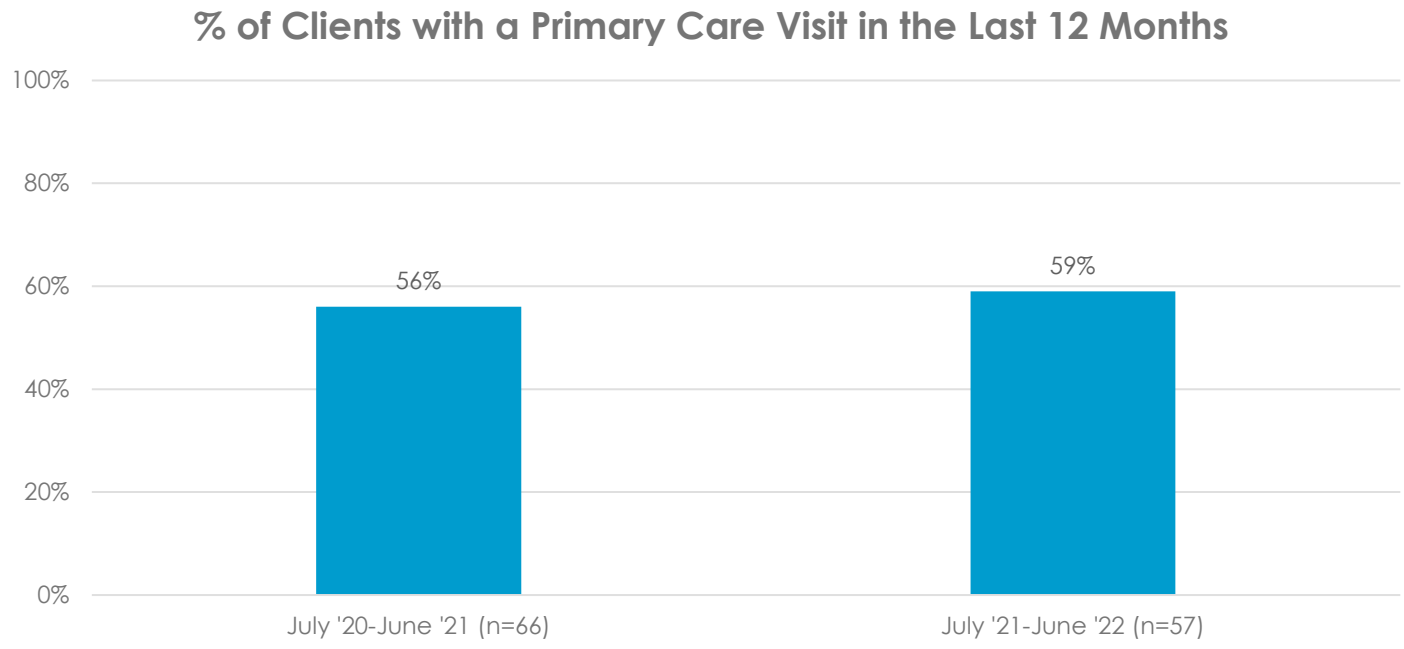
Impact Outcomes ("Is anyone better off?")





BMH RBA Report FY 2022

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of days in FSP per client	Average length of stay for primary program episodes which have closed since the beginning of the reporting period	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include MAA	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program	Of clients with a completed CANS/ANSA, what percentage of them had an assessment at least every six months?	Objective Arts
% of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month	Clients must be been open to a provider for at least 30 days in order to be included in this metric. Phone contacts are included during the pandemic. Days in subacute or jail not counted, but services are counted.	Yellowfin
% of clients with no service gap of over 30 days	Maximum days each Level 1 client went without service during their episode(s) in the reporting period. Only considered clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with FSP staff within 7 and within 30 calendar days	Follow-up rates for individuals open to Level 1 providers at the time of MH hospital discharge.	Yellowfin

BMH RBA Report FY 2022

#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin
# of clients transferred to another program, by level of care	Of clients discharged in the reporting period, # who were transferred to a full service partnership program, service team, or outpatient services in Alameda County within 90 days of discharge.	Yellowfin
% of clients who had a reduction in days in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a decrease in hospitalization	Decrease in hospital admits and hospitalization days in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital admit in the 12 months prior to admission and remained in the program for at least 1 year	Yellowfin
% of clients who had a reduction in jail days	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a primary care visit in the last 12 months	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/CHCN primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin

BMH RBA Report FY 2022

Crisis, Assessment, Triage (CAT) and Transitional Outreach Team (TOT)

Reporting Period: July 2021-June 2022 (Baseline)

Process Outcomes ("How much did we do?")

721 Clients Served

=100 clients

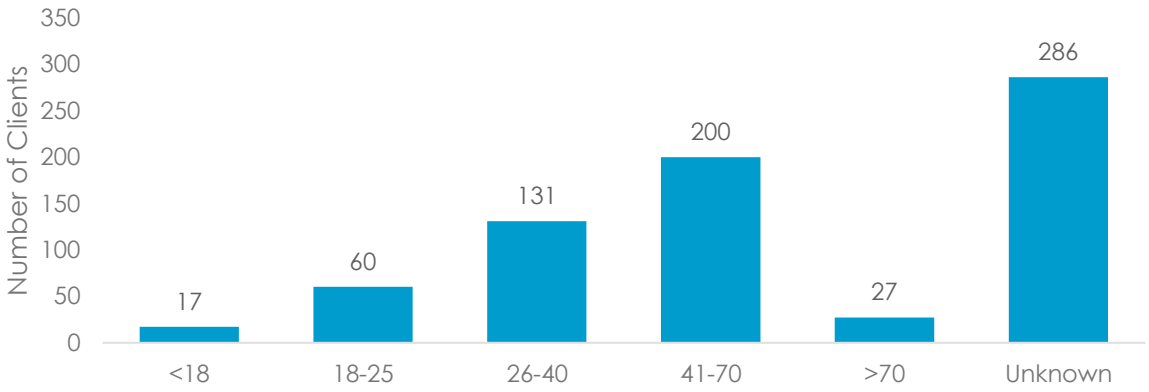
1448 Contacts

=100 contacts

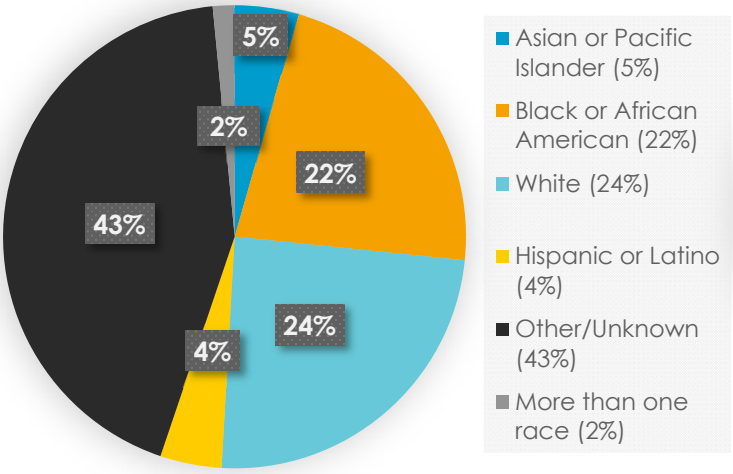
Program Description

CAT/TOT is BMH's intake and follow-up team for Adult Mental Health Services. This team provides screening/assessment for ongoing mental health services, linkage to community-based resources, crisis support, and coordination with other agencies. Services include, but are not limited to: psychiatric services, transportation, food access, medical care, health insurance, benefits, legal assistance, affordable housing listings, utilities and energy assistance resources. Services are provided in person at our clinic, as well as via the team phone line.

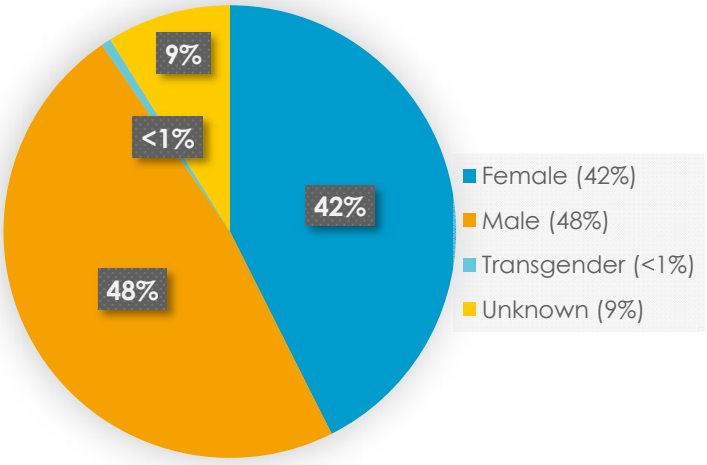
Demographics (Age)



Demographics (Race)



Demographics (Gender Identity)

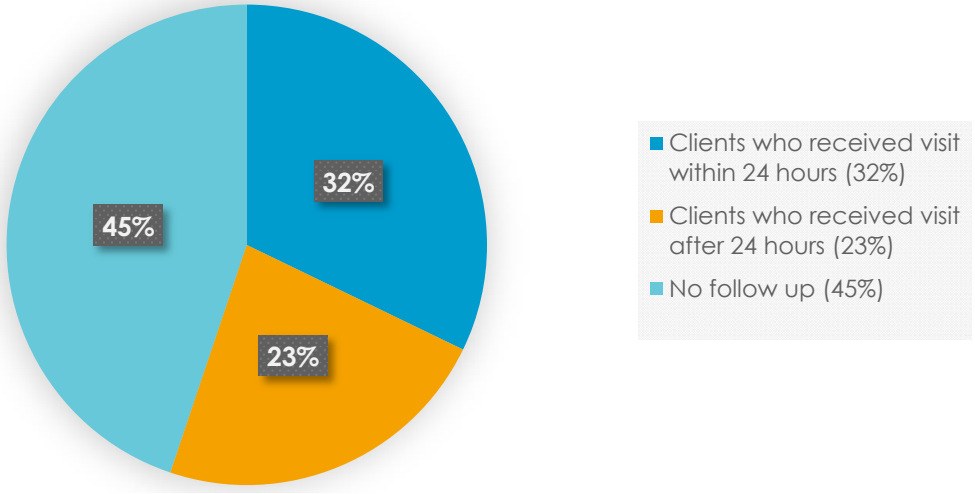


*Sexual Orientation data not available

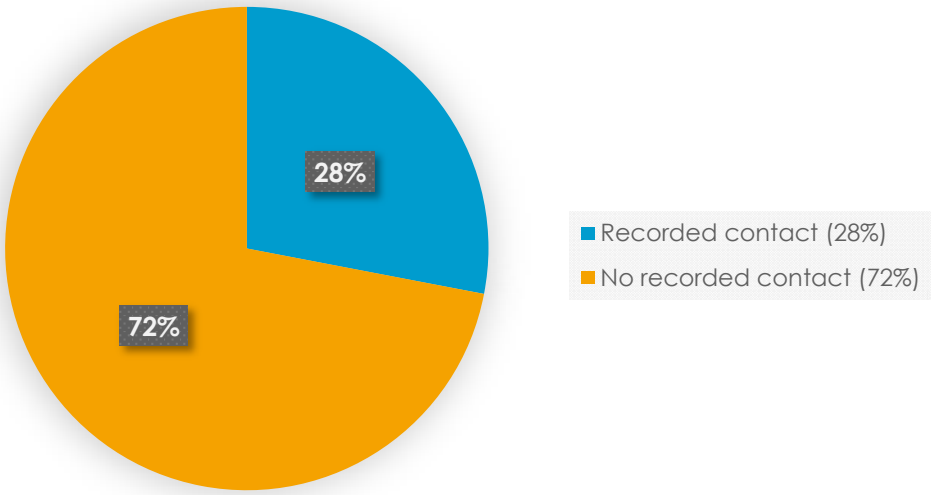
BMH RBA Report FY 2022

Quality Outcomes ("How well did we do it?")

Follow-up after hospitalization (n=87)



MCT contacts with CAT attempt to contact (n=932)



BMH RBA Report FY 2022

Measure	Definition	Data Source
# clients served	Total clients served	MCT & CAT Contact Log
# of documented contacts	Total number of documented incidents	MCT & CAT Contact Log
Follow-up after hospitalization	% of clients who receive a visit (phone contact with client or hospital service provider) in the 24 hours after hospitalization	MCT & CAT Contact Log
% of MCT contacts who had a CAT attempt to contact	Of Client IDs in MCT contact log, % which also have record in CAT contact log	MCT & CAT Contact Log

BMH RBA Report FY 2022

Comprehensive Community Treatment Team (CCT)

Reporting Period: July 2021-June 2022 (Baseline)

Process Outcomes ("How much did we do?")

198

Clients Served

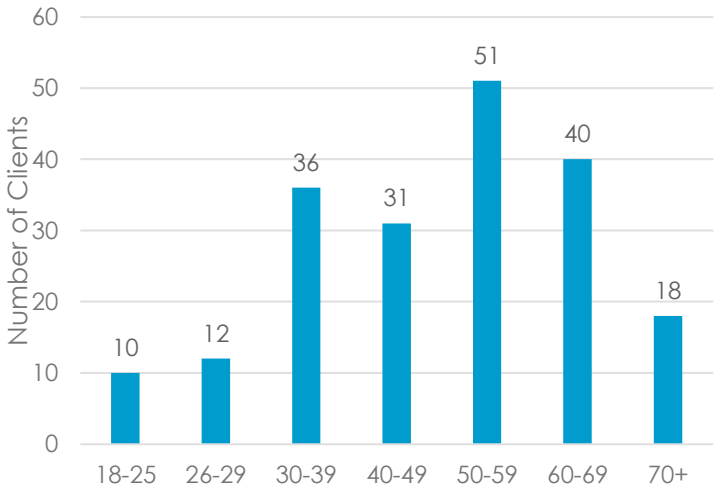
12

New Clients

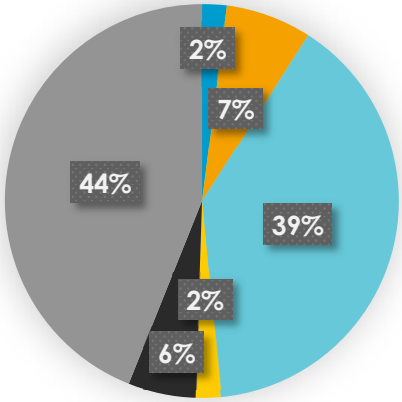
Program Description: The CCT team is responsible for providing services to adults with severe and persistent mental illness who require specialty mental health services. Staff provide case management, therapeutic services, and group services both in the field and in the clinic.

represents 10 clients

Demographics (Age)

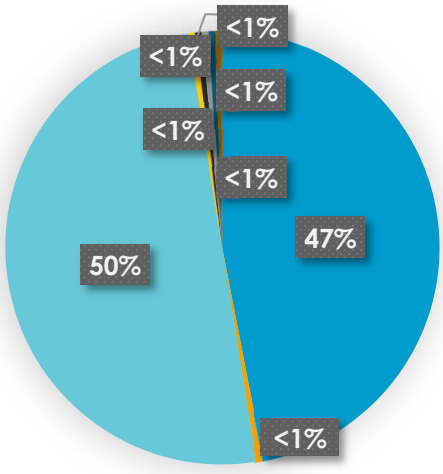


Demographics (Race)



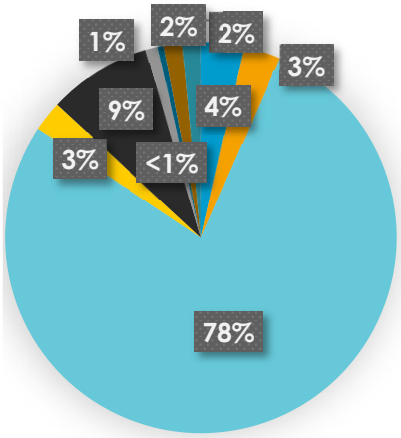
- Alaska Native or American Indian (2%)
- Asian or Pacific Islander (7%)
- Black or African American (39%)
- Hispanic or Latino (2%)
- Other (6%)
- White (44%)

Demographics (Gender Identity)



- Female (47%)
- Female to Male (<1 %)
- Male (50%)
- Missing (<1%)
- Multiple gender identities (<1%)
- Non-conforming (<1%)
- Other (<1%)
- Prefer not to answer (<1%)

Demographics (Sexual Orientation)



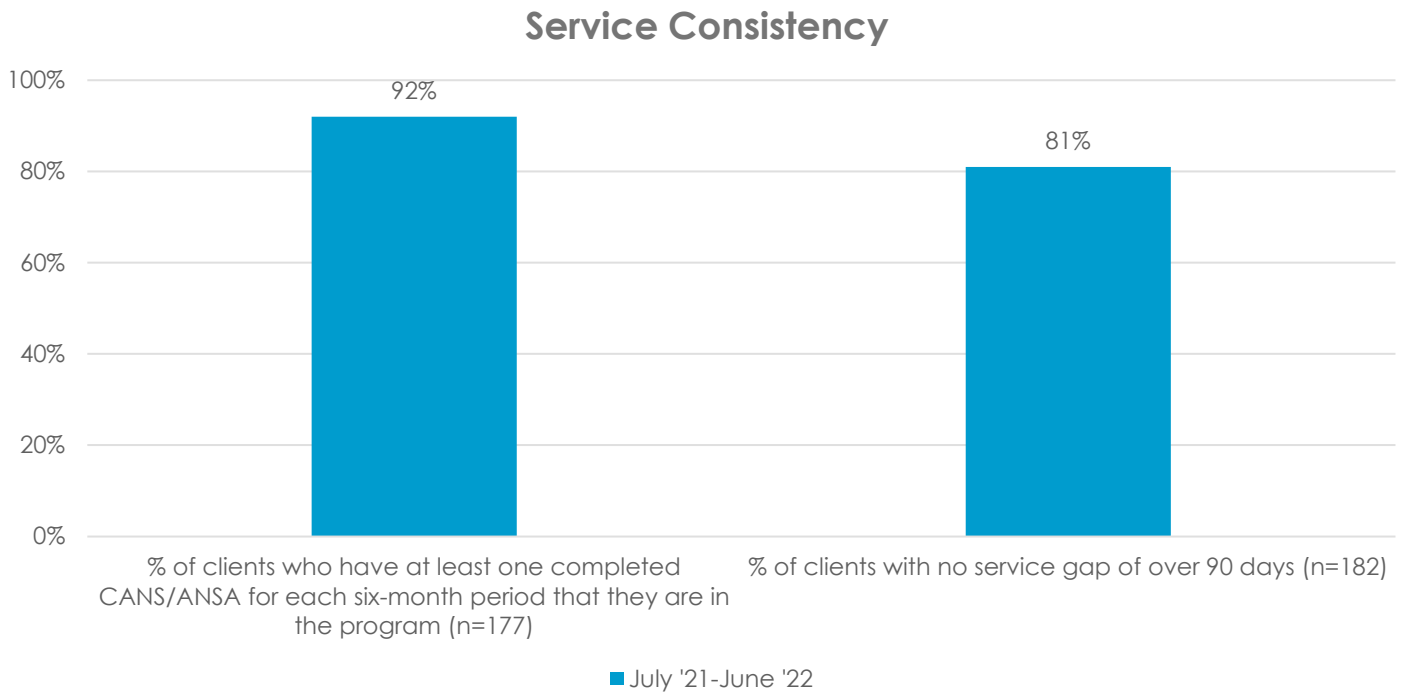
- Bisexual (4%)
- Gay (3%)
- Heterosexual (78%)
- Lesbian (3%)
- Missing (9%)
- Multiple sexual orientations (1%)
- Other (<1%)
- Prefer not to answer (2%)
- Queer (2%)

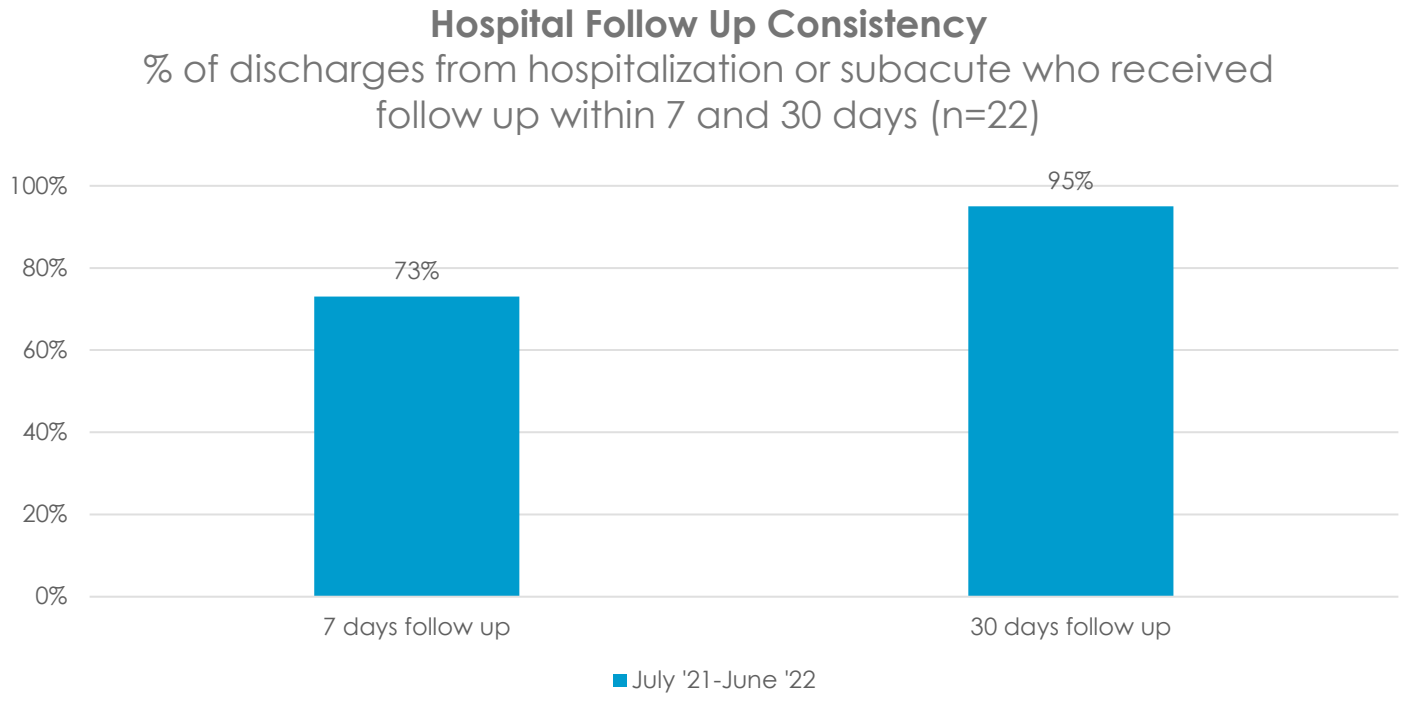
BMH RBA Report FY 2022

The average client served in 2021-2022 received:

- received **3.3 hrs** of services per month
- received **3.3 services** per month

Quality Outcomes ("How well did we do it?")





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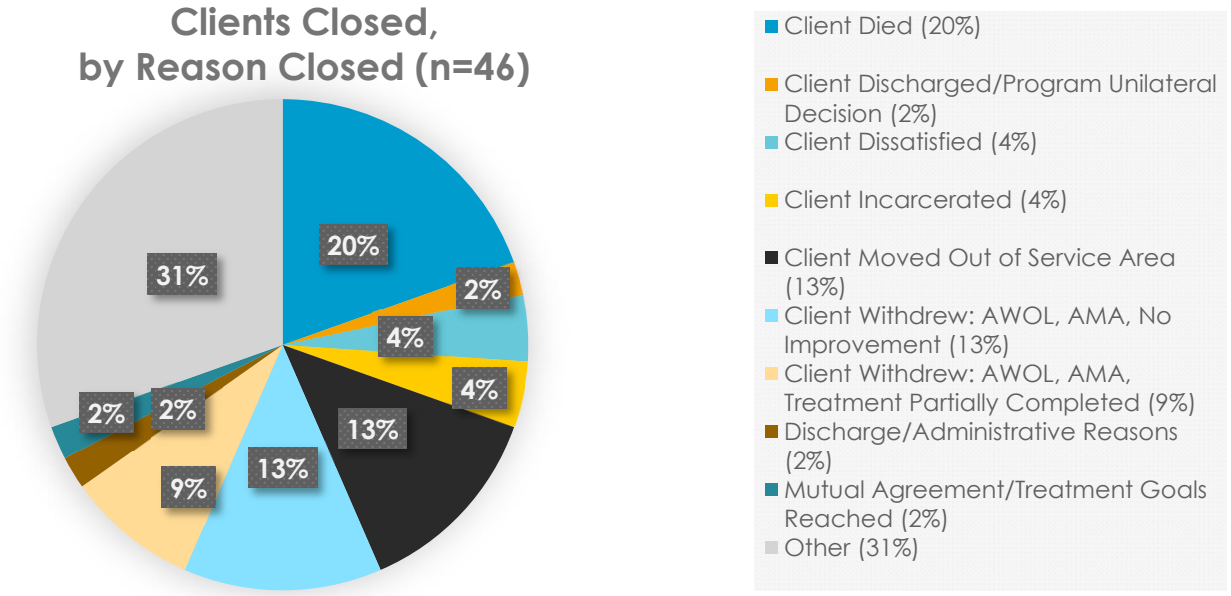

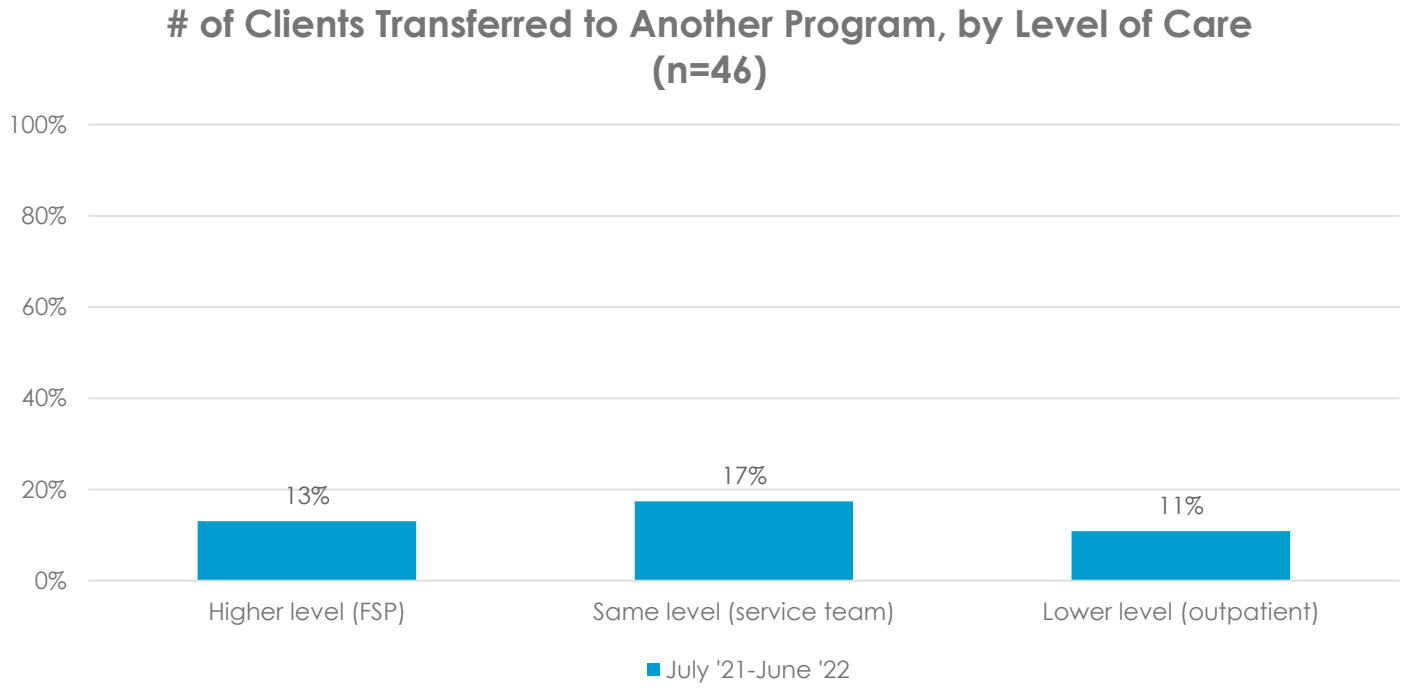

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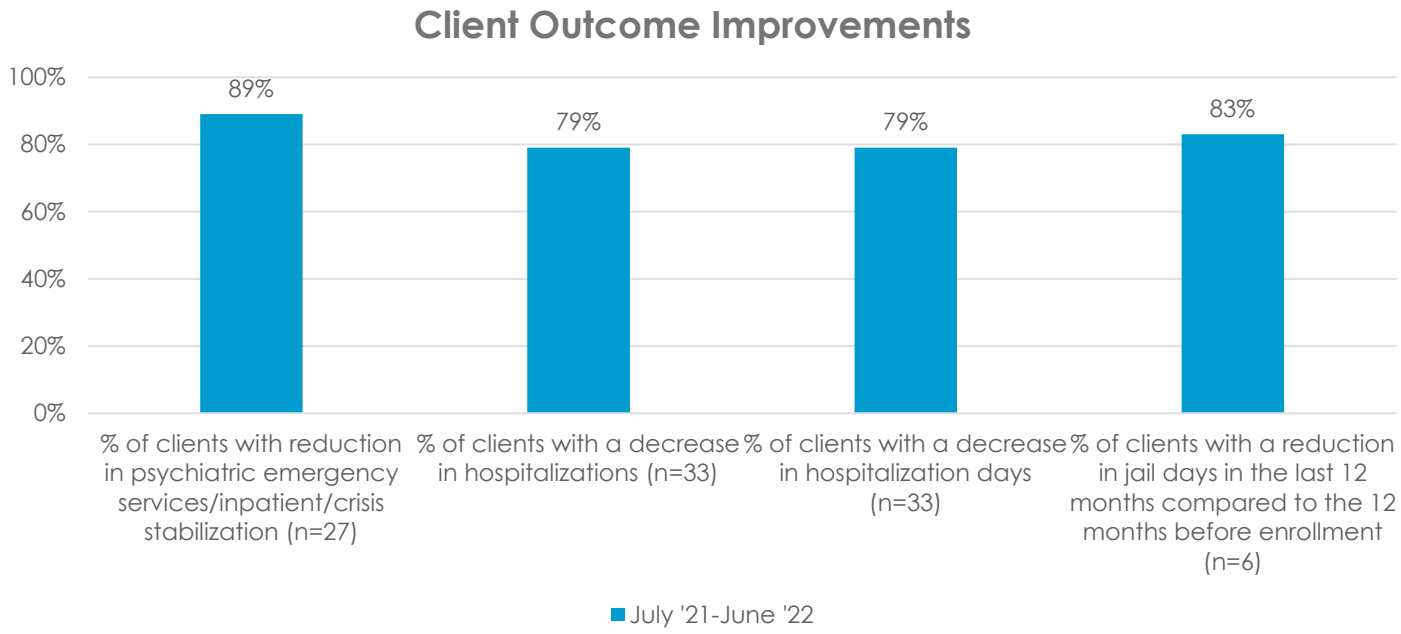
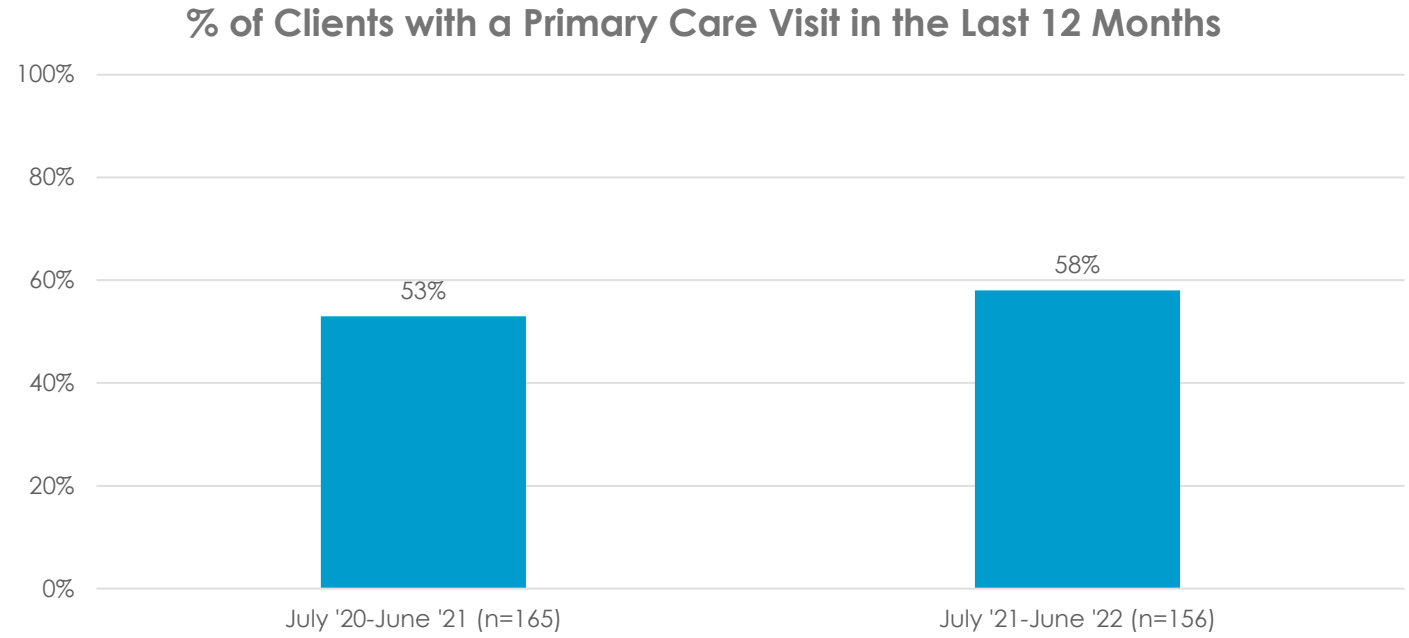
Impact Outcomes ("Is anyone better off?")





BMH RBA Report FY 2022

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients opened for ongoing services	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include MAA	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program (n=177)	Of clients with a completed CANS/ANSA, what percentage of them had an assessment at least every six months?	Objective Arts
% of clients with no service gap of over 90 days (n=182)	% of clients with less than 90 days maximum without service during their episode(s) in the fiscal year. Only includes clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with staff within 7 and within 30 calendar days (n=22)	Follow-up rates for individuals open to Level 1 providers at the time of MH hospital discharge.	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin
# of clients transferred to another program, by level of care	Of clients discharged in the reporting period, # who were transferred to a full service partnership program, service team, or outpatient services in Alameda County within 90 days of discharge	Yellowfin

BMH RBA Report FY 2022

% of clients who had a reduction in days in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a decrease in hospitalization	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year	Yellowfin
% of clients with a reduction in jail days in the last 12 months compared to the 12 months before enrollment (n=6)	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% increase in number of clients with connection to primary care compared to the last 12 months (FY22 n=156, FY21 n=165)	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/CHCN primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin

BMH RBA Report FY 2022

Child Full Service Partnership (FSP)

Reporting Period: July 2021-June 2022 (Baseline)

Process Outcomes ("How much did we do?")

14

Clients Served

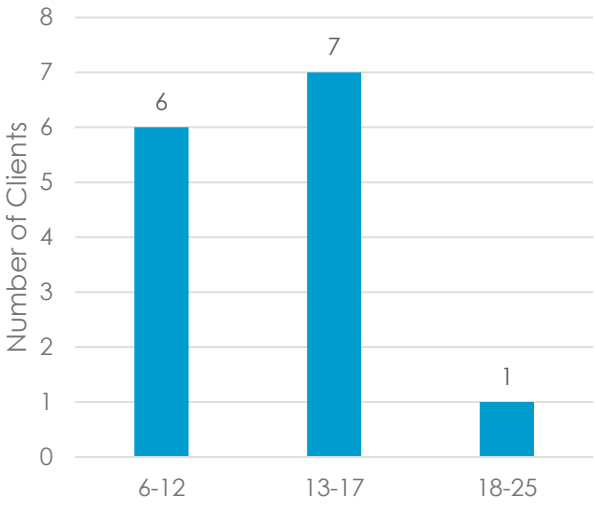
7

New Clients

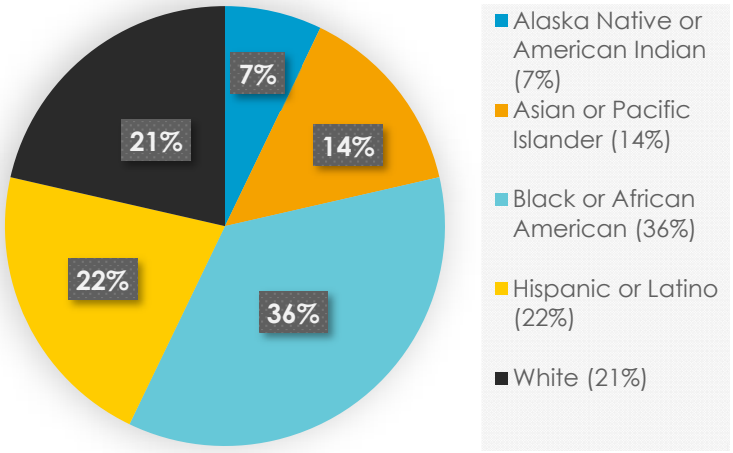
represents 5 clients

Program Description: This team provides wrap around services to children and families with acute needs, who meet the following criteria: child is at risk of/has been removed from their parent/guardian; child is involved with the Juvenile Justice System or at risk of that; has been recently had a psychiatric hospitalization or is at risk of a hospitalization.

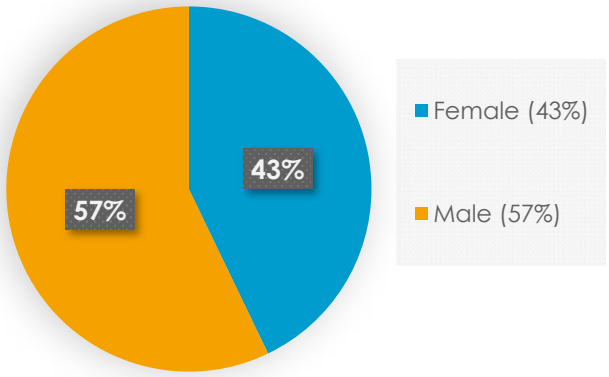
Client Demographics (Age)



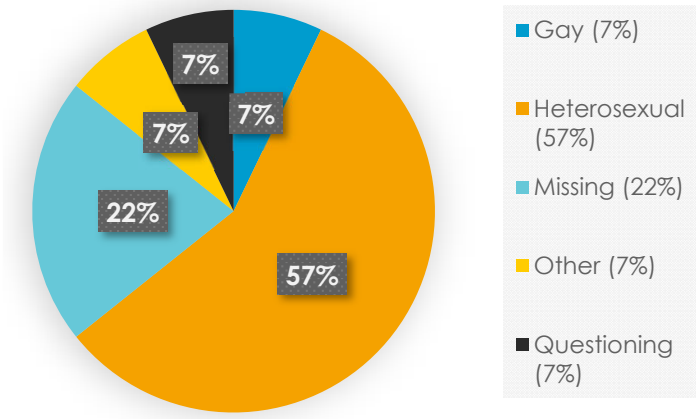
Client Demographics (Race)



Client Demographics (Gender Identity)



Client Demographics (Sexual Orientation)



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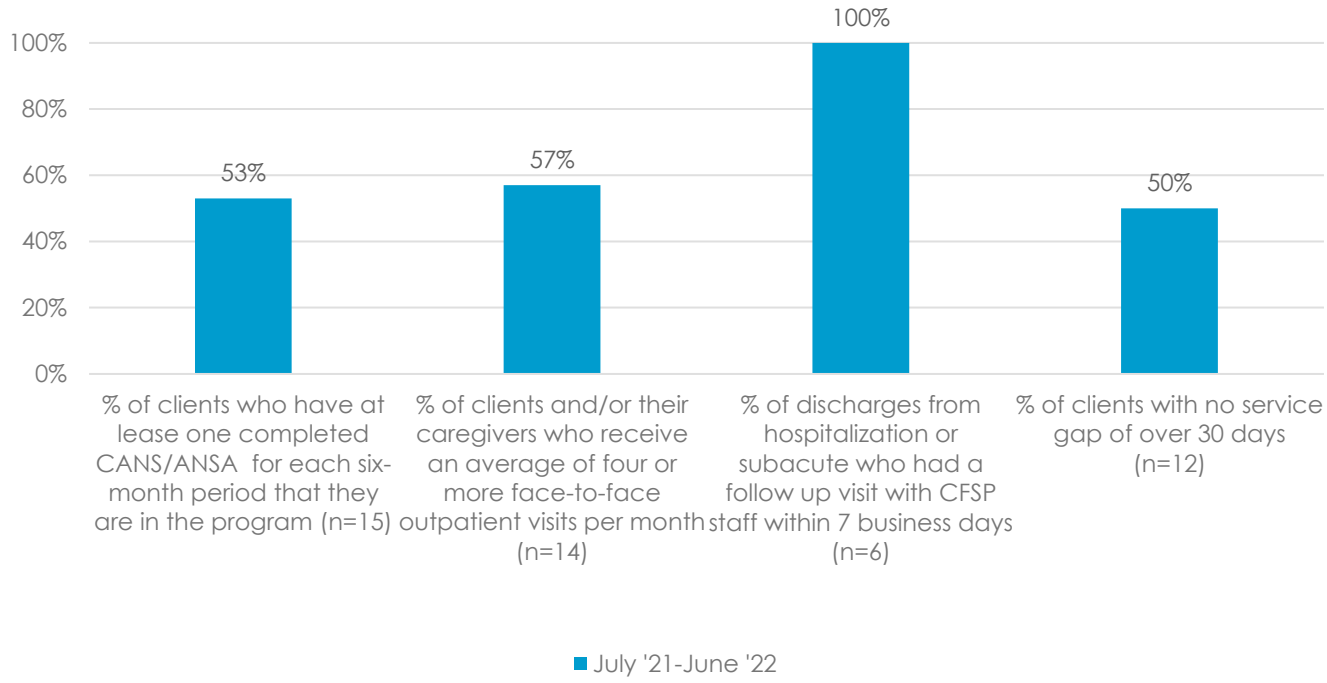
Quality Outcomes ("How well did we do it?")

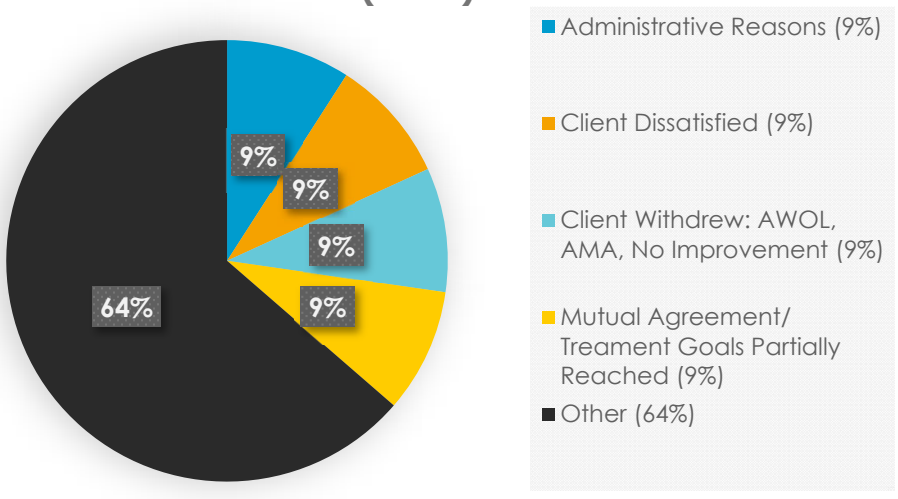
The average client served in 2021-2022:

- remained in the FSP program for **336 days**
- received **10.22 hrs** of services per month
- received **6.88 services** per month

Service Consistency

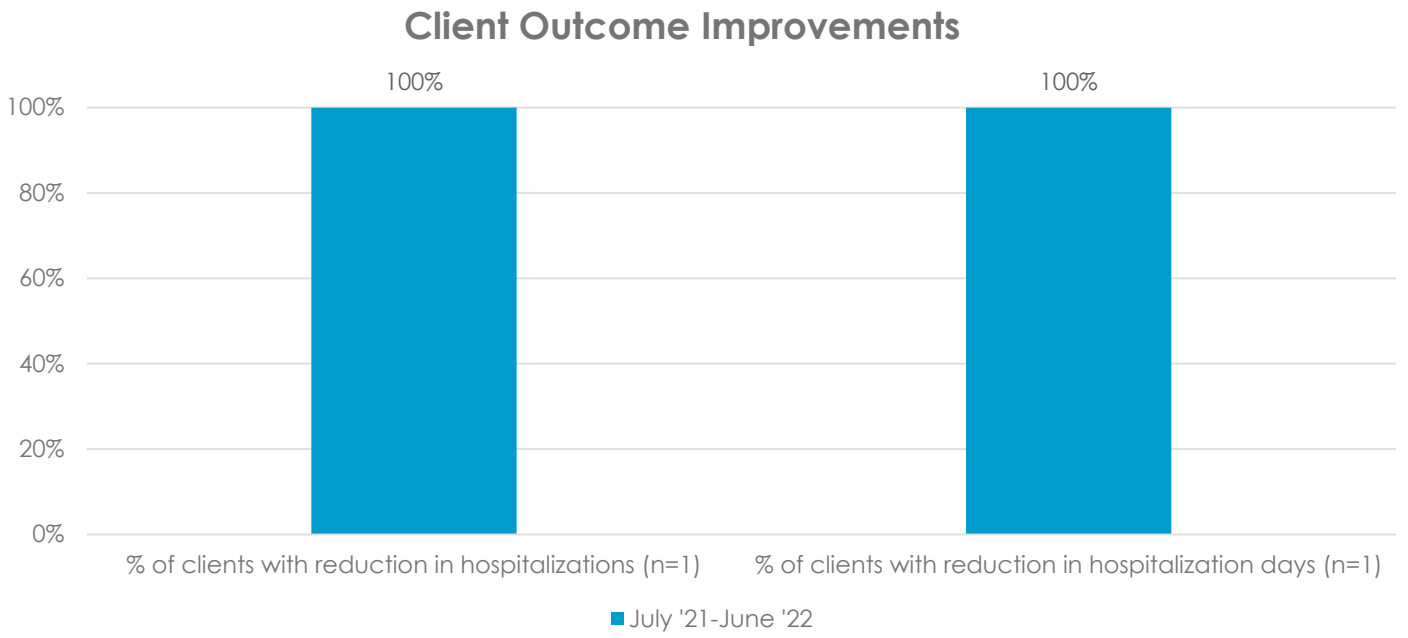


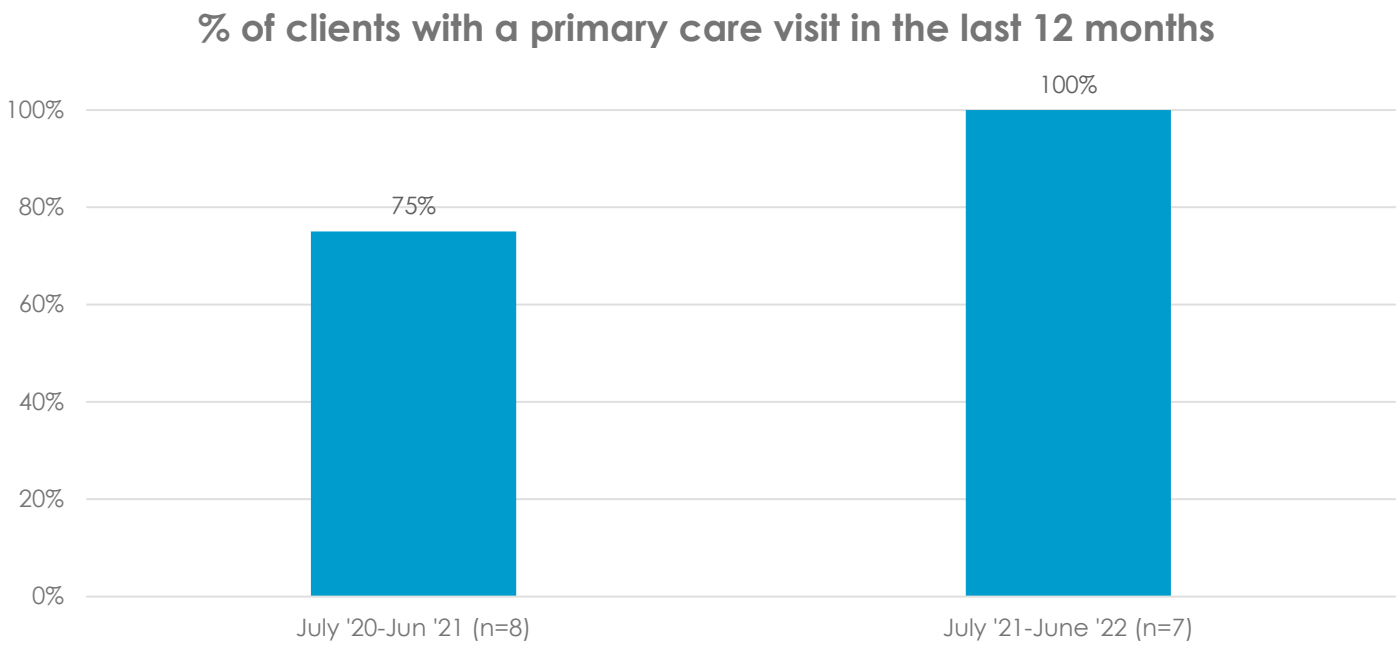
Clients Closed, by Reason Closed (n=11)



BMH RBA Report FY 2022

Impact Outcomes ("Is anyone better off?")





BMH RBA Report FY 2022

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of days in FSP per client	Average length of stay for primary program episodes which have closed since the beginning of the reporting period	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include MAA	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program	Of clients with a completed CANS/ANSA, what percentage of them had an assessment at least every six months?	Objective Arts
% of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month	Clients must be been open to a provider for at least 30 days in order to be included in this metric. Phone contacts are included during the pandemic. Days in subacute or jail not counted, but services are counted.	Yellowfin
% of clients with no service gap of over 30 days	Maximum days each Level 1 client went without service during their episode(s) in the reporting period. Only considered clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with FSP staff within 7 business days	Follow-up rates for individuals open to Level 1 providers at the time of MH hospital discharge.	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin

% of clients with a decrease in hospitalization	Decrease in hospital admits and hospitalization days in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital admit in the 12 months prior to admission and remained in the program for at least 1 year	Yellowfin
% of clients with a primary care visit in the last 12 months	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/CHCN primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin

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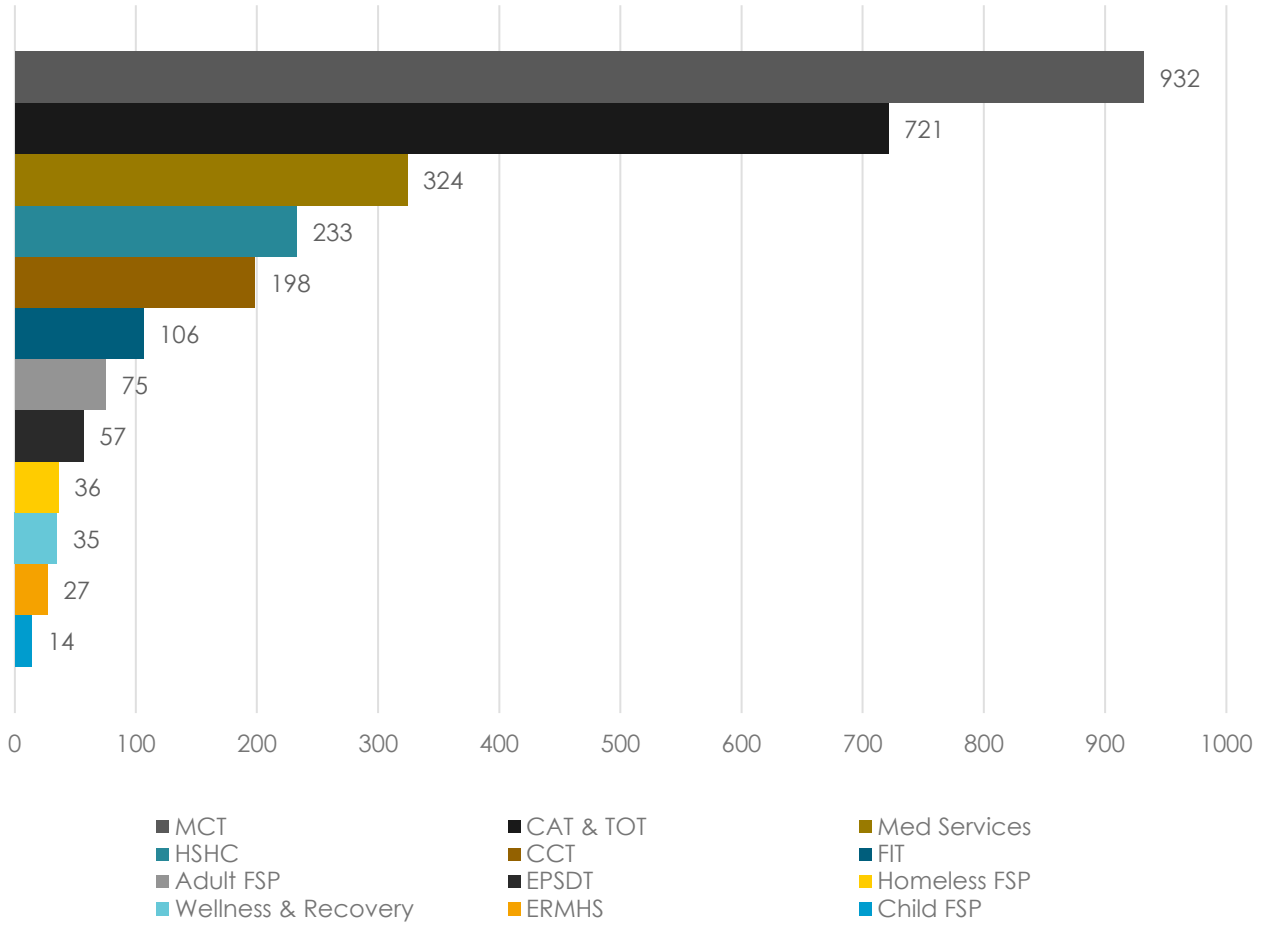
Berkeley Mental Health - Division-Level
Reporting Period: July 2021-June 2022 (Baseline)

Process Outcomes ("How much did we do?")

Description Berkeley Mental Health provides mental health services to eligible adults, children, youth, and their families. Services focus on low-income residents and unhoused people with severe mental illnesses. Staff provide counseling and case management services with the goal of helping people to better manage their mental health symptoms, obtain and maintain housing and other community resources, and move forward in their recovery.

Clients Served, by Program



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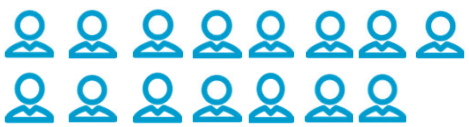

represents 50 clients

Unduplicated Clients Served (includes FSPs, CCT, FIT, ERMHS, EPSDT, HSHC, Medical Services, and Wellness)

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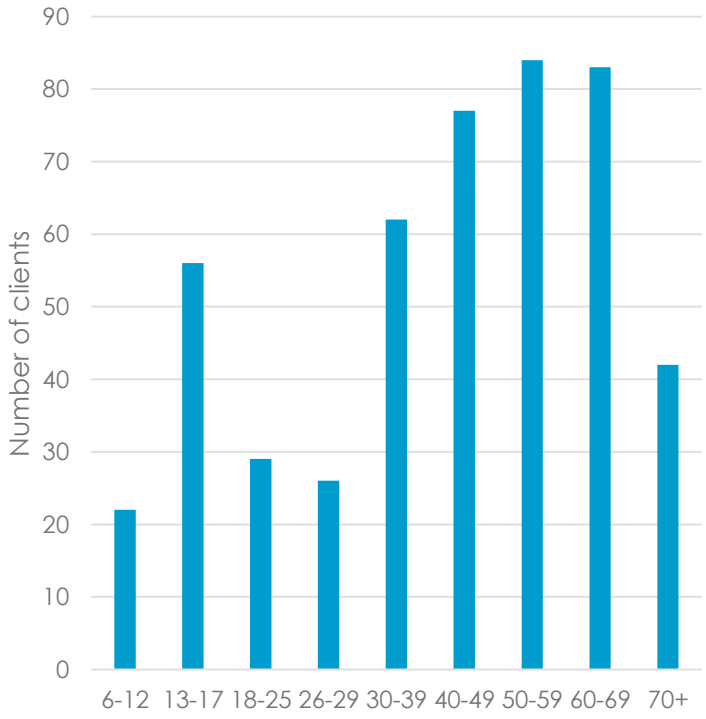
Quality Outcomes ("How well did we do it?")

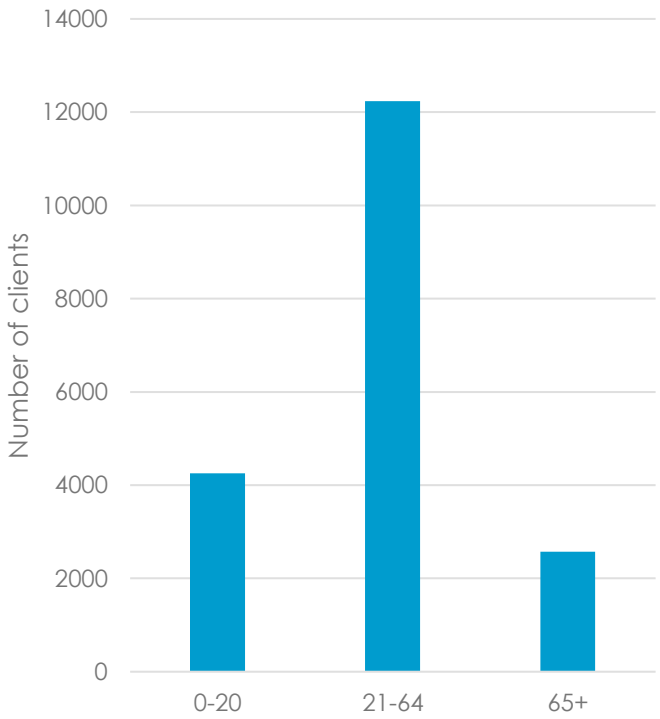
Equity of Services

Client demographics compared to the Medi-Cal population of Berkeley

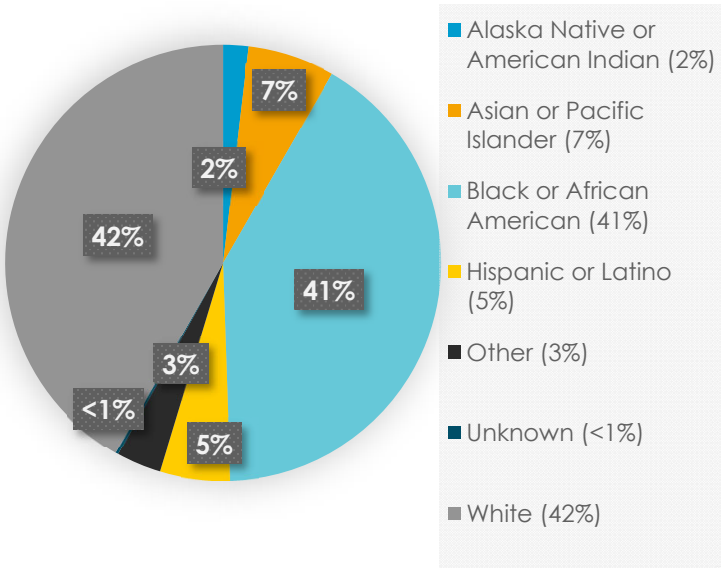
BMH Demographics (Age) (n=481)



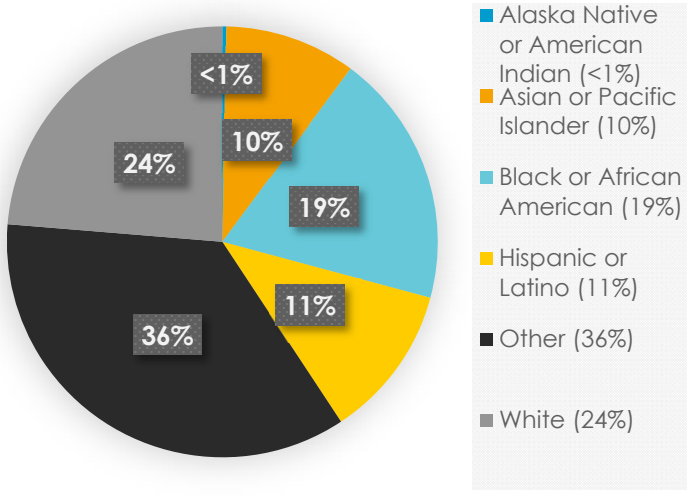
Medi-Cal Demographics (Age) (n=19,064)



BMH Demographics (Race) (n=481)



Medi-Cal Demographics (Race) (n=19,064)



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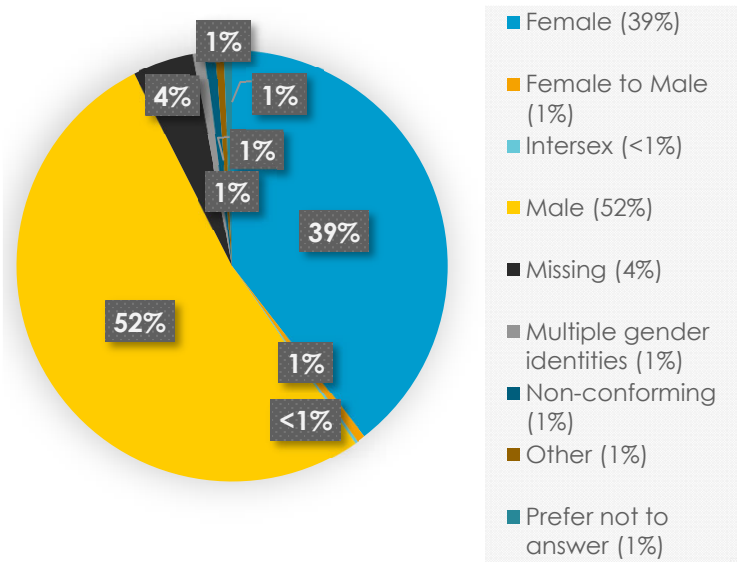
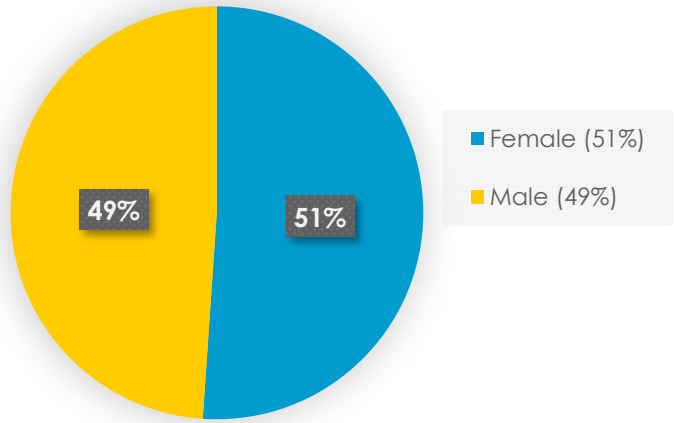
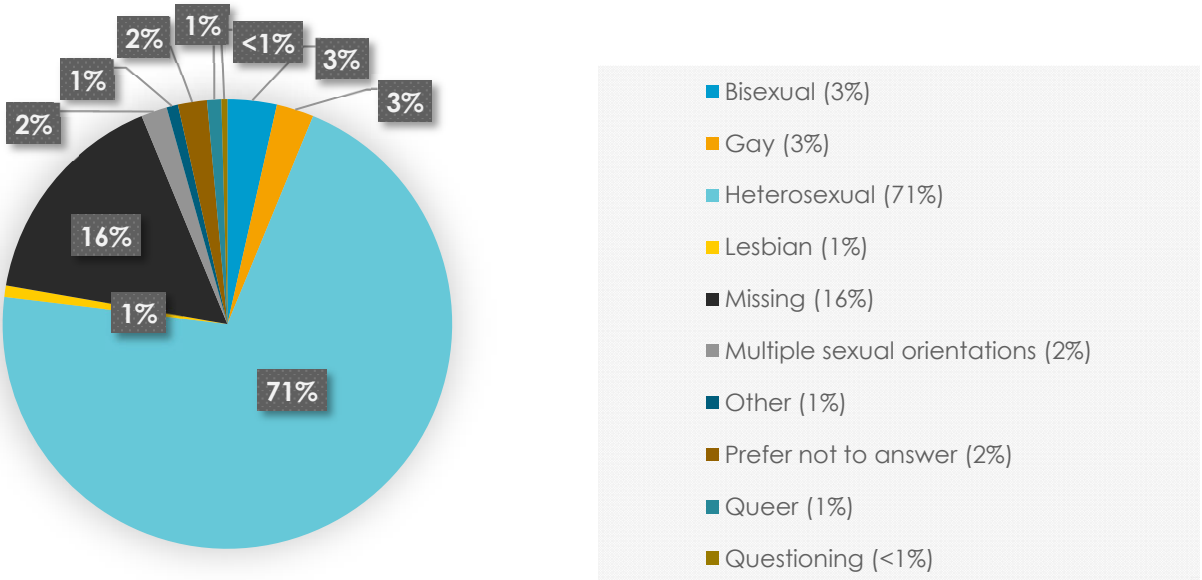
BMH Demographics (Gender Identity) (n=481)



Medi-Cal Demographics (Gender Identity) (n=19,064)



BMH Demographics (Sexual Orientation) (n=481)



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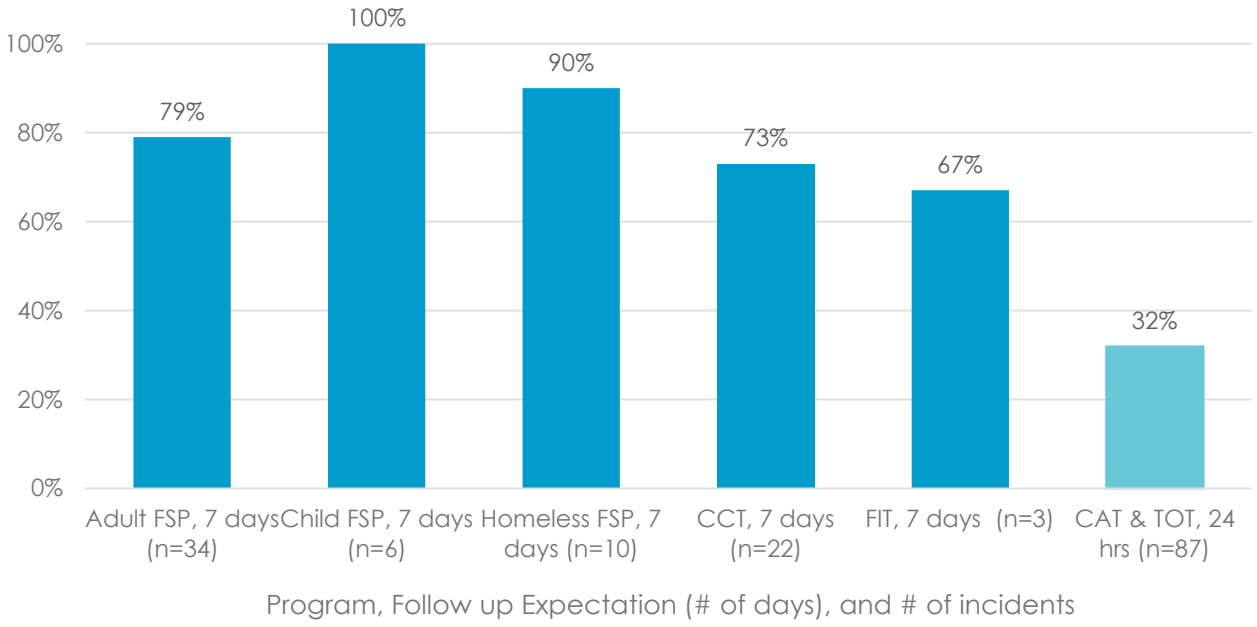
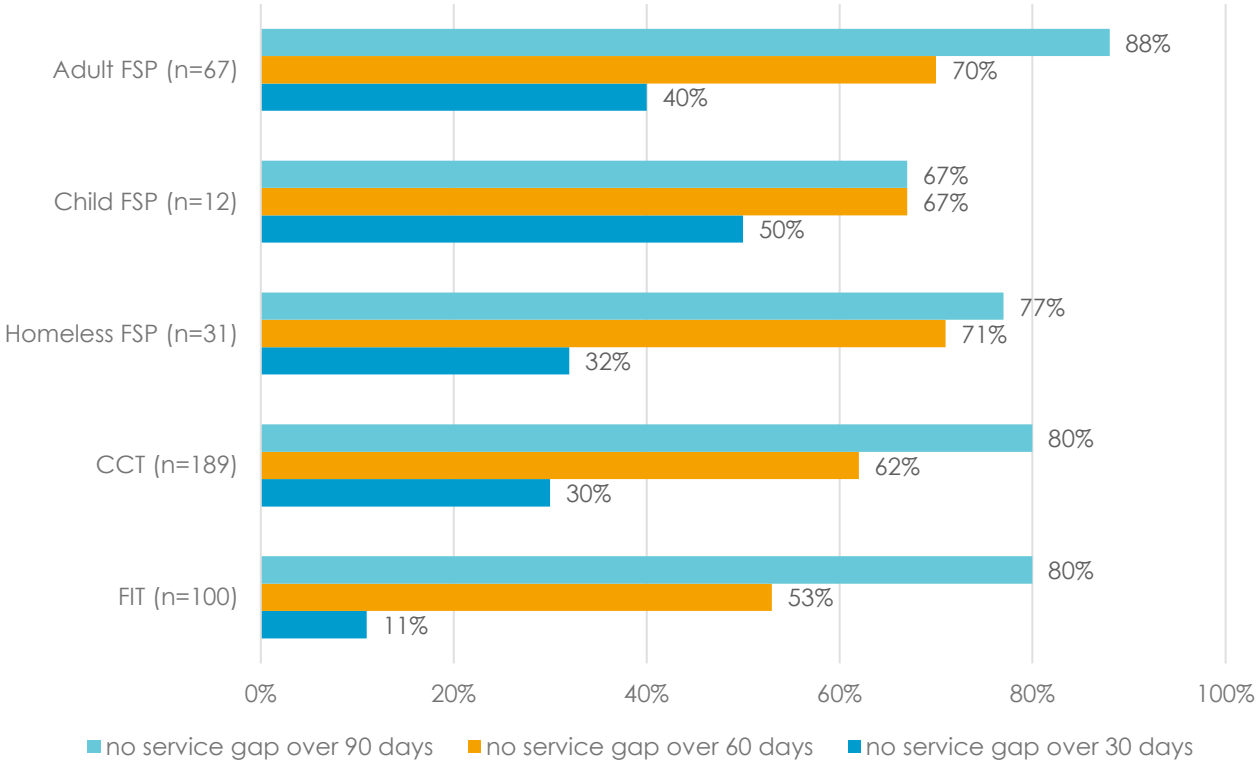
Responsiveness of Service

(% of discharges from hospitalization or subacute who had a follow up visit within specified time period)



Consistency of Service

(% of clients with no service gap over 30/60/90 days)



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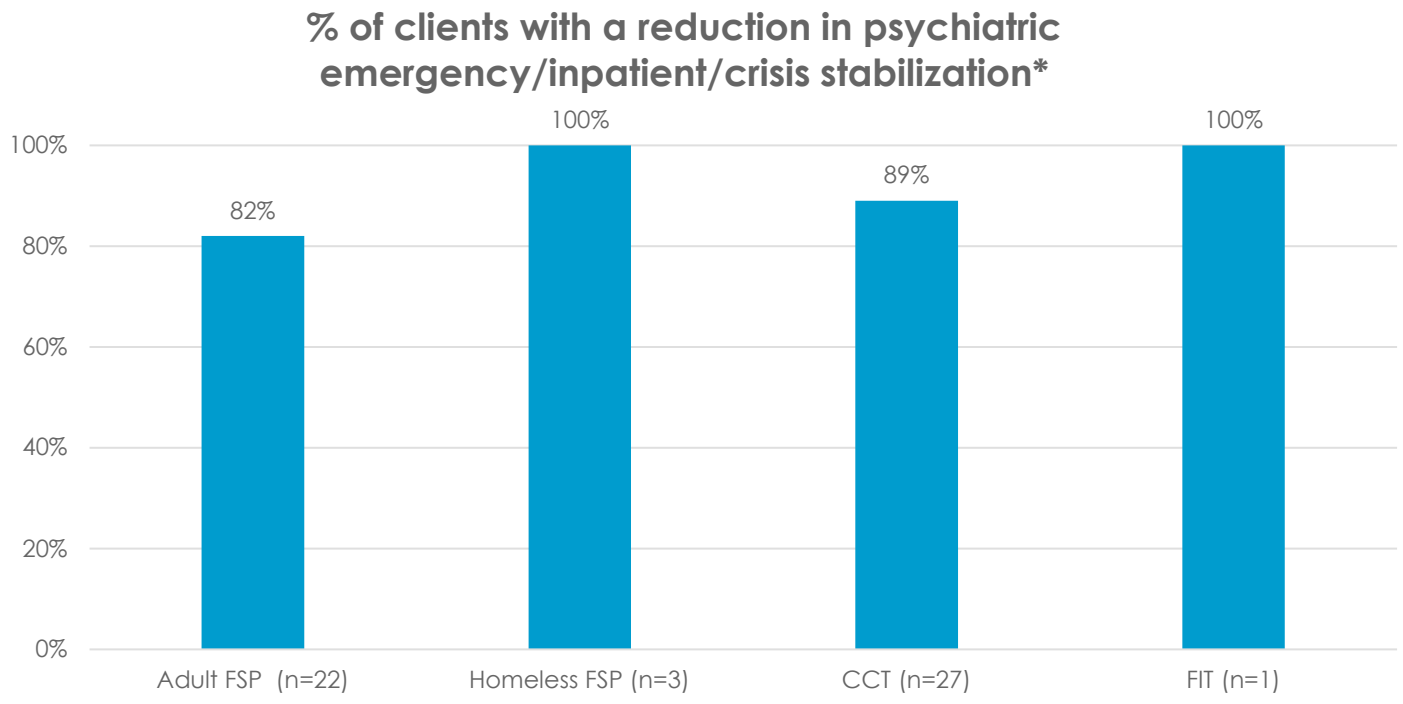
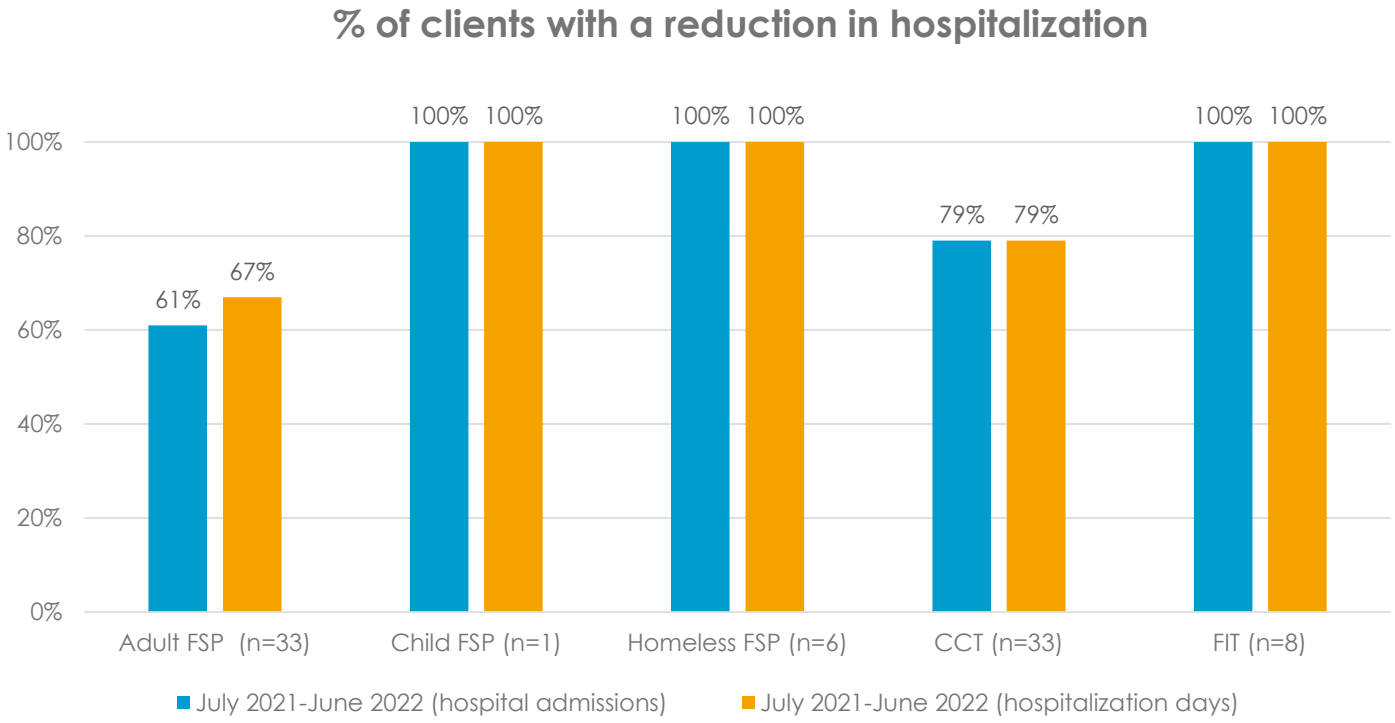
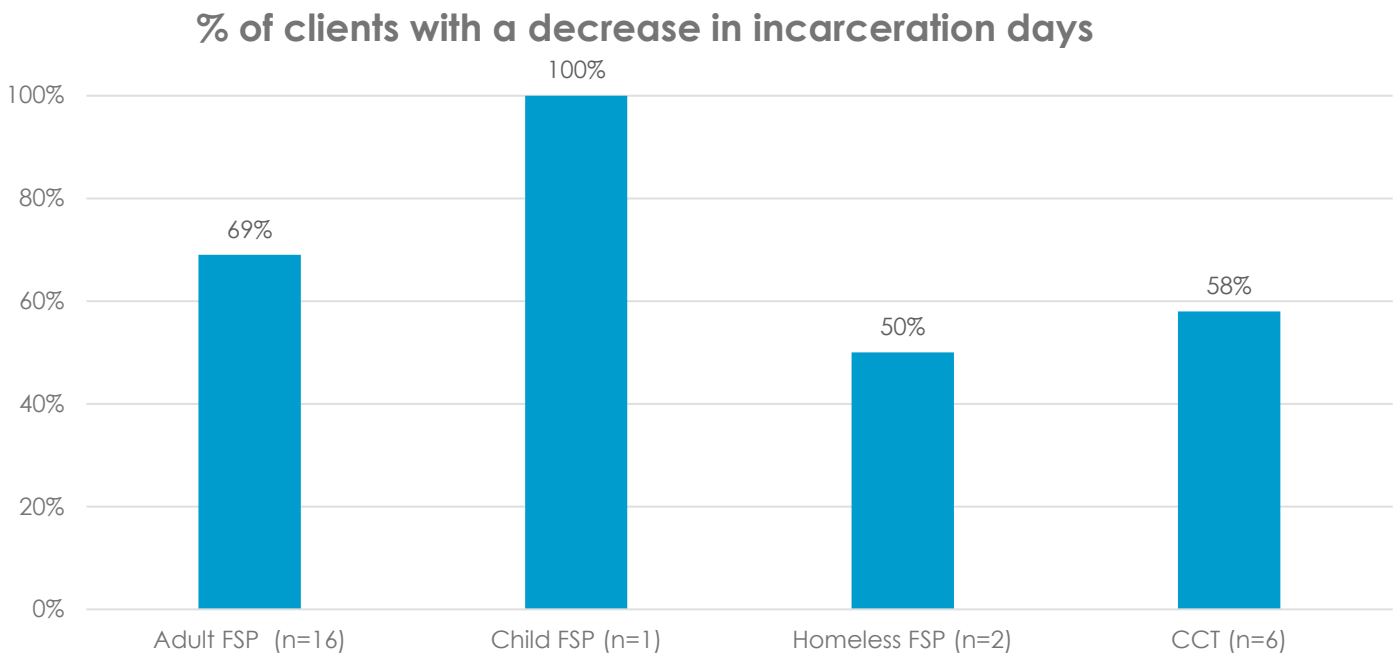
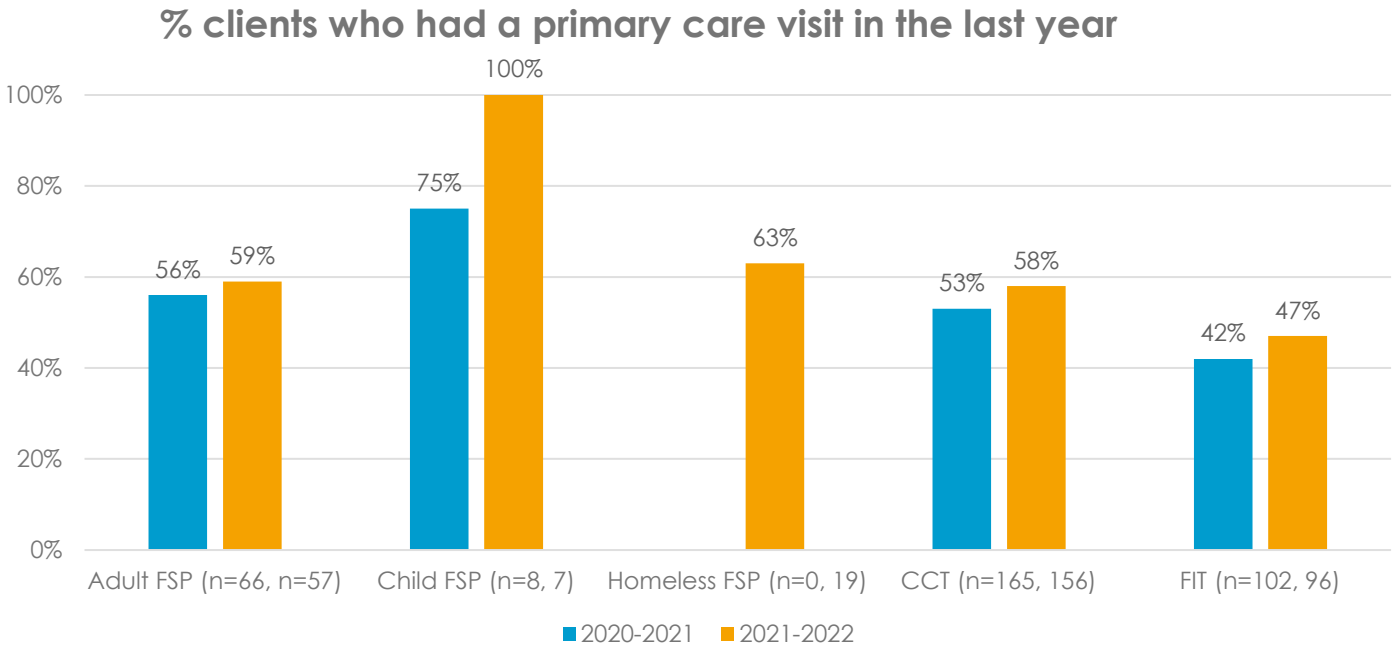
Impact Outcomes ("Is anyone better off?")





BMH RBA Report FY 2022





BMH RBA Report FY 2022

Measure	Definition	Data Source
# clients served	Total number of clients served during the reporting period. Available for: all clients served for Adult FSP, Children's FSP, Homeless FSP, CCT, FIT, ERMHS, EPSDT, High School Health Center, Medical Services, and Wellness & Recovery Services. Does not include clients from MCT, CAT/TOT (may be duplicated)	Yellowfin, ETO, Wellness Recovery Group Attendance
Equity of services (demographics compared to Medi-Cal population)	Age, race, and gender identity of BMH clients and Medi-Cal beneficiaries in the City of Berkeley. Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT. No data available for sexual orientation of Medi-Cal beneficiaries. Does not include clients from CAT/TOT, High School Health Center, MCT, Medical Services, Wellness (may be duplicated or limited data available)	Yellowfin
Responsiveness of service (% of discharges from hospitalization or subacute who had a follow up visit within specified time period)	Follow-up rates for individuals open to providers at the time of MH hospital discharge. Expected follow-up time period set by programs. Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT, CAT & TOT.	Yellowfin, CAT Contact Log
Consistency of service (% of clients with no service gap over 30/60/90 days)	% of clients with less than 30/60/90 days maximum without service during their episode(s) in the fiscal year. Only includes clients open to a provider for at least a total of 1/2/3 months during the reporting fiscal year. Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT.	Yellowfin
% of clients who had a reduction in days in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year. Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT.	Yellowfin
% of clients with a decrease in hospitalization	Decrease in hospital admits and hospitalization days in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital admit in the 12 months prior to admission and remained in the program for at least 1 year Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT.	Yellowfin

% of clients with a decrease in incarcerations	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year. Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT.	Yellowfin
% clients who had a primary care visit in the last year	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/CHCN primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail). Available for: Adult FSP, Children's FSP, Homeless FSP, CCT, FIT.	Yellowfin

BMH RBA Report FY 2022

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Reporting Period: July 2021-June 2022 (Baseline)

Process Outcomes ("How much did we do?")

57

Clients Served

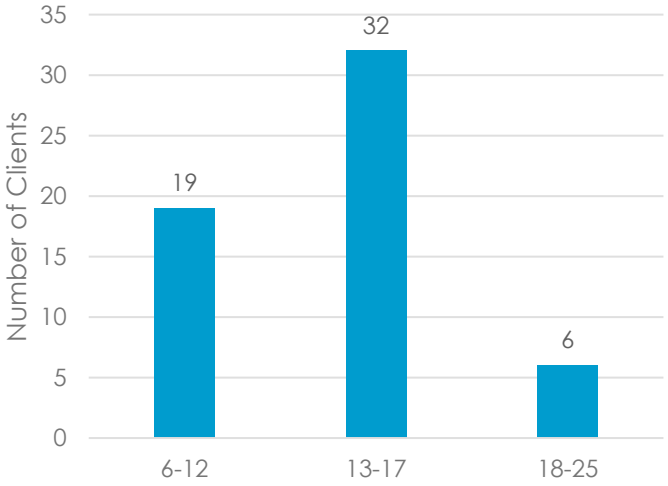
26

New Clients

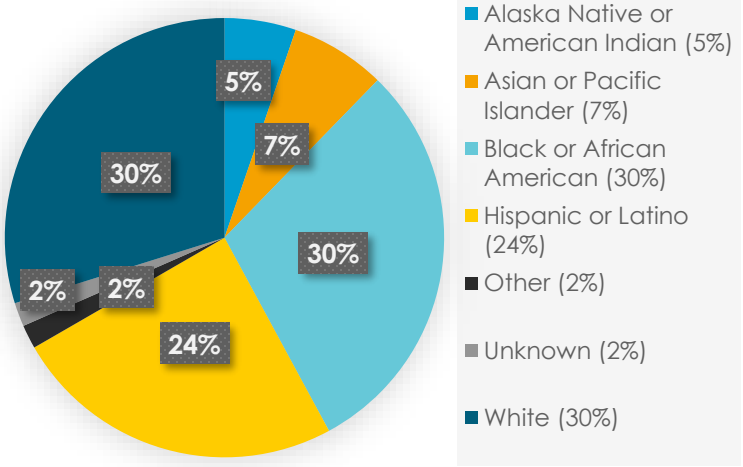
represents 10 clients

Program Description: EPSDT team provides comprehensive and preventive child health services which include assessment, plan development, individual/family/group therapy, rehabilitation, collateral, case management, and medication referrals.

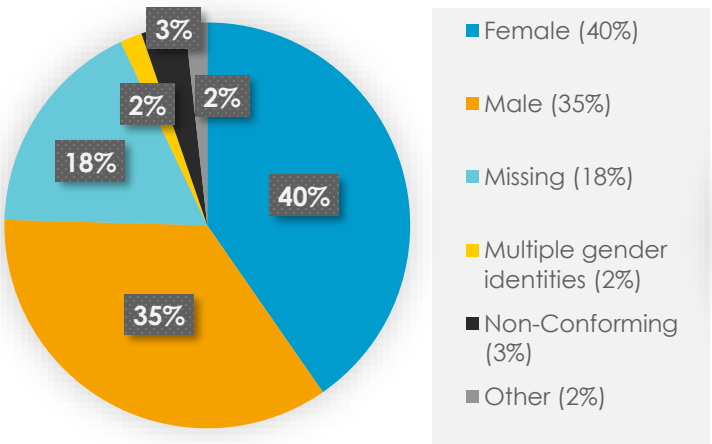
Demographics (Age)



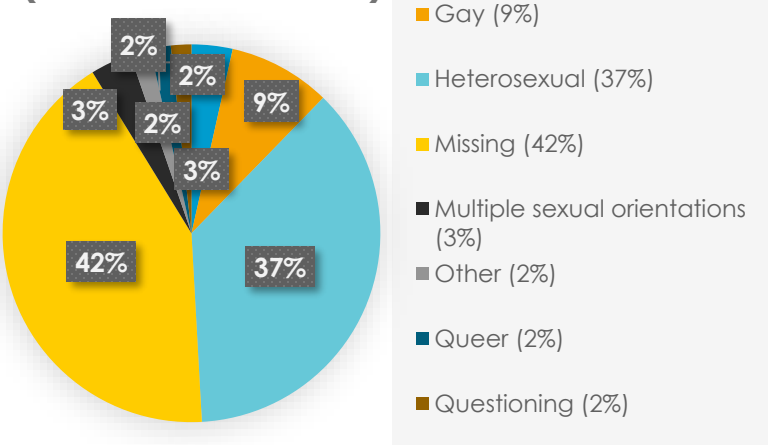
Demographics (Race)



Demographics (Gender Identity)



Demographics (Sexual Orientation)



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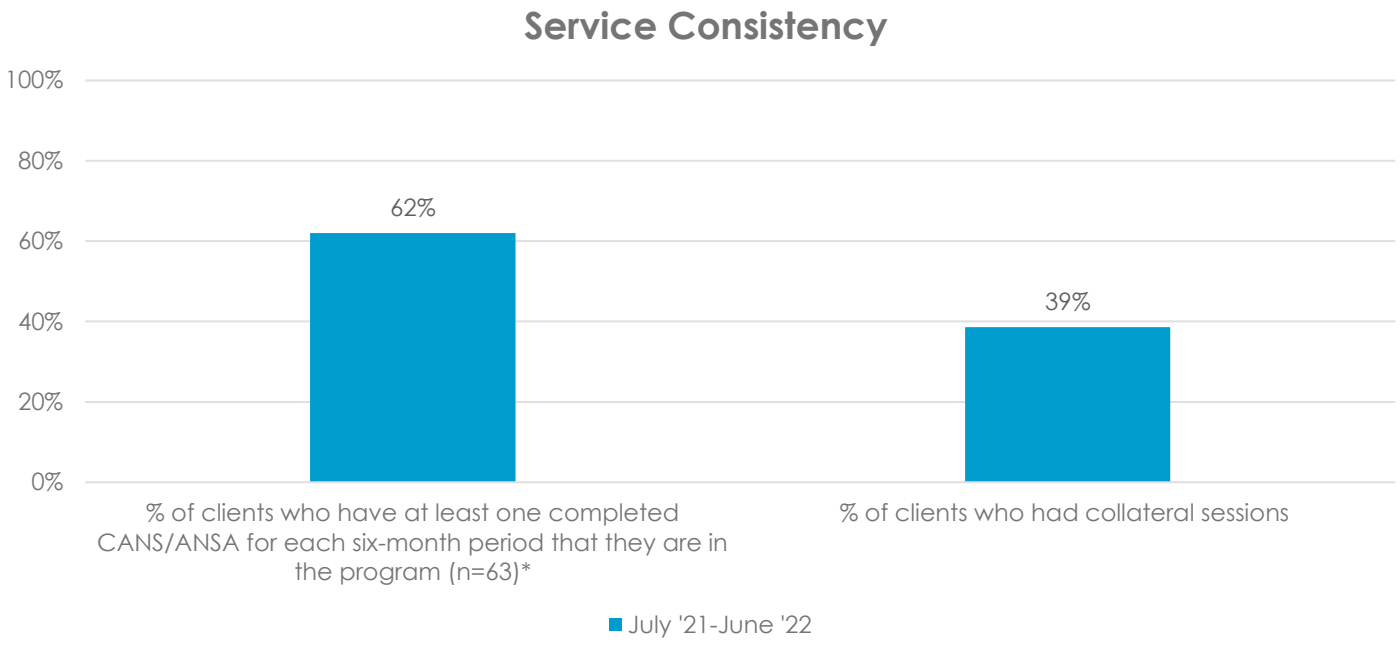
In 2021-2022, the EPSDT program provided:

- **1,016 hours** of individual therapy
- **1.25 hours** of collateral per client

Quality Outcomes ("How well did we do it?")



*Note: number of clients with CANS assessments is higher than total number of clients in Yellowfin

Impact Outcomes ("Is anyone better off?")

In 2021-2022, **32%** of discharged EPSDT clients (n=31) met their mental health goals:

- **29%** of clients fully met their mental health goals
- **3%** of clients partially reached their mental health goals

BMH RBA Report FY 2022

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients opened for ongoing services	Clients who were not served by the program in the previous fiscal year	Yellowfin
# of individual therapy hours provided	Total individual therapy hours recorded for clients. Includes all procedures in the "ind therapy" service catergory.	Yellowfin
# of collateral hours per client	Total collateral hours recorded for clients divided by all clients. Includes all procedures in the "Collateral" category.	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program	Of clients with a completed CANS/ANSA, what percentage of them had an assessment at least every six months?	Objective Arts
% of clients who had collateral sessions	Total clients who received collateral sessions divided by all clients. Includes all clients with recorded procedures in the "Collateral" category.	Yellowfin
Of clients who were discharged from the program, #/% who met mental health goals	Percent of discharged clients who had a discharge reason of either "Mutual Agreement/Treatment Goals Reached" or "Mutual Agreement/Treatment Goals Partially Reached"	Yellowfin

BMH RBA Report FY 2022

Educationally Related Mental Health Services (ERMHS)

Reporting Period: July 2021-June 2022 (Baseline)

Process Outcomes ("How much did we do?")

27

Clients Served

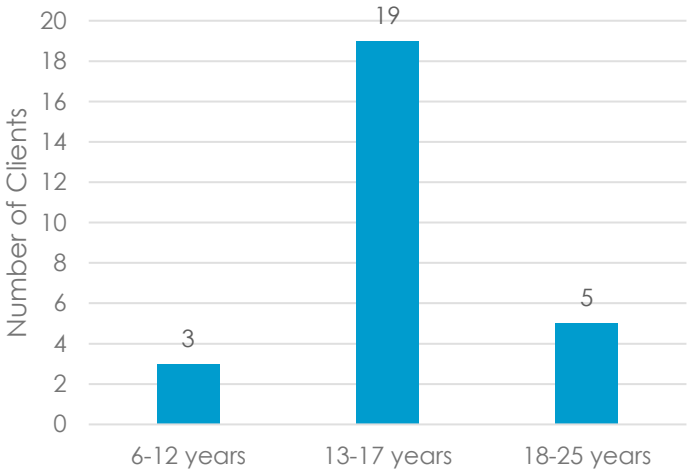
8

New Clients

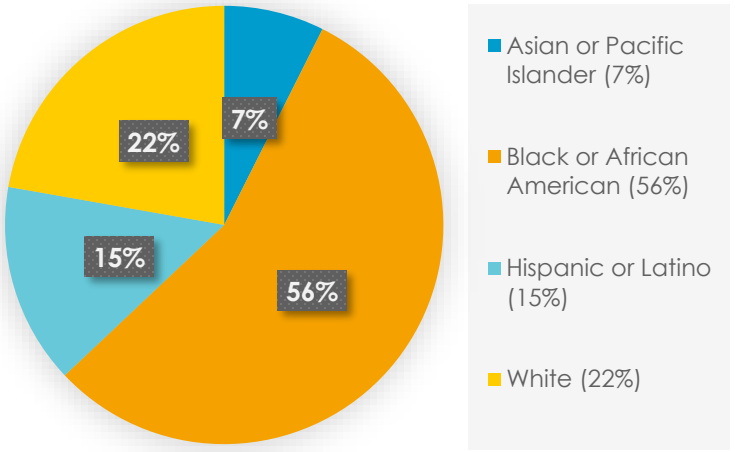
represents 10 clients

Program Description: The ERMHS program provides mental health services to the special education population in Berkeley Unified School District. Services include assessment, plan development, individual therapy, and collateral.

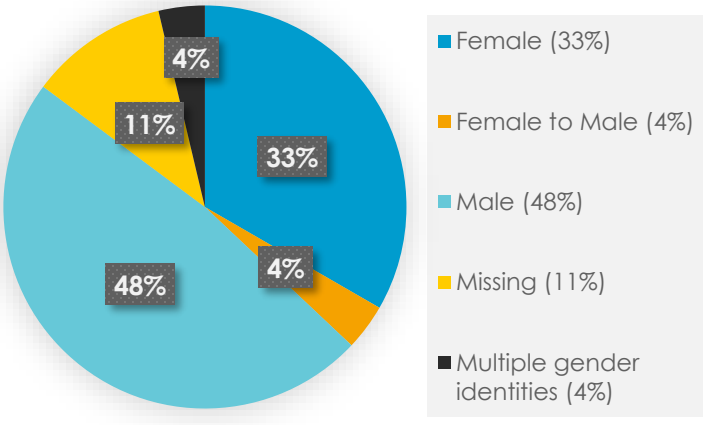
Demographics (Age)



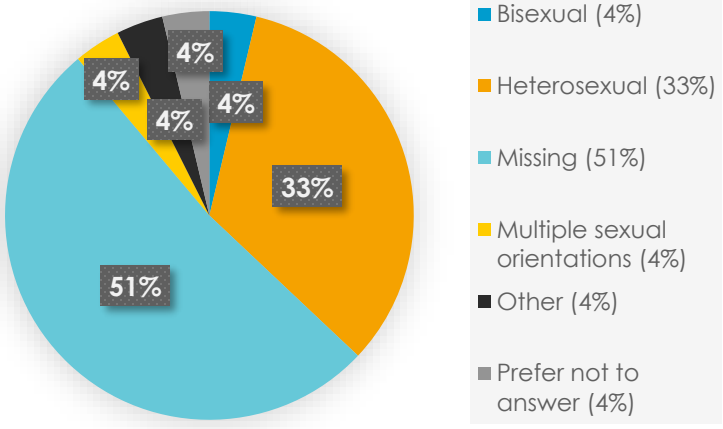
Demographics (Race)



Demographics (Gender Identity)



Demographics (Sexual Orientation)



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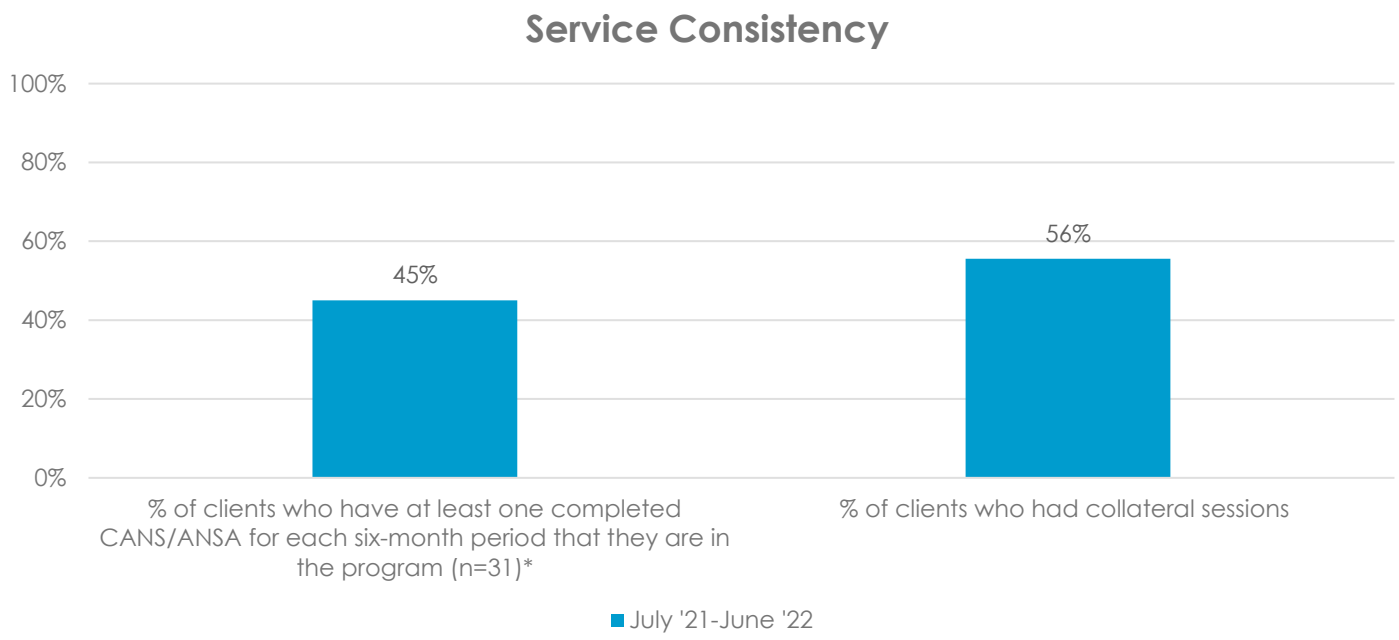
In 2021-2022, the ERMHS program provided:

- **379 hours** of individual therapy
- **1 hour** of collateral per client

Quality Outcomes ("How well did we do it?")



*Note: number of clients with CANS assessments is higher than total number of clients in Yellowfin

Impact Outcomes ("Is anyone better off?")

In 2021-2022, **30%** of discharged ERMHS clients (n=20) met their mental health goals:

- **15%** of clients fully met their mental health goals
- **15%** of clients partially reached their mental health goals

BMH RBA Report FY 2022

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients opened for ongoing services	Clients who were not served by the program in the previous fiscal year	Yellowfin
# of individual therapy hours provided	Total individual therapy hours recorded for clients. Includes all procedures in the "ind therapy" service catergory.	Yellowfin
# of collateral hours per client	Total collateral hours recorded for clients divided by all clients. Includes all procedures in the "Collateral" category.	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program	Of clients with a completed CANS/ANSA, what percentage of them had an assessment at least every six months?	Objective Arts
% of clients who had collateral sessions	Total clients who received collateral sessions divided by all clients. Includes all clients with recorded procedures in the "Collateral" category.	Yellowfin
Of clients who were discharged from the program, #/% who met mental health goals	Percent of discharged clients who had a discharge reason of either "Mutual Agreement/Treatment Goals Reached" or "Mutual Agreement/Treatment Goals Partially Reached"	Yellowfin

BMH RBA Report FY 2022

Focus on Independence Team (FIT)
Reporting Period: July 2021-June 2022 (Baseline)

Process Outcomes ("How much did we do?")

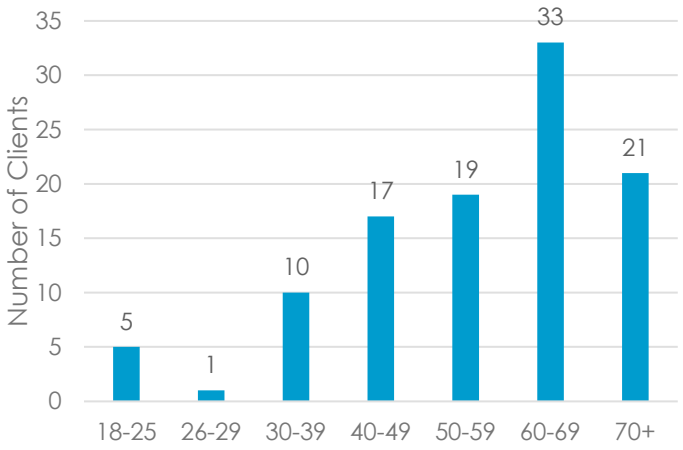
106
Clients Served

9
New Clients

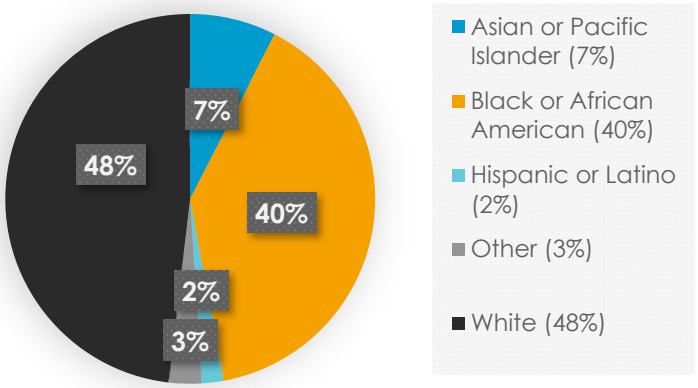
represents 10 clients

Program Description: The Focus on Independence Team is responsible for providing services to clients who have graduated from higher levels of care within the clinic. Services are provided both in the field and in the clinic depending on client needs.

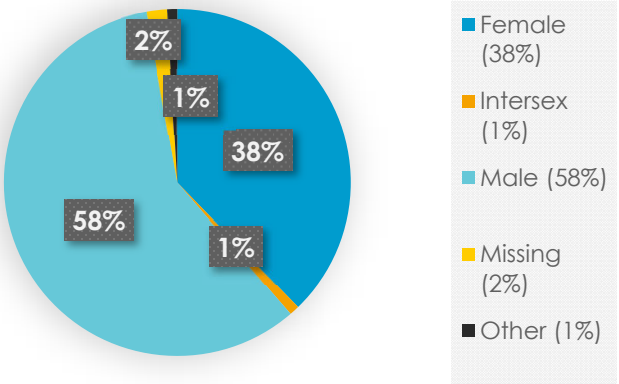
Demographics (Age)



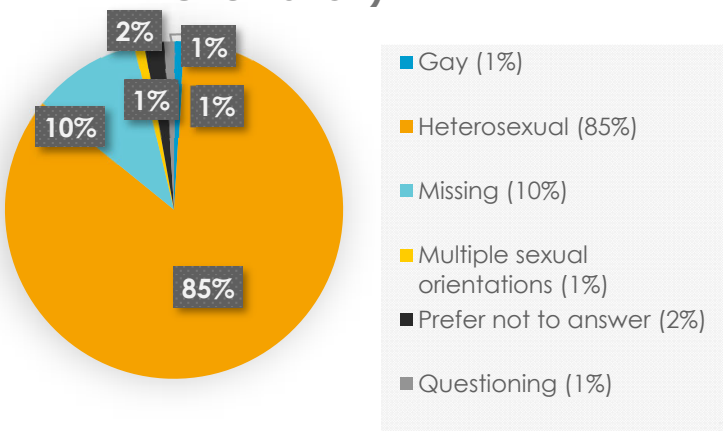
Demographics (Race)



Demographics (Gender Identity)



Demographics (Sexual Orientation)



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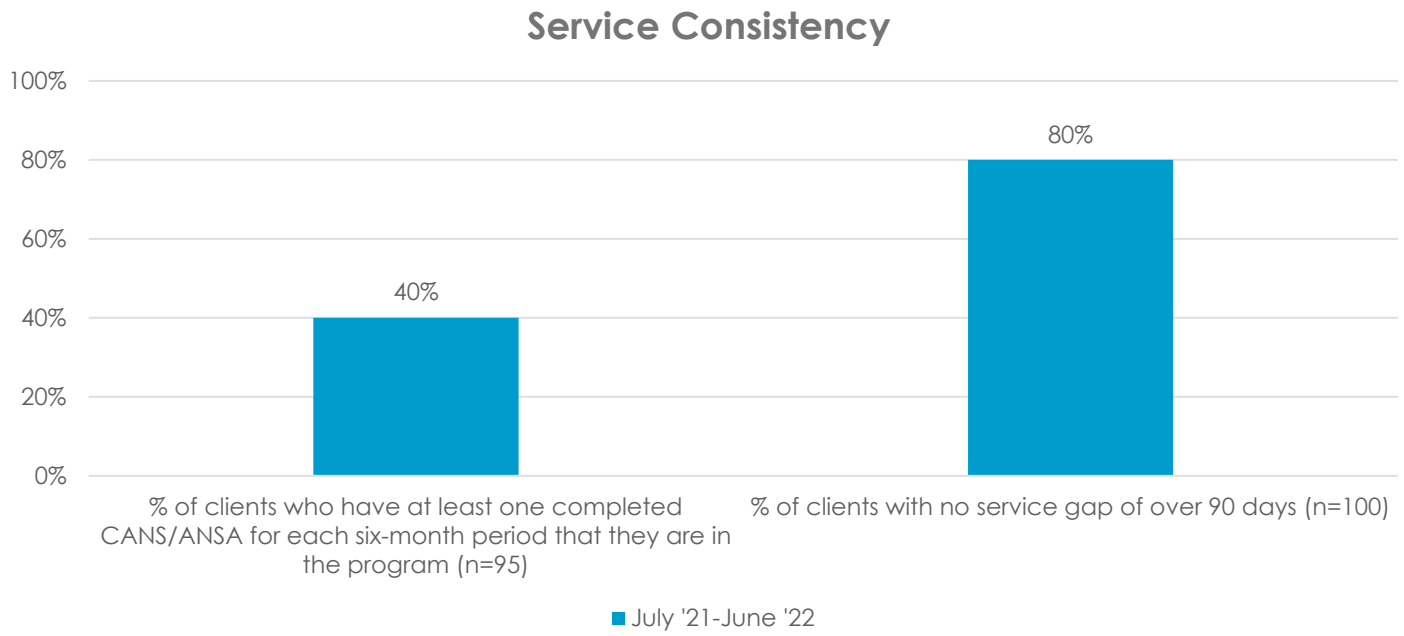
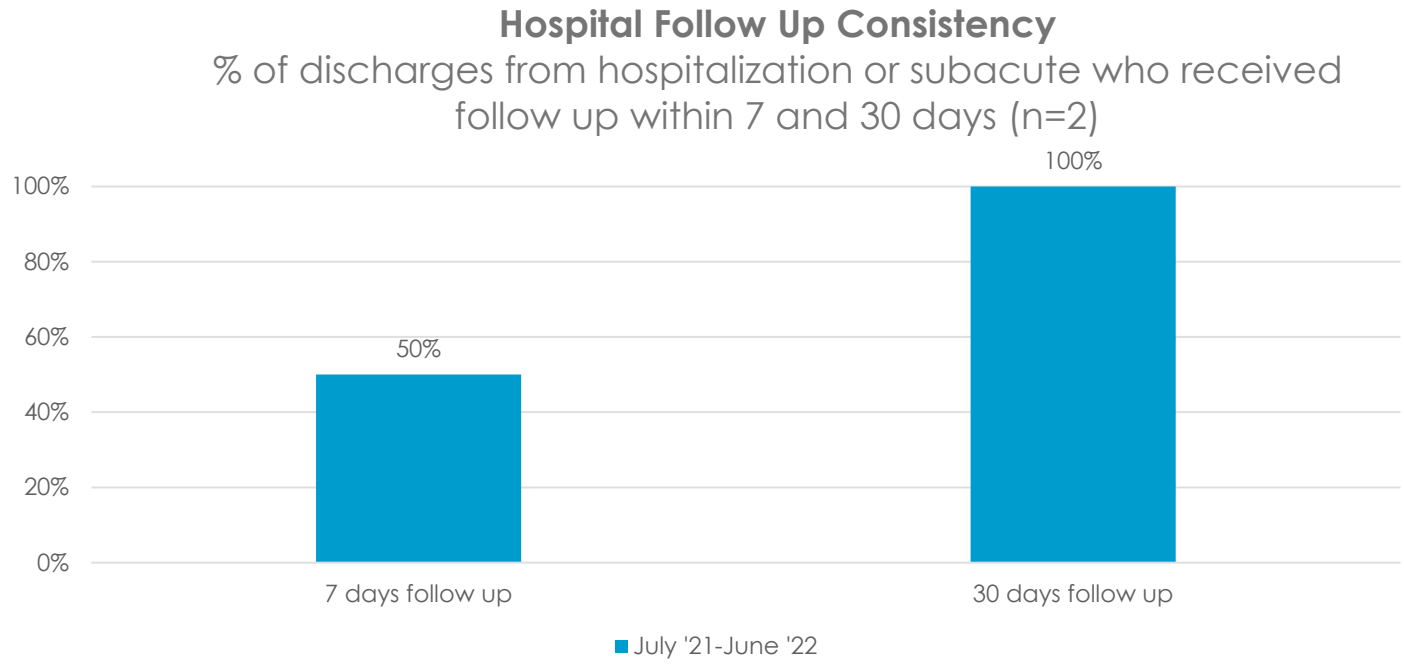
The average client served in 2021-2022 received:

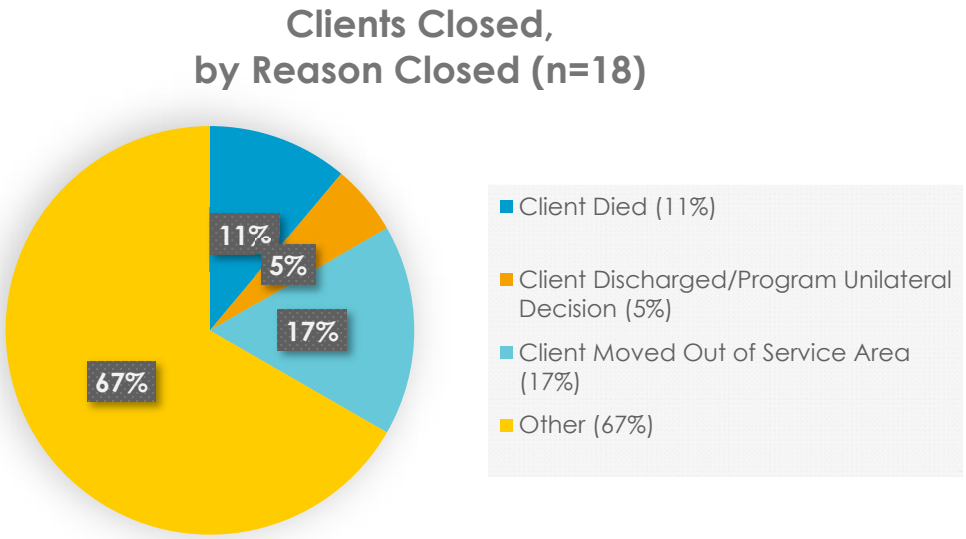
- received **1.76 hrs** of services per month
- received **2.28 services** per month

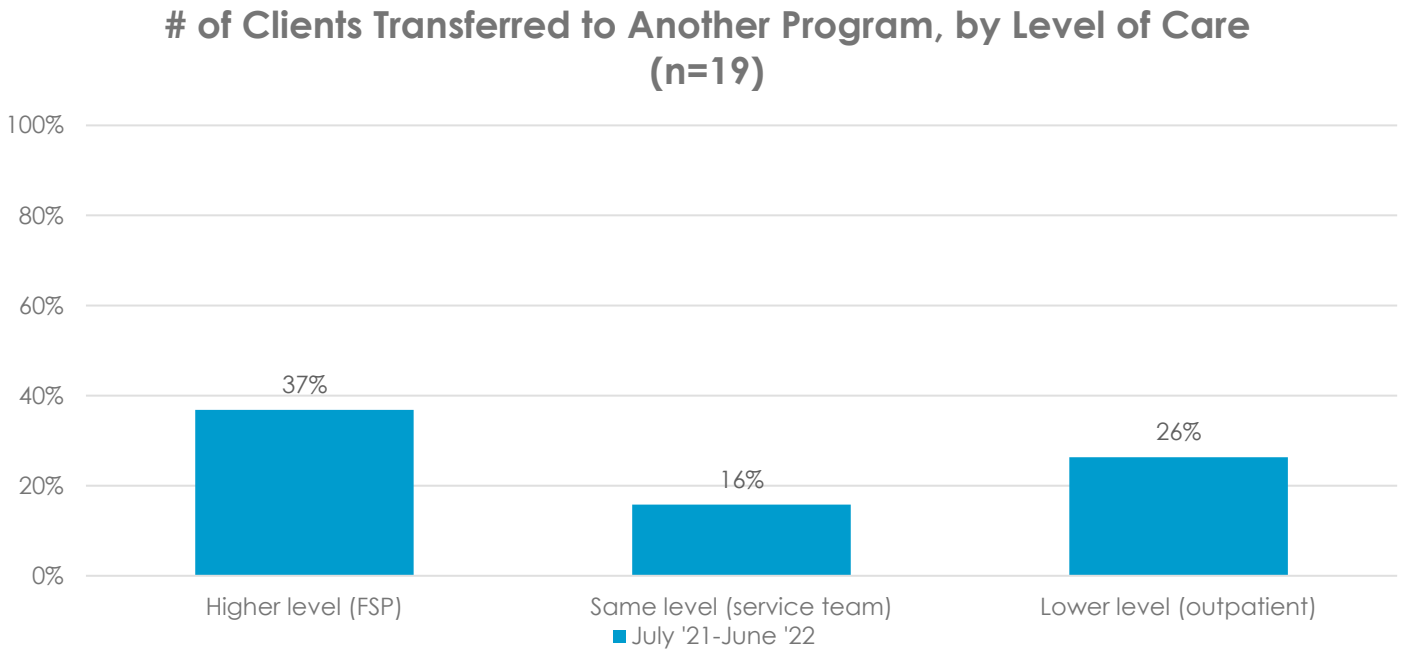
Quality Outcomes ("How well did we do it?")





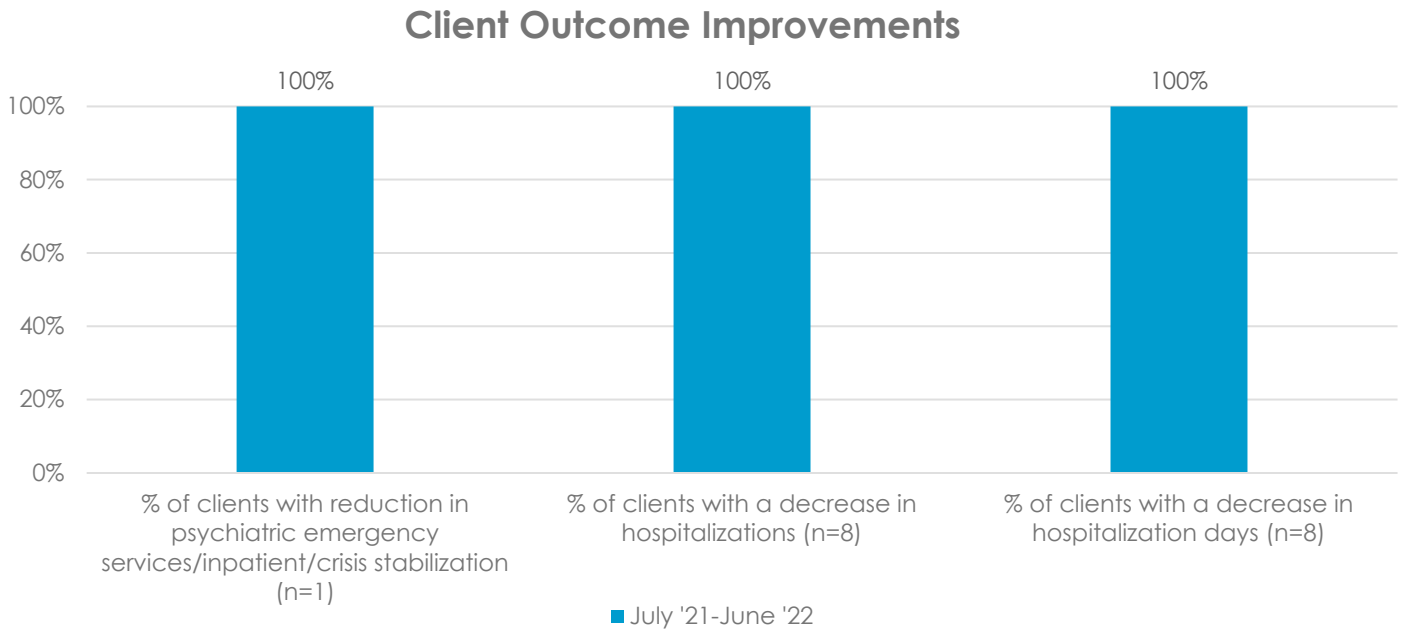
BMH RBA Report FY 2022

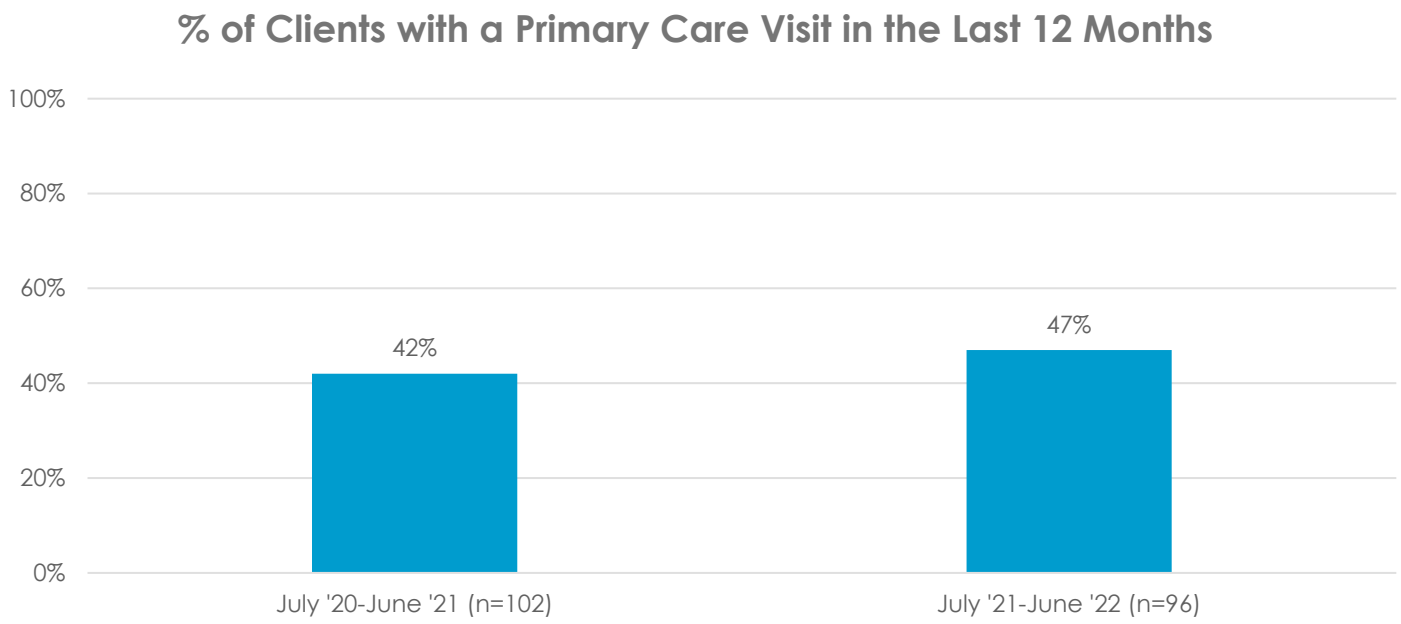




BMH RBA Report FY 2022

Impact Outcomes ("Is anyone better off?")





BMH RBA Report FY 2022

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients opened for ongoing services	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include MAA	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program (n=95)	Of clients with a completed CANS/ANSA, what percentage of them had an assessment at least every six months?	Objective Arts
% of clients with no service gap of over 90 days (n=100)	% of clients with less than 90 days maximum without service during their episode(s) in the fiscal year. Only includes clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with staff within 7 and within 30 calendar days	Follow-up rates for individuals open to Level 1 providers at the time of MH hospital discharge.	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin
# of clients transferred to another program, by level of care	Of clients discharged in the reporting period, # who were transferred to a full service partnership program, service team, or outpatient services in Alameda County within 90 days of discharge	Yellowfin
% of clients who had a reduction in days in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin

% of clients with a decrease in hospitalization	Decrease in hospital days/admissions in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital day in the 12 months prior to admission and remained in the program for at least 1 year	Yellowfin
% of clients with a primary care visit in the last 12 months (n=96)	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/CHCN primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin

BMH RBA Report FY 2022

Homeless Full Service Partnership (FSP)
Reporting Period: July 2021-June 2022 (Baseline)

Process Outcomes ("How much did we do?")

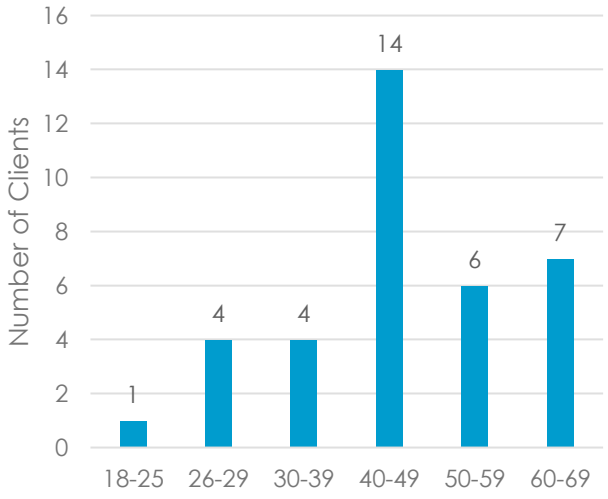
36
Clients Served

34
New Clients

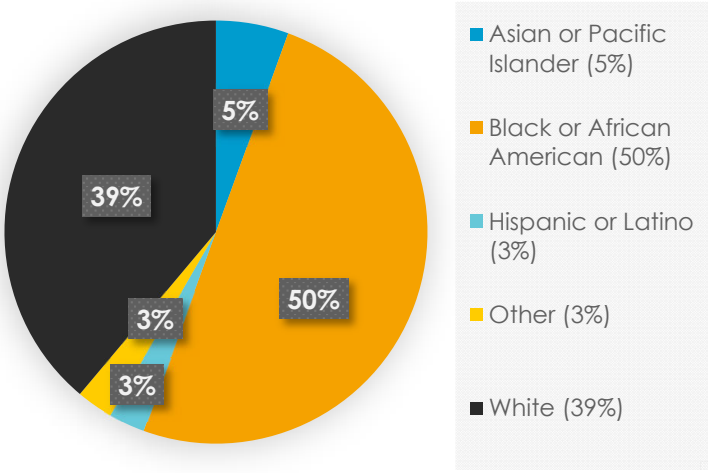
Program Description: HFSP serves unhoused residents of Berkeley in an Assertive Community Treatment (ACT) model at high staff to client ratios, providing intensive case management and mental health services in a multi-disciplinary team approach. This team serves those with the highest level of need, supporting a population that is primarily unhoused and has multiple severe functional impairments.

represents 10 clients

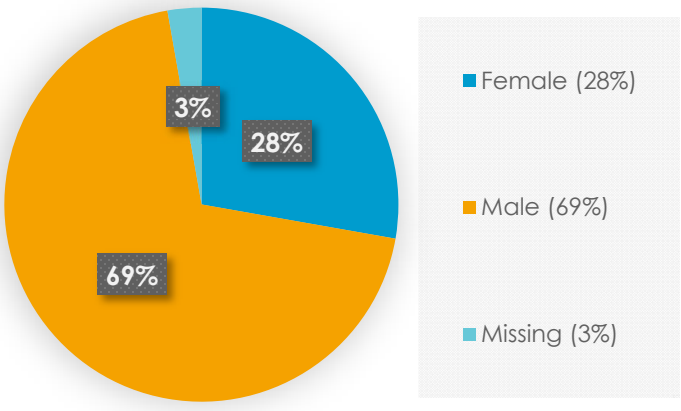
Client Demographics (Age)



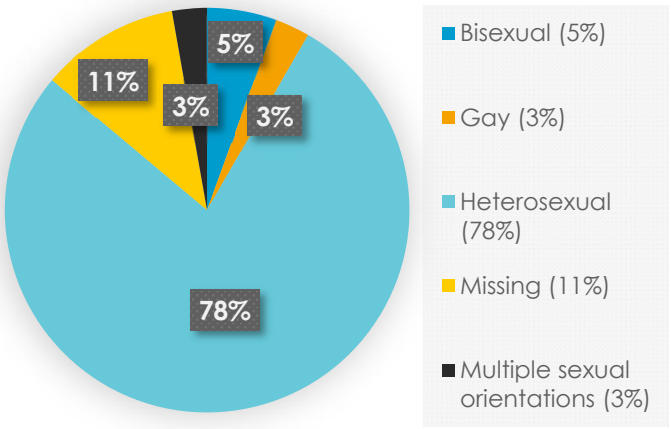
Client Demographics (Race)



Client Demographics (Gender Identity)



Client Demographics (Sexual Orientation)



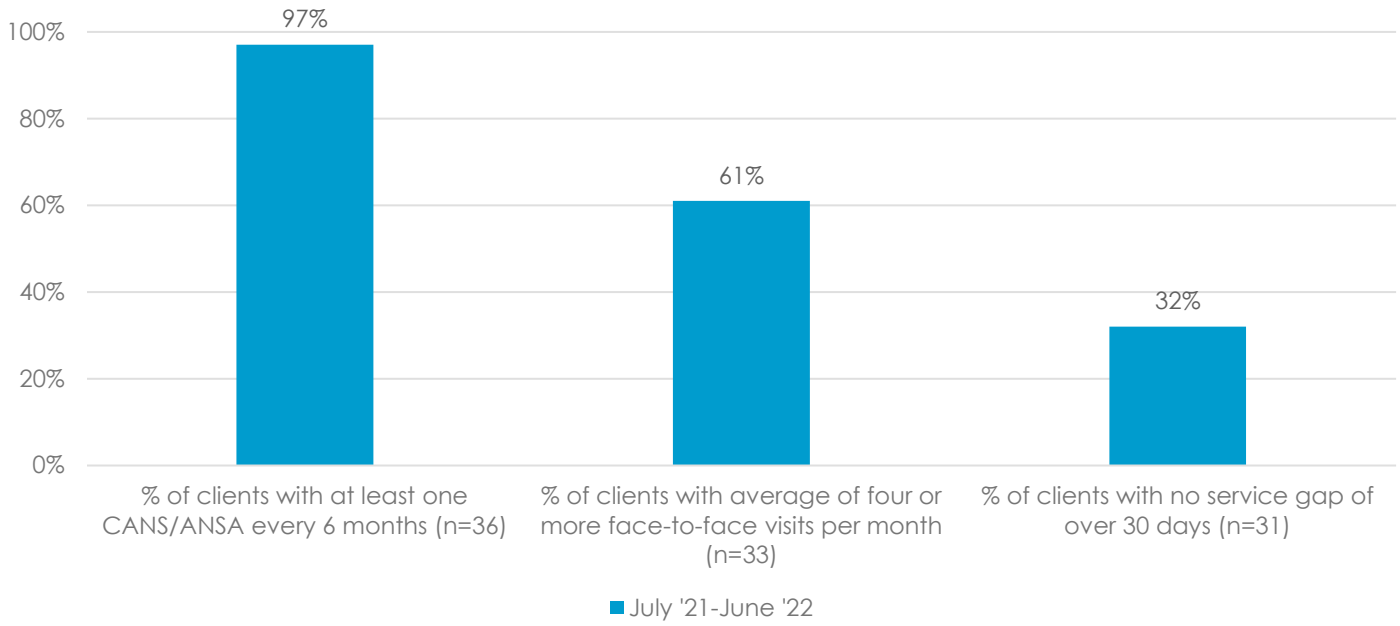
BMH RBA Report FY 2022

Quality Outcomes ("How well did we do it?")

The average client served in 2021-2022:

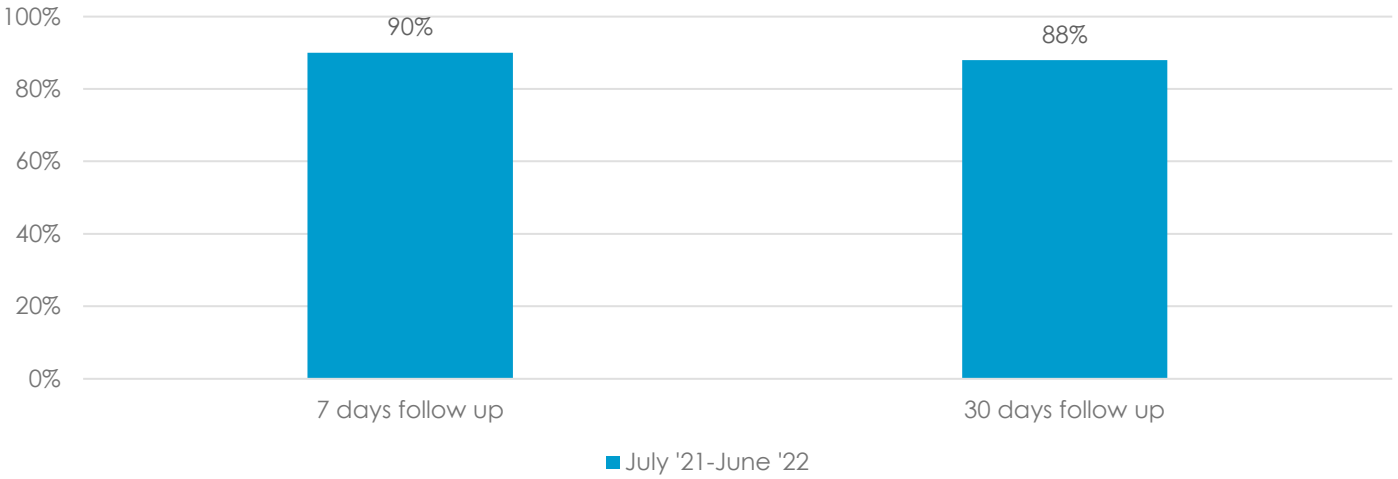
- remained in the FSP program for **263 days**
- received **8.82 hrs** of services per month
- received **6 services** per month

Service Consistency

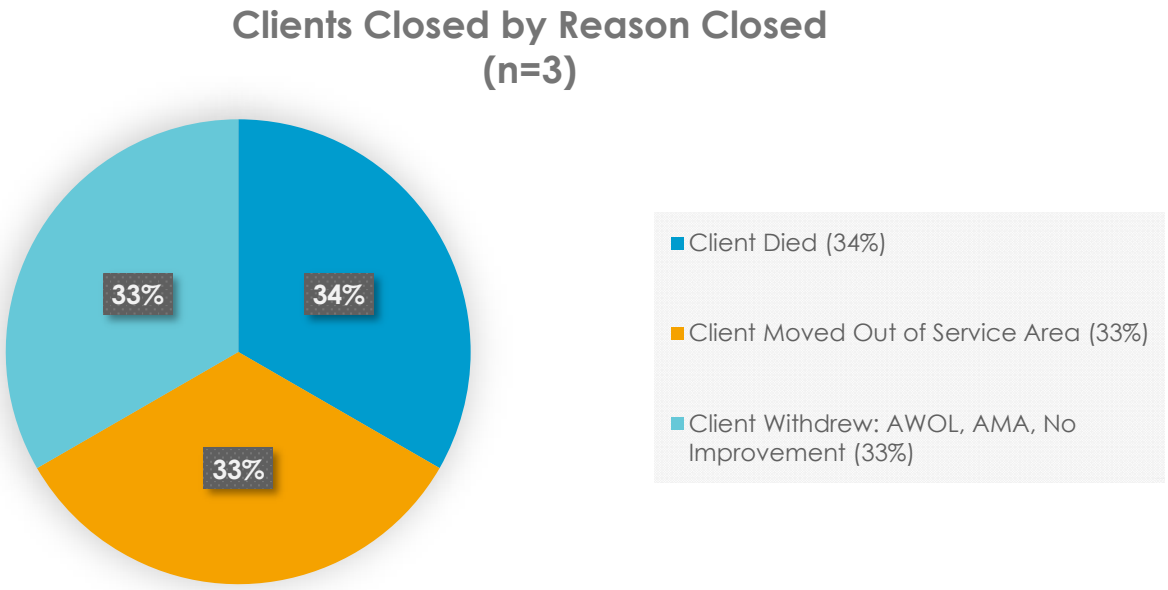


Hospital Follow Up Consistency

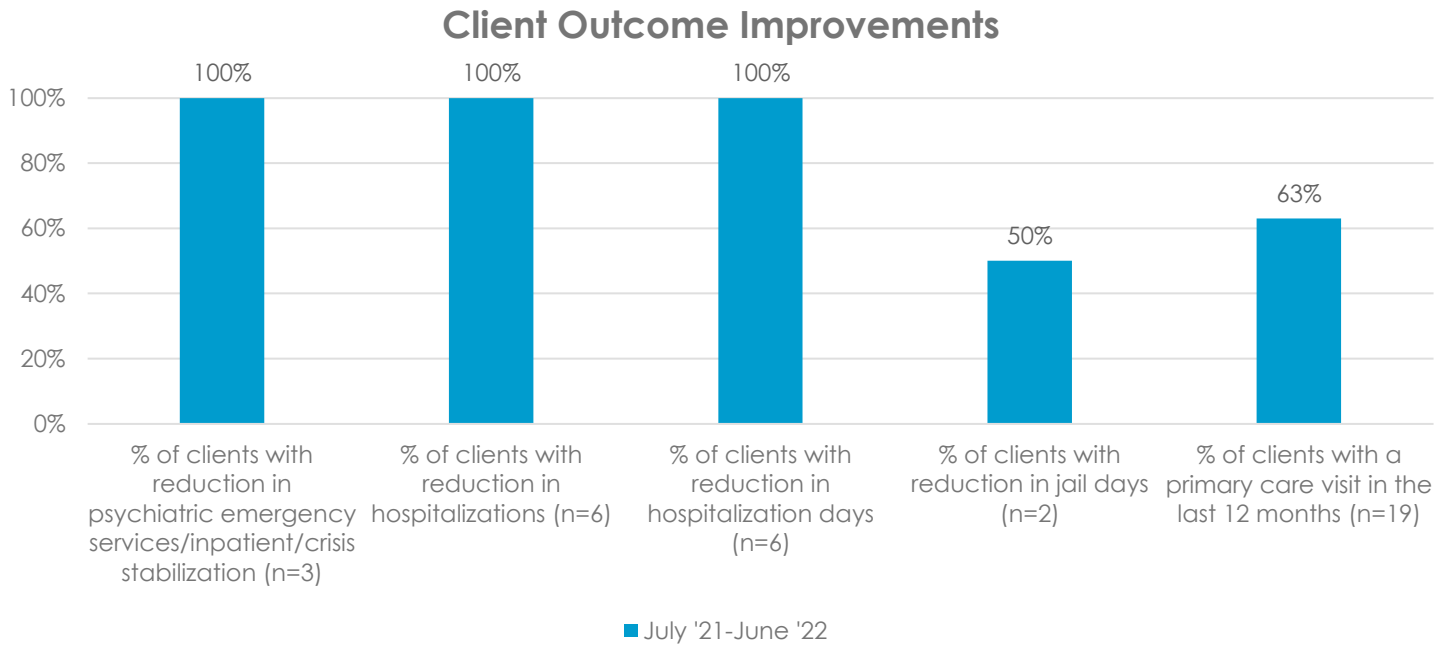
% of discharges from hospitalization or subacute who received FSP follow up within 7 and 30 days (n=10)



BMH RBA Report FY 2022



Impact Outcomes ("Is anyone better off?")



BMH RBA Report FY 2022

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
# of new clients	Clients who were not served by the program in the previous fiscal year	Yellowfin
Average # of days in FSP per client	Average length of stay for primary program episodes which have closed since the beginning of the reporting period	Yellowfin
Average # of service hours per client per month	Average of hours of service in a month divided by clients served in a month. Includes all services recorded for clients. Does not include MAA	Yellowfin
Average # of services per client per month	Average services in a month divided by clients served in a month. Includes all services recorded for clients. Note: more than one service can be provided during a single contact. Does not include MAA	Yellowfin
% of clients who have at least one completed CANS/ANSA for each six-month period that they are in the program	Of clients with a completed CANS/ANSA, what percentage of them had an assessment at least every six months?	Objective Arts
% of clients and/or their caregivers who receive an average of four or more face-to-face outpatient visits per month	Clients must be been open to a provider for at least 30 days in order to be included in this metric. Phone contacts are included during the pandemic. Days in subacute or jail not counted, but services are counted.	Yellowfin
% of clients with no service gap of over 30 days	Maximum days each Level 1 client went without service during their episode(s) in the reporting period. Only considered clients open to a provider for at least a total of three months during the reporting fiscal year.	Yellowfin
% of discharges from hospitalization or subacute who had a follow up visit with FSP staff within 7 and within 30 calendar days	Follow-up rates for individuals open to Level 1 providers at the time of MH hospital discharge.	Yellowfin
#/% of clients closed, by reason closed	Discharge reason for clients discharged during the reporting period	Yellowfin

BMH RBA Report FY 2022

% of clients who had a reduction in days in psychiatric emergency services/inpatient/crisis stabilization units	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in psychiatric emergency services, inpatient or crisis stabilization unit other than Amber House, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in jail and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a decrease in hospitalization	Decrease in hospital admits and hospitalization days in the years that a client was active in the program compared to the year prior to program admission. Includes clients who had at least one hospital admit in the 12 months prior to admission and remained in the program for at least 1 year	Yellowfin
% of clients who had a reduction in jail days	Of clients who completed six consecutive months during the 12-month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year. Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.	Yellowfin
% of clients with a primary care visit in the last 12 months	Of clients who completed 6 consecutive months during the fiscal year, percentage who had an appointment with a Anthem/Alliance/CHCN primary care provider during the fiscal year. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).	Yellowfin

BMH RBA Report FY 2022

High School Health Center (HSHC)

Reporting Period: July 2021-June 2022 (Baseline)

Process Outcomes ("How much did we do?")

233

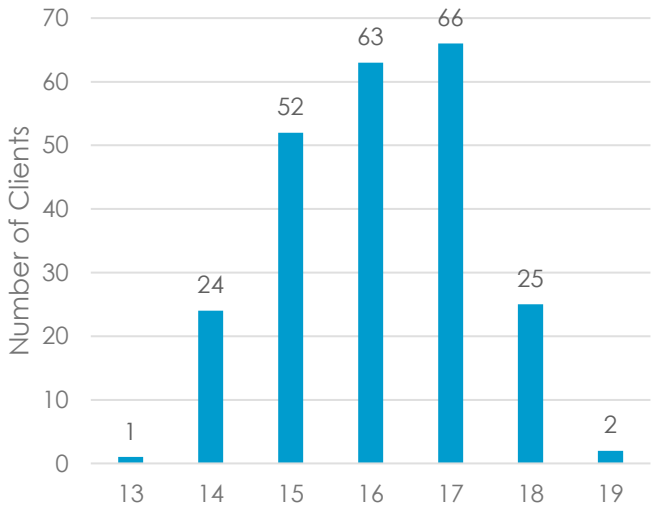
Clients Served

represents 20 clients

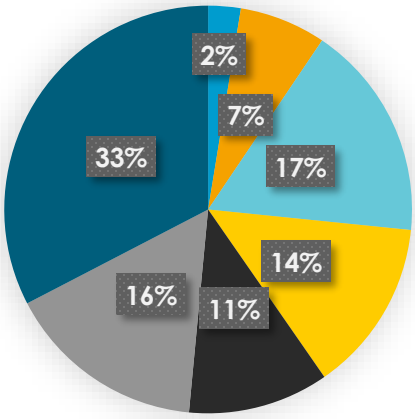
Program Description

The HSHC team provides mental health services on site at Berkeley High School; these services include individual and group therapy, crisis assessments, and drop in support. The program also hosts graduate students for training.

Demographics (Age)

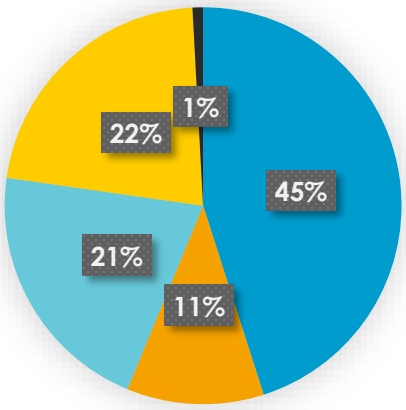


Demographics (Race)



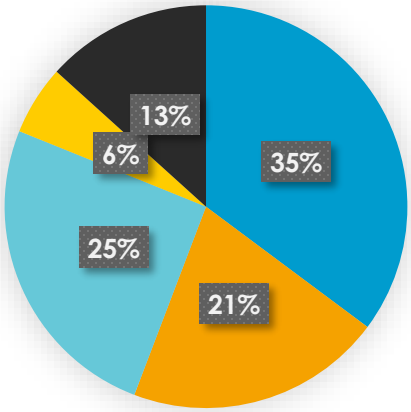
- Alaska Native or American Indian (2%)
- Asian or Pacific Islander (7%)
- Black or African American (17%)
- More than one race (14%)
- Other (11%)
- Prefer not to answer (16%)
- White (33%)

Demographics (Gender Identity)



- Female (45%)
- Gender nonconforming, transgender, genderqueer (11%)
- Male (21%)
- Missing (22%)
- Prefer not to answer (1%)

Demographics (Sexual Orientation)

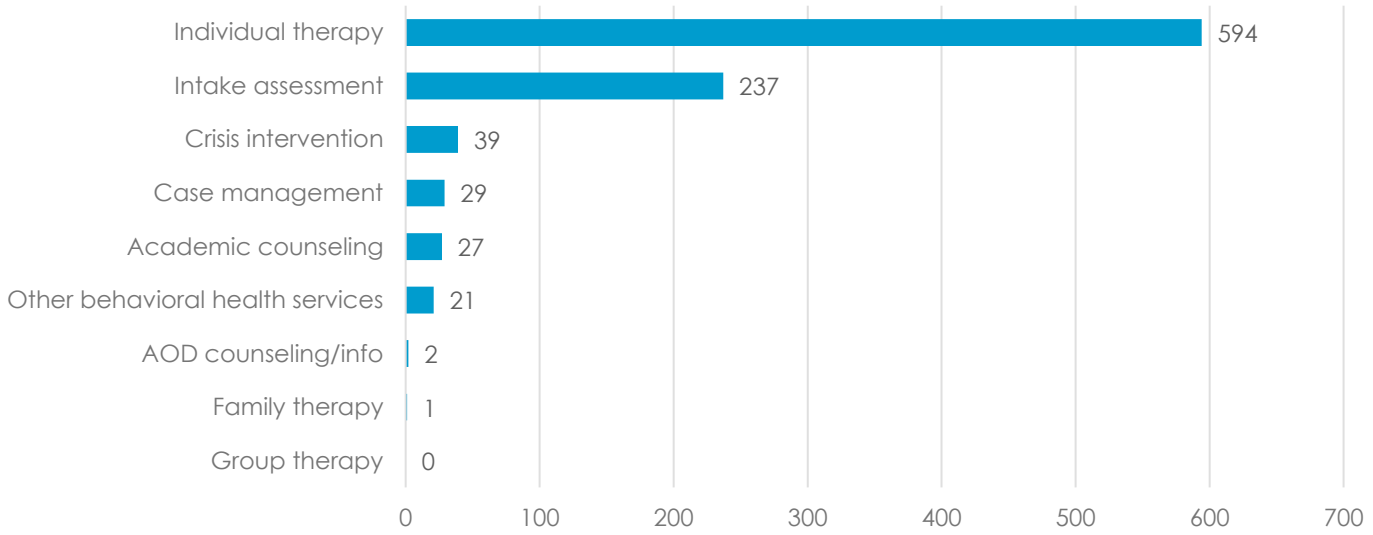


- Heterosexual (35%)
- LGBTQ* (21%)
- Missing (25%)
- Prefer not to answer (6%)
- Unknown/unsure (13%)

*includes students who self-identified as aromantic, asexual, bisexual, gay, homosexual, lesbian, pansexual, queer, and questioning

BMH RBA Report FY 2022

Services Provided by Service Type

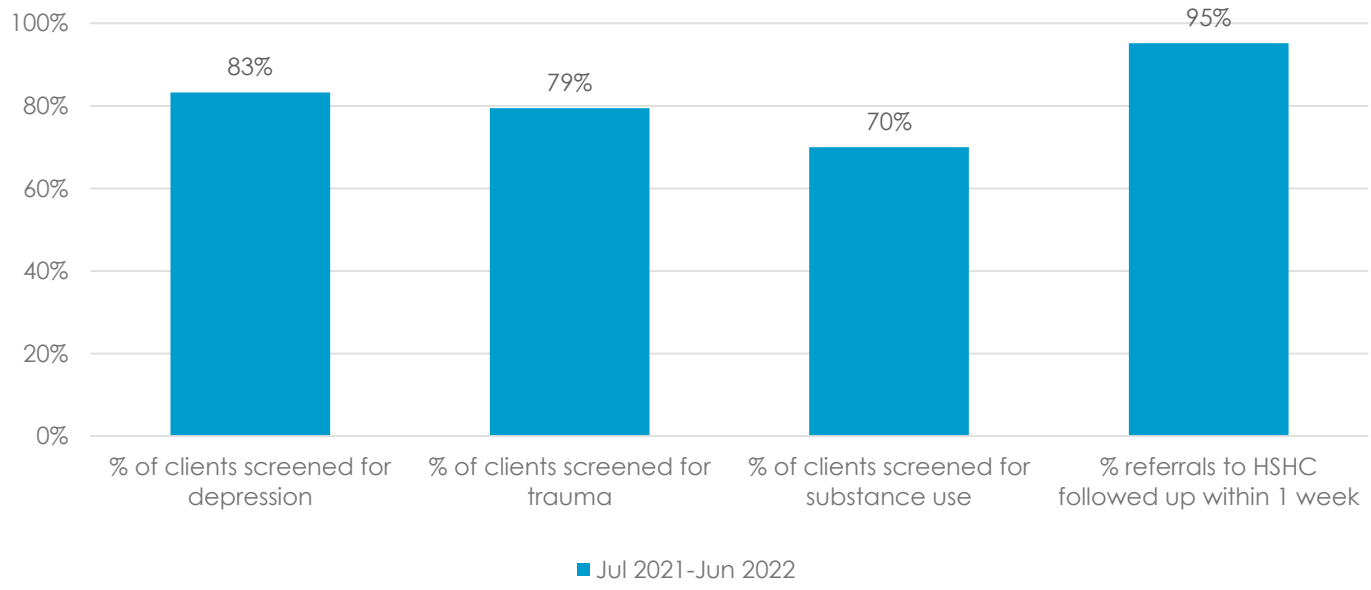


Note that multiple services could be provided in one visit (e.g. crisis assessment and referral) so total services by type (n=950) is greater than total encounters (n=846)

Quality Outcomes ("How well did we do it?")

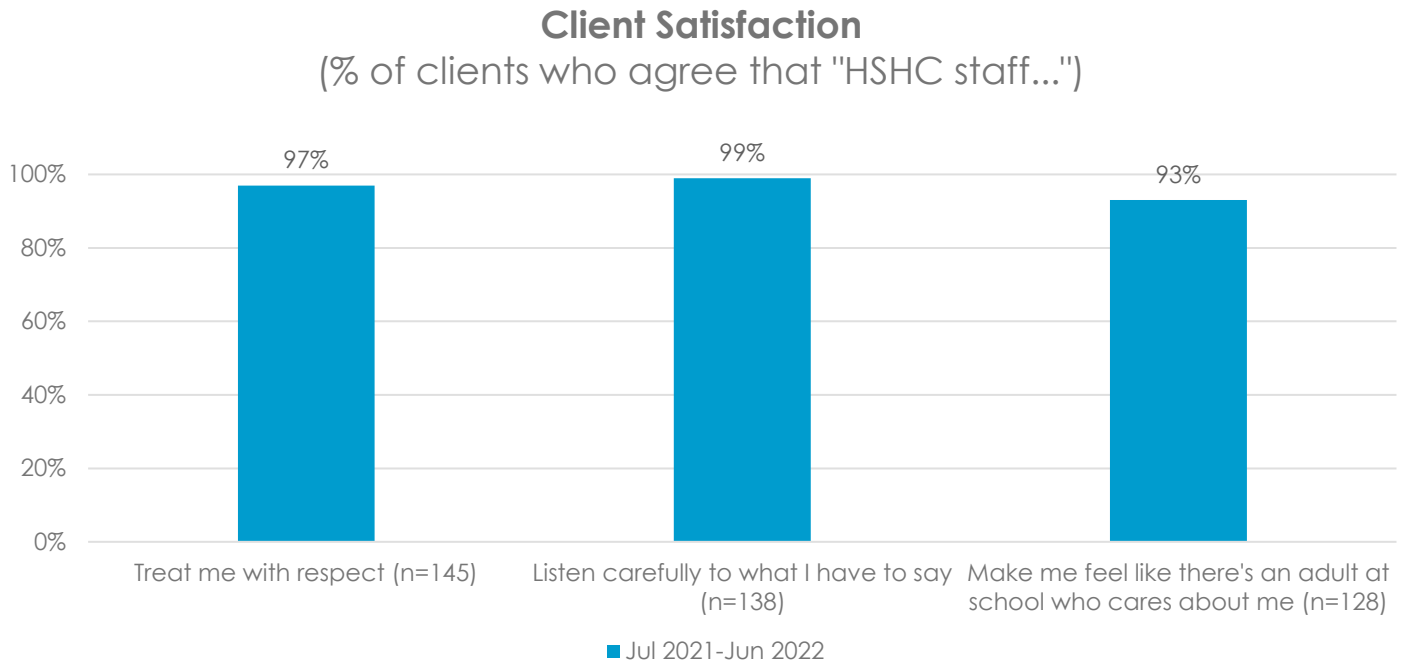
In 2021-2022, the HSHC program served **7%** of the school population.

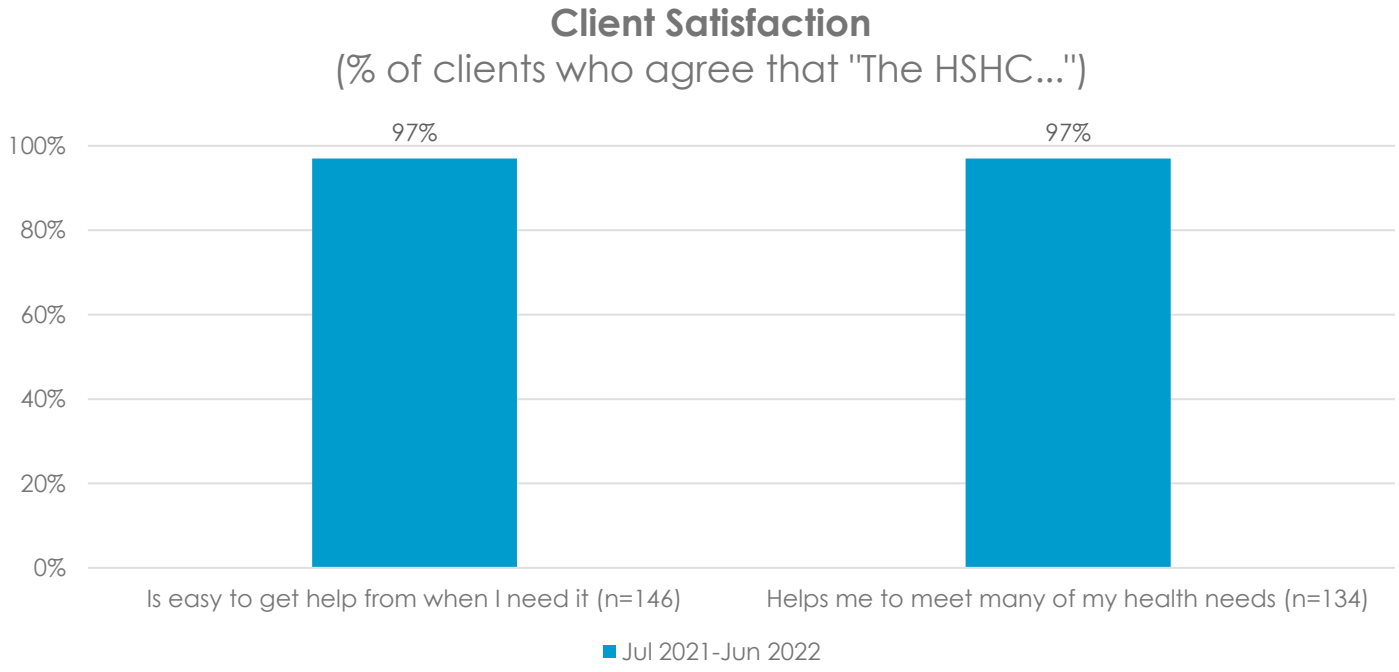
Service Consistency



BMH RBA Report FY 2022

Impact Outcomes ("Is anyone better off?")





BMH RBA Report FY 2022

Measure	Definition	Data Source
# clients served	Total clients served	ETO/RedCap
# services provided by service type	# of services coded as behavioral_service with codes BHSV1-8. Key code accompanies Redcap data. Each incident could include more than one service provided.	ETO/RedCap
% clients screened for depression, trauma, and substance use	Percent of total clients that were recorded as having been screened for depression, trauma, and/or substance abuse at least one time during reporting period.	ETO/RedCap
% referrals to HSHC followed up within one week	Percentage of referrals that had 7 days or less between referral date and response date. Calculation reflects % of total referrals, not % of total clients.	Referral Log
% of school population served	Unique clients served by HSHC divided by total student population	ETO/RedCap; BHS data
% of clients satisfied with services, as measured by % of clients who agree with various statements	% of responses marked as "agree" or "strongly agree" for various survey questions. Note: these responses are from all students who accessed the health center and answered the survey, not just those who received mental health services.	Berkeley SBHC Client Survey
% of clients able to receive needed care, as measured by % of clients who agree with various statements	% of responses marked as "agree" or "strongly agree" for various survey questions. Note: these responses are from all students who accessed the health center and answered the survey, not just those who received mental health services.	Berkeley SBHC Client Survey

BMH RBA Report FY 2022

Mobile Crisis Team (MCT)

Reporting Period: July 2021-June 2022 (Baseline)

Process Outcomes ("How much did we do?")

932 Clients Served

=100 clients

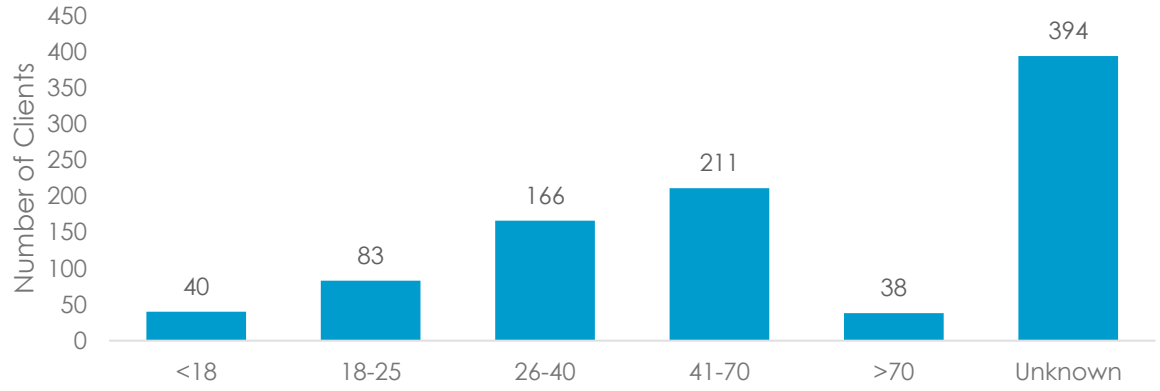
1486 Incidents Responded To

=100 incidents

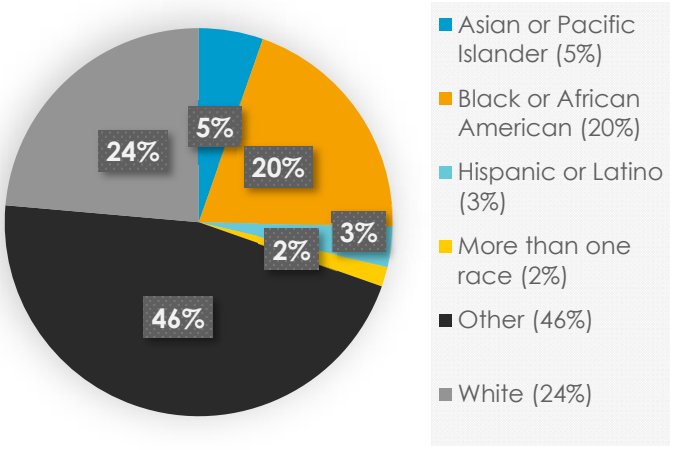
Program Description

The Mobile Crisis Team (MCT) provides mobile crisis services to residents of Berkeley, from 11:30a-10p each day of the week, when fully staffed. It provides crisis interventions, including but not limited to 5150 evaluations, consultations, and referrals/linkages.

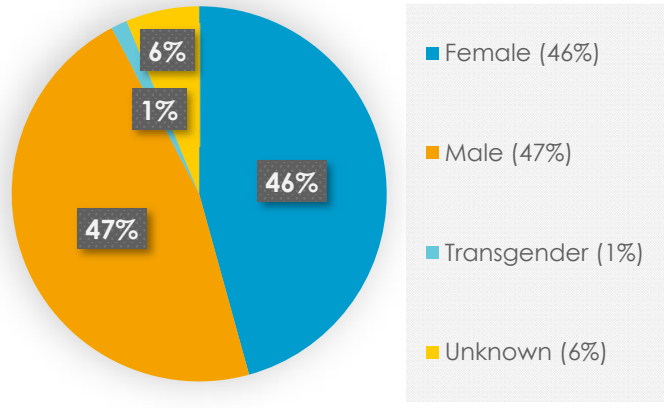
Demographics (Age)



Demographics (Race)



Demographics (Gender Identity)

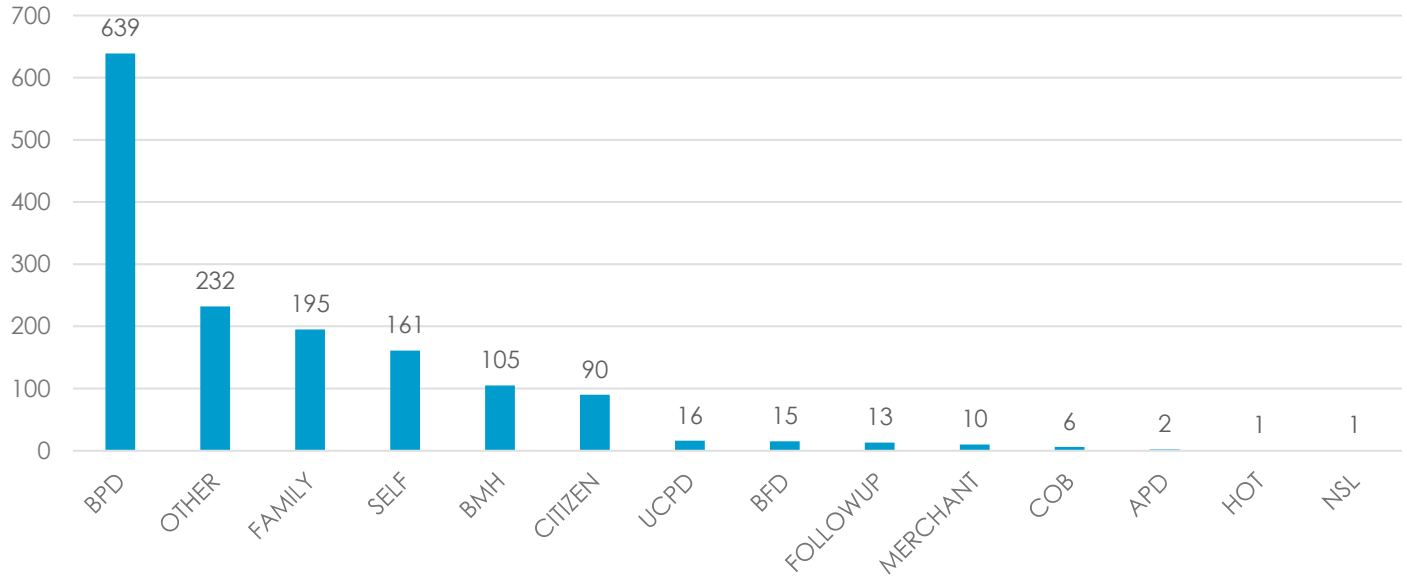


*Sexual Orientation data not available

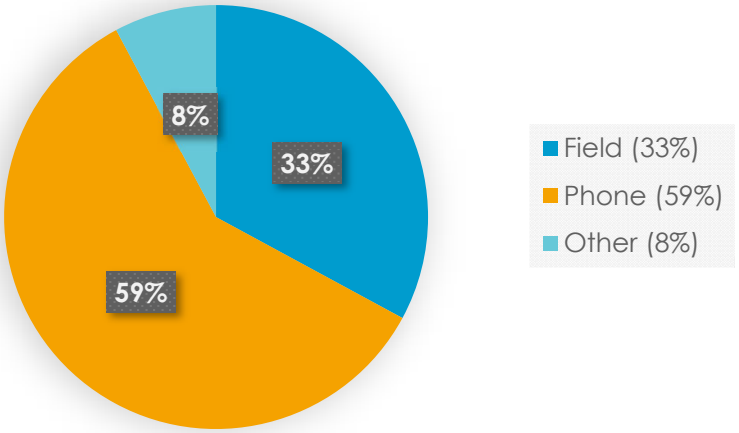
BMH RBA Report FY 2022

In 2021-2022, the MCT program performed **395** 5150 Evaluations

Total Referrals, by Referring Party (n=1486)



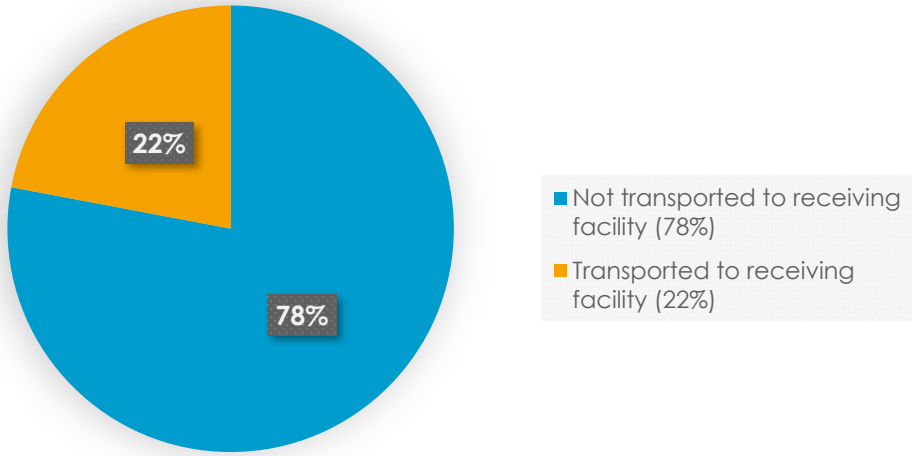
Client Contact Types (n=1486)



BMH RBA Report FY 2022

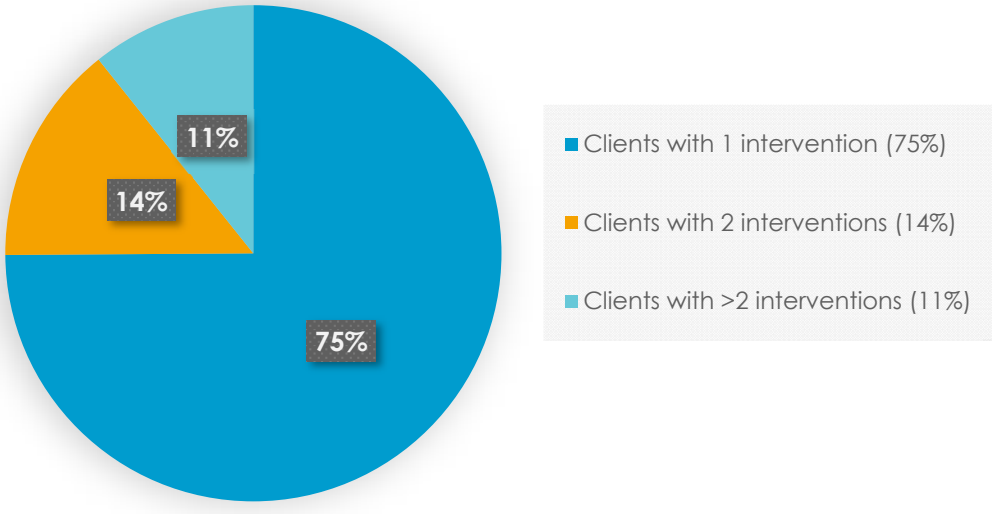
Quality Outcomes ("How well did we do it?")

Results of 5150 Evaluations (n=395)



Impact Outcomes ("Is anyone better off?")

Number of Interventions per Client (n=932)



BMH RBA Report FY 2022

Measure	Definition	Data Source
# clients served	Total unique clients served	MCT Contact Log
Client contact types	# of client contacts made, by a. Field contacts b. Phone contacts c. Other	MCT Contact Log
Total referrals, by referring party	# of crisis services referrals made to the MCT, by referring party (i.e. BPD, BFD, BMH, community, etc.)	MCT Contact Log
# of 5150 evaluations conducted	Total number of incidents with 5150 Evaluations of any sort	MCT Contact Log
Results of 5150 Evaluations	% of 5150 evaluations that did or did not result in transportation to a receiving facility for further evaluation	MCT Contact Log
Number of interventions per client	% of clients who had one, two, or more than two interventions	MCT Contact Log

BMH RBA Report FY 2022

Medical Services

Reporting Period: July 2021-June 2022 (Baseline)

Process Outcomes ("How much did we do?")

324

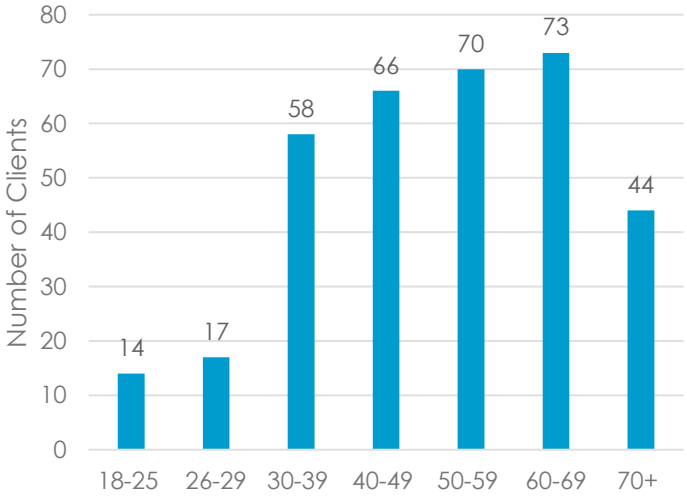
Clients Served

represents 25 clients

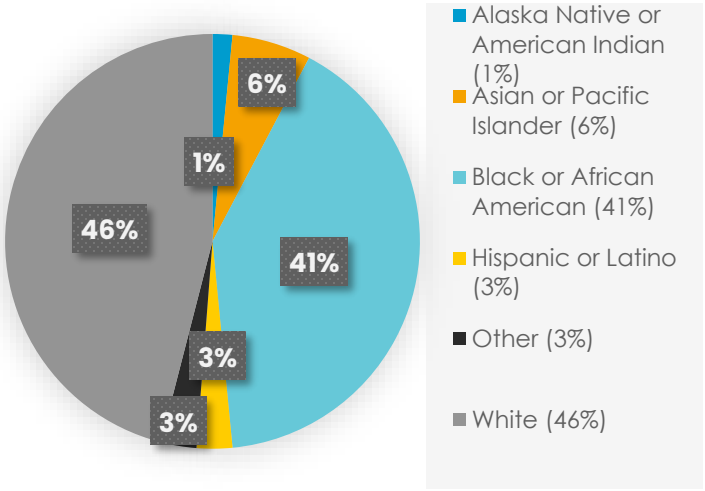
Program Description

The Medical Services Team provides psychiatric and nursing services to patients on Adult Services (FIT, CCT, & FSP), Crisis Services, and Family, Youth, and Children's Services.

Client Demographics (Age)



Client Demographics (Race)



Quality Outcomes ("How well did we do it?")

73%

of appointments were kept

Impact Outcomes ("Is anyone better off?")

48%

of clients were connected to a primary care provider

BMH RBA Report FY 2022

Measure	Definition	Data Source
# clients served	Total clients served	Yellowfin
% of appointments kept	Of scheduled appointments, % which were kept for the time period	MD Attendance Tracker
% of clients connected to a primary care provider	Of total clients, % who had Primary Care Practitioner listed in Primary Care Tracker	Primary Care Provider Tracker

BMH RBA Report FY 2022

Wellness & Recovery Services

Reporting Period: July 2021-June 2022 (Baseline)

Process Outcomes ("How much did we do?")

Program Description The Wellness and Recovery Program is designed to provide outreach, support, education, activities, and advocacy to consumer members living with mental illness and living in Berkeley. Wellness group activities include: Berkeley Pool of Consumer Champions (POCC), Card Groups, Mood Groups, Walking Groups, and field trips.

35

Participants served

8

Different groups convened

139

Group events

20

Participants who meet the requirements for "Telling Your Story"

represents 10 clients/events/groups

Quality Outcomes ("How well did we do it?")

71%

of participants returned for group events

Impact Outcomes ("Is anyone better off?")

4 out of 5

participants reported feeling less shame about their experiences and challenges (n=5).

3 out of 5

participants reported recognizing progress in their recovery (n=5).

BMH RBA Report FY 2022

Measure	Definition	Data Source
# participants served	Total # of participants served	Wellness Recovery Group Attendance Tracker
# of different groups convened	Number of different types of groups (i.e. walking group, mood group, Telling Your Story group) convened	Wellness Recovery Group Attendance Tracker
Group events	Total number of meetings held	Wellness Recovery Group Attendance Tracker
# of participants who meet the requirements for "Telling Your Story"	Total number of participants in all "Telling Your Story" meetings	Wellness Recovery Group Attendance Tracker
# of participants who return for group events	Of total number of participants, % who returned for more than one event or meeting	Wellness Recovery Group Attendance Tracker
% of participants who reported feeling less shame about their experiences and challenges	Of participants who took the survey, percent who responded "agree" or "strongly agree" to the question.	Telling Your Story Survey
% of participants who reported recognizing progress in their recovery	Of participants who took the survey, percent who responded "agree" or "strongly agree" to the question.	Telling Your Story Survey

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Monday, April 10, 2023 8:25 AM
To: Works-Wright, Jamie
Subject: FW: Mental Health Advisory Board Meeting (April 10, 2023)
Attachments: MHAB Main Board Agenda 04.10.2023.pdf; MHAB Meeting Minutes (UNAPPROVED) 03.20.2023.pdf; SB 43.pdf; Modernizing California's Behavioral Health System.pdf; MHAB Recruitment Flyer.pdf; MHSA Presentation (April 2023).pdf; MHSA Three Year Plan FY 2023-2026 (DRAFT).pdf

Public

Hello commissioners,

Please see the information attached

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: MHB Communications, ACBH <ACBH.MHBCommunications@acgov.org>
Sent: Friday, April 7, 2023 3:06 PM
Subject: Mental Health Advisory Board Meeting (April 10, 2023)

Good afternoon,

Please see attached agenda/materials for the Mental Health Advisory Board (MHAB) meeting scheduled for Monday, April 10, 2023.

The meeting will be held at 1100 San Leandro Blvd., *Redwood Conference Room,* San Leandro, CA. Members of the public are invited to observe and participate in person or participate remotely via Zoom.

To participate via Zoom, please click on the meeting link below:

Join from PC, Mac, Linux, iOS or Android:
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Password: 774947

Or Telephone:

One tap mobile:
+14044436397,,,937417# US Toll
+18773361831,,,937417# US Toll-free

Dial:
USA 404 443 6397
USA 877 3361831 (US Toll Free)
Conference code: 937417

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Numbers: https://www.teleconference.att.com/servlet/glbAccess?process=1&accessNumber=4044436397&accessCode=937417

Alameda County
Mental Health Advisory Board

Mental Health Advisory Board Agenda

Monday, April 10, 2023 ◊ 3:00 PM – 5:00 PM

1100 San Leandro Blvd., Redwood Conference Room, San Leandro

This meeting will also be conducted through videoconference and teleconference

https://us02web.zoom.us/j/87366080958?pwd=YWZaQkd5RWEwZW1sbjRTVTh4Q3pNUT09

Teleconference: (877) 336-1831 | Meeting ID: 873 6608 0958 | Code: 937417

MHAB Members:			
Brian Bloom *(Interim Chair, District 4)*	**Thu Quach** *(District 2)*	**Juliet Leftwich** *(District 5)*
Warren Cushman *(Interim Vice Chair, District 3)*	**Loren Farrar** *(District 3)*	**Abigail West** *(District 5)*
Christina Aboud (*District 1*)	**Ashlee Jemmott** *(District 3)*	**Amy Shrago** (*BOS Representative)*
Terry Land *(District 1)*	**Anh Thu Bui** *(District 5)*	

Committees

Adult Committee
Terry Land, Co-Chair
Thu Quach, Co-Chair

Children's Advisory Committee
Vacant

Criminal Justice Committee
Brian Bloom, Co-Chair
Juliet Leftwich, Co-Chair

MHAB Mission Statement

The Alameda County Mental Health Advisory Board has a commitment to ensure that the County's Behavioral Health Care Services provide quality care in treating members of the diverse community with dignity, courtesy and respect. This shall be accomplished through advocacy, education, review and evaluation of Alameda County's mental health needs.

3:00 PM **Call to Order** _____ **Interim Chair Bloom**

3:00 PM **I. Roll Call**

3:05 PM **II. Approval of Minutes**

3:10 PM **III. Public Comments (Agenda Items)**

3:15 PM **IV. Interim Chair's Report**
- A. MHAB Member Update
- B. SB43 Update
- C. Modernizing California's Behavioral Health System
- D. Glenn Dyer Update
- E. MHAB Recruitment Flyer

3:25 PM **V. John George Psychiatric Hospital Tour (May 1, 2023 at 12:00 PM)**

3:30 PM **VI. ACBH Director's Report**

3:40 PM **VII. Committee and Liaison Reports**
- A. Adult Committee
- B. Criminal Justice Committee
- C. Care First, Jail Last Task Force Liaison
- D. Mental Health Services Act Liaison

3:45 PM **VIII. MHSA Information Session and Three-Year Plan Update**

4:45 PM **IX. Public Comment (Non-Agenda Items Only)**

5:00 PM **X. Adjourn**

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Mental Health Advisory Board UNAPPROVED Minutes
Tuesday, March 20, 2023 ◊ 3:00pm-5:00pm

Meeting Conducted In-Person and through Video/Telephone Conference

Alameda County Mental Health Advisory Board

MHAB Members:	☒ **Brian Bloom** *(Interim Chair, District 4)* ☒ **Warren Cushman** *(Interim Vice Chair, District 3)* ☐ **Christina Aboud** *(District 1)* ☒ **Terry Land** *(District 1)*	☒ **Thu Quach** *(District 2)* ☒ **Loren Farrar** *(District 3)* ☒ **Ashlee Jemmott** *(District 3)* ☒ **Anh Thu Bui** *(District 5)*	☒ **Juliet Leftwich** *(District 5)* ☒ **Amy Shrago** *(BOS Representative)*
ACBH Staff:	☒ **Dr. Karyn Tribble** *(ACBH Director);* ☒ **James Wagner;** ☒ **Asia Jenkins;** ☒ **Dainty Castro** *(Administrative Liaison);*		
Unexcused Absences:			

Meeting called to order at 3:03 PM by **Interim Chair Brian Bloom**

ITEM	DISCUSSION	DECISION/ACTION
Roll Call / Introductions	Roll Call completed.	
Approval of Minutes	Minutes from the February 21, 2023 meeting were approved.	
Interim Chair's Report	Interim Vice-Chair Cushman shared that there have been four (4) deaths at the Santa Rita Jail thus far in 2023. All of the deceased had not been at the jail long. This is something that needs to be given more attention and explored further. The County Administrator's Office should be presenting to the Board of Supervisors (BOS) sometime in the next month or so, responding to Supervisor Miley's inquiry regarding funds the Forensic plan. There was a meeting organized by some of the community providers focusing on the Mobile Crisis Team that was attended by Interim Vice Chair Cushman. He encouraged the MHAB to invite this type of presentation to the MHAB meeting. John George Psychiatric Hospital is very anxious to have the MHAB tour the facility. Member Leftwich will take the lead to ensure a tour is scheduled soon.	

ITEM	DISCUSSION	DECISION/ACTION
Director's Report	**<u>The CARE Act/CARE Court Update</u>** Dr. Tribble provided a presentation that addressed the CARE Act (Community Assistance, Recovery and Empowerment Act). In summary, the presentation addressed the SB 1338 overview. Also, the differences between prior programs were addressed. CARE is different from LPS Conservatorship in that it does not include custodial settings or long-term involuntary medications. CARE is also different than LPS/Laura's Law as it relates to the way it can be initiated, the criteria for consideration, and the allowance of a "Supporter". Prior negative outcomes are not a requirement to be considered for CARE. CARE Court is designed to work together with other agencies to coordinate care. CARE Court is already adopted into the State budget. $16.5 million is allocated for county costs on implementing CARE Court for the FY 23-24. $66.5 million is proposed for FY 24-25, and $108.5 million is proposed for FY 25-26. There are seven cohort counties currently involved. $26 million has been allocated among the counties for planning. The CARE Working Group is established to be a part of the stakeholders' progress. Housing will pay an important role in CARE Court Programs statewide. One of the programs Alameda County will be applying for Bridge Housing. This program is designed for temporary housing that will help serve as a "bridge" so that individuals can ultimately make connections on a permanent basis. While Bridge Housing is not required by CARE Court, nor is CARE Court required to use Bridge Housing, however the State has been clear in indicating that counties would benefit from utilizing Bridge Housing. There are certain administrative requirements for executing this program. Bridge Housing will support individuals regardless of their issue (Mental Health or SUD). Alameda County anticipates approximately $46M to be received. This amount must be spent no later than 6/30/2027.	
Committee Reports	**<u>Adult Committee & MHSA Stakeholders Committee</u>** Tracy Hazelton made a presentation at the last meeting. The link to the report can be found on the Adult Committee website. MHSA is allotted approximately $170M dollars, which is approximately 26% of the overall County BH budget. The breakdown of the usage is available on the presentation slides. The next 3-year plan is due April 1, and thereafter will be available for public comment before going to the BOS for approval. The public comment deadline is April 30. Meetings are held on the 4th Thursday of each month at 4:00 p.m.	

ITEM	DISCUSSION	DECISION/ACTION
	Criminal Justice Committee The CJC did not meet in March. They plan to meet in April. **MHAB Legislative Ad Hoc Committee** No report as the committee has been on hiatus. It was suggested that the Governor's plan for ballot measures be placed on the agenda for discussion. It was also suggested that Eileen Ng be contacted to return to come back and present again. **Children's Advisory Committee** On hiatus. **Quality Improvement Committee** No report. Loren Farrar explained the purpose of this committee. **MHAB Data Ad Hoc Committee** No specific information to report, as the committee is on hiatus. **Care First, Jails Last Taskforce** This committee meets the 4th Thursday of each month. Progress is being made and the Taskforce continues to look at the various intercepts.	
Discussion Items	**MHAB Main Meeting for April** Discussion ensued regarding a change of date for the April meeting due to Chair Bloom's inability to attend the regularly scheduled meeting. It was suggested and agreed that the meeting be rescheduled to April 10th. The Executive Committee will meet on April 6th. **Recruitment** The recruitment flyer was reviewed by the Board and discussed revisions, particularly so that it would be a one-page flyer. ACBH will notify the board when applications are received. The applications should be received via email. It was suggested that the MHAB members reach out to the BOS staff in their district to solicit assistance with the recruiting efforts. It would be helpful to also email the flyer to the BOS staff member for a broader distribution.	
Public Comment	Public comment was given.	
Adjournment	Adjourned at 5:05 PM	

SB 43: Expanded definition of grave disability for civil commitment purposes

SB 43 amends Welfare and Institutions Code section 5008(h)(1) to add a new subsection (C) which sets forth the expanded definition of grave disability:

(C)(i) A condition in in which a person, as a result of a mental health disorder or a substance use disorder, or both, is at substantial risk of serious harm to their physical or mental health.

(ii) "Serious harm" means significant deterioration, debilitation, or illness due to the person's failure to meet one or more of the following conditions:

(I) Satisfy the need for nourishment.

(II) Attend to necessary personal or medical care.

(III) Utilize adequate shelter.

(IV) Be appropriately or adequately clothed.

(V) Attend to self-protection or personal safety.

(iii) A substantial risk of serious harm to the physical or mental health of the person may be evidenced by one or more of the following:

(I) The person is presently suffering adverse effects to their physical or mental health.

(II) The person previously suffered adverse effects to their physical or mental health in the historical course of their mental health disorder or substance use disorder, their condition is again deteriorating, they are unable to understand their disorder, and their decision-making is impaired due to their lack of insight into their disorder.

(iv) The existence of a mental health disorder or substance use disorder diagnosis does not alone establish a substantial risk of serious harm to the physical or mental health of a person.

Modernizing California's Behavioral Health System

March 2023

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

CalHHS
California Health & Human Services Agency

Context

- Since 2019, California has embarked on massive investments and policy reforms to re-envision the state's mental health and substance use system.

- We have invested more than $10 billion in a range of efforts that begin to build up the community-based care the sickest Californians desperately need. This includes investments in prevention and early intervention programs for kids, to investments in programs like the CARE Act and system improvements in Medi-Cal through CalAIM.

- But more can and must be done. Now it's time to take the next step and build upon what we have already put in place – continuing the transformation of how California treats mental illness and substance abuse.

Key Elements

1. Authorize a general obligation bond to fund unlocked community behavioral health residential settings
    - The bond would also provide housing for homeless veterans
2. Modernize the Mental Health Services Act (MHSA)
3. Improve statewide accountability and access to behavioral health services

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Authorize General Obligation Bond

Authorize a General Obligation Bond

- Build thousands of new unlocked community behavioral health beds in residential settings to house Californians with mental illness and substance use disorders
- Provide more funding for housing of homeless veterans
- $3-5 billion bond on 2024 ballot

97

Adding New Behavioral Health Settings

Multi-Property Settings

Residential campus-style settings where multiple individuals can live, attend groups, recover, and further stabilize with a number of onsite supportive services.

Cottage Settings

Smaller residential settings, where many services will be available but will also allow individuals to access existing services in the community.

Home Settings

Permanent Supportive Housing and Scattered Site Housing offer even smaller settings to integrate individuals into the community and provide long-term housing stability.

86

Modernize the Mental Health Services Act

Modernize the Mental Health Services Act

- Update local categorical funding buckets – lifting up housing interventions and workforce
- Broaden the target population to include those with debilitating substance use disorders
- Focus on the most vulnerable
- Fiscal accountability, updates to county spending and revise county processes
- Restructure role of the Mental Health Services Oversight Accountability Commission
- Many components will require 2024 Ballot initiative
- Multi-year implementation starting in July 2025

100

Update Local Categorical Funding Buckets

- 30% for housing and enhanced care in residential settings for individuals with serious mental illness/serious emotional disturbance and/or substance use disorder.
  - Counties will manage the funds and direct the funds toward local priorities that meet designated purposes described above
- A services bucket with two sub-categories:
  - 35% of the local assistance for Full Service Partnership (FSP) which should be optimized to leverage Medicaid as much as is allowable
  - 35% for other services including Community Services and Supports (non FSP), Prevention and Early Intervention, Capital Facilities and Technological Needs, Workforce Education and Training, and prudent reserve
- To reduce overlap with the Children and Youth Behavioral Health Initiative and close the gap in preventive services, Prevention and Early Intervention (PEI) dollars for schools should be focused on schoolwide behavioral health supports and programs and not services and supports for individuals.

101

Housing Interventions and Supports

- Dedicate 30% in local MHSA funding for housing interventions for people living with serious mental illness/serious emotional disturbance and/or substance use disorder who are experiencing homelessness. 30% is approximately $1 billion but will vary year to year.

- Funding could be used for full spectrum of housing services and supports, rental subsidies, operating subsidies, and non-federal share for Medi-Cal covered services, including clinically enriched housing. It also could be used to further the California Behavioral Health Community-Based Continuum Demonstration.

- Funding may also be used for capital development projects, subject to DHCS limits established through bulletin authority.

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Workforce

- Expand the use of local MHSA funds under the Workforce Education and Training (WET) component to include activities for workforce recruitment, development, and retention.

- The use of these funds could include professional licensing and/or certification testing and fees, loan repayment, stipends, internship programs, retention incentives, and continuing education and that increase the racial/ ethnic and geographic diversity of the workforce.

- In addition to expanding the local MHSA funds under WET, allocate MHSA funds to create a new Behavioral Health Workforce Initiative, while drawing down additional federal funds for a five-year period.

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Broaden Target Population

- Authorize MHSA funding to provide treatment and services to individuals who have a debilitating substance use disorder (SUD) but do not have a co-occurring mental health disorder.

- Increase access to SUD services for individuals with moderate and severe SUD.

- Require counties to incorporate SUD prevalence and local unmet need data into spending plans. Use data to inform and develop accountability to improve the balance of funding for SUD.

104

Focus on Most Vulnerable

Adults

- Adults with serious mental illness (SMI) or substance use disorder (SUD) who are or at risk of experiencing homelessness or are or are at risk of being justice-involved, and/or meet the criteria for behavioral health linkages under the CalAIM Justice-Involved Initiative
- Adults with SMI at-risk of conservatorship

Children and Youth

- Children and youth with serious emotional disturbance or SUD, who are experiencing homelessness, are involved or at risk of being justice-involved, meet the criteria for behavioral health linkages under the CalAIM Justice-Involved Initiative or are in or transitioning out of the child welfare system

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Fiscal Accountability and County Spending

- Require counties to bill Medi-Cal for all reimbursable services in accordance with Medicaid State Plan and applicable waivers, to further stretch scarce dollars and leverage MHSA to maximize federal funding for services.
- Reduce allowable prudent reserve amounts from 33% to 20% for large counties and 25% for small counties.
- Reassess prudent reserve more frequently from every 5 years to every 3 years.
- Authorize up to 2 percent of local MHSA revenue to be used for administrative resources to assist counties in improving plan operations, quality outcomes, reporting fiscal and programmatic data and monitoring subcontractor compliance for all county behavioral health funding.

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Revise County Process

- Pare back the requirements for Three-Year Program and Expenditure Plans, standardize the level of detail and submission process, and provide additional flexibilities for transparent amendment process.

- Provide county behavioral health agencies with more flexibility to adjust spending.

- Transform the MHSA planning process into a broader county/region behavioral health planning process. Require counties to work with Medi-Cal Managed Care Plans in the development of their Population Needs Assessments and with Local Health Jurisdictions in the development of their Community Health Improvement Plans and for these reports to inform the MHSA planning process to ensure strategic alignment of funding and local cross-system collaboration.

- Require plans be approved by boards of supervisors by June 30.

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Mental Health Services Oversight Accountability Commission

- Move the Mental Health Services Oversight Accountability Commission (MHSOAC) under the California Health and Human Services Agency so that it is connected with the rest of the behavioral health system.

- Require that the Commission would become advisory, and its Executive Director would be a gubernatorial appointee.

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Improve Statewide Accountability and Access to Behavioral Health Services

Fiscal Transparency

Require counties to report:

- Annual allocation of MHSA, Realignment, and all federal block grants;
- Annual spend on non-federal match payments including MHSA, Realignment or other county sources;
- MHSA, Realignment and Block Grant only spend;
- Any other behavioral health investments using local General Fund or other funds;
- Any unspent MHSA, Realignment or block grant funds for that fiscal year;
- Cumulative unspent MHSA, Realignment or block grant funds, inclusive of reserves;
- Admin costs, and
- Information on services provided to persons not covered by Medi-Cal, including commercial insurance, Medicare, and uninsured.

110

County Accountability and Infrastructure

- Develop outcome measures, not just process measures, to drive toward meaningful and measurable system change.

- Align county Behavioral Health (BH) plans (including MHPs and DMC-ODS) and Medi-Cal Managed Care Plan contract requirements when the same requirements exist across programs. This includes, but is not limited to:
  - Require key administrative positions (e.g., quality director, chief financial officer, operations director, compliance officer)
  - Compliance oversight and monitoring of subcontractors
  - Post on their website network adequacy filings, annual number of utilizers and utilization by service type
  - Establish a robust set of quality metrics for county BH plans and establish quality thresholds/goals
  - Require county BH plans annually report utilization and quality to Board of Supervisors (BOS) and require the BOS to attest that they are meeting their obligation under Realignment
  - Require county BH plans to form member advisory council to inform policy and programs
  - Implement closed loop referrals

Alignment between Medi-Cal and Commercial Coverage of Behavioral Health Services

- Over the next year, DMHC and DHCS will develop a plan for achieving parity between commercial and Medi-Cal mental health and substance use disorder benefits. This may include, but is not limited to, phasing in alignment of utilization management, benefit standardization, and coverage of county-provided services.

- DMHC and DHCS will establish a stakeholder process that will include health plans and other system partners to develop framework.

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Next Steps

Next Steps

- We look forward to working with the Legislature, system and implementation partners, and a broad set of stakeholders, including those impacted by behavioral health conditions, to set these reforms into motion to deliver equitable, accessible, and affordable community-based behavioral health care for All Californians.

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Questions?

For questions and inquiries, contact
BehavioralHealthTaskForce@chhs.ca.gov

Alameda County
Mental Health Advisory Board

Contact the Mental Health Advisory Board at:

ACBH.MHBCommunications@acgov.org

BOARD APPLICANTS WANTED

Members:

Brian Bloom
Interim Chair
District 5

Warren Cushman
Interim Vice-Chair
District 4

Terry Land
District 1

Thu Quach
District 2

Loren Farrar
District 3

Ashlee Jemmott
District 3

Thu A. Bui
District 5

Juliet Leftwich
District 5

Amy Shrago
BOS Representative
District 5

What is the Mental Health Advisory Board (MHAB)?
Every California county is required by state law to have a mental health advisory body. In Alameda County, members of the board are appointed by the Alameda County Board of Supervisors (BOS) for a three-year term. The MHAB's charge is to review and evaluate Alameda County's mental health needs, facilities, services and special problems; advise the BOS and the Alameda County Mental Health Director on any aspect of the local mental health programs; review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council; provide input into the development of the county's Mental Health Services Act (MHSA) plan; and submit an annual report to the BOS on the needs and performance of the county's mental health system.

Looking for passionate and dedicated team players to join the board!
Alameda County is seeking Alameda County residents who are passionate about ensuring and advocating for responsive, equitable mental health prevention, intervention and treatment services, who want to use their voice and expertise towards this end. Qualifying board members include consumers of mental health services and their family members, as well as community members and individuals who have experience with and knowledge of mental health systems.

In order to ensure diverse perspectives and round out current MHAB membership, individuals representing the following groups are particularly desired:

- Have expertise and/or a strong interest in children and youth-related issues
- Identify as Latinx
- Have worked in the field or have special knowledge of the field
- Are interested in and/or have expertise in local or state legislation
- Have experience working in county or city services or government

What does serving on the MHAB involve?
As a board member, you will be required to:

- Work in collaboration with other board members to fulfill the responsibilities of the MHAB
- Attend 10 regular in-person monthly board meetings each year
- Attend Special Meetings from time to time
- Serve on at least one committee and/or serve as a Board Liaison to another entity or organization (usually monthly meetings)

Interested in joining? Next Steps
For more information about the MHAB click here. If you have questions or would like to apply, please email ACBH.MHBCommunications@acgov.org. Interested individuals are encouraged to attend at least one board meeting prior to application.

Mental Health Services Act Information Session/ Public Comment

Presented by:
Tracy Hazelton, MPH
MHSA Division Director, Alameda County Behavioral Health Care Services

Alameda County Mental Health Advisory Board
April 10, 2023

MHSA Presentation Highlights:

Presentation Purpose: Education and Information on the draft MHSA Three Year Plan FY 23/24-25/26

Presentation Highlights:

- Review of MHSA Principles, Components, Regulations
- ACBH Departmental Strategies
- Highlights from the Community Program Planning Process (CPPP)
- Full Service Partnership Outcomes
- FY 23/24 Budget
- FY 22/23 Program Changes
- Modernizing our Behavioral Health System: MHSA Changes
- Where to find MHSA Information/public comment

MHSA Core Principles:

The Mental Health Services Act (MHSA) emphasizes Transformation of the Mental Health System and Improving the Quality Of Life for people living with mental illness and those at-risk for mental illness and/or mental health challenges.

- Community Collaboration
- Cultural Competence
- Wellness Focus: Recovery and Resilience
- Client and Family Driven Mental Health Services
- Integrated Service Experience

ACBH Strategic Framework: True North Metrics

To Learn more about our strategic framework go to:
Office of the Director – Alameda County Behavioral Health (acbhcs.org)

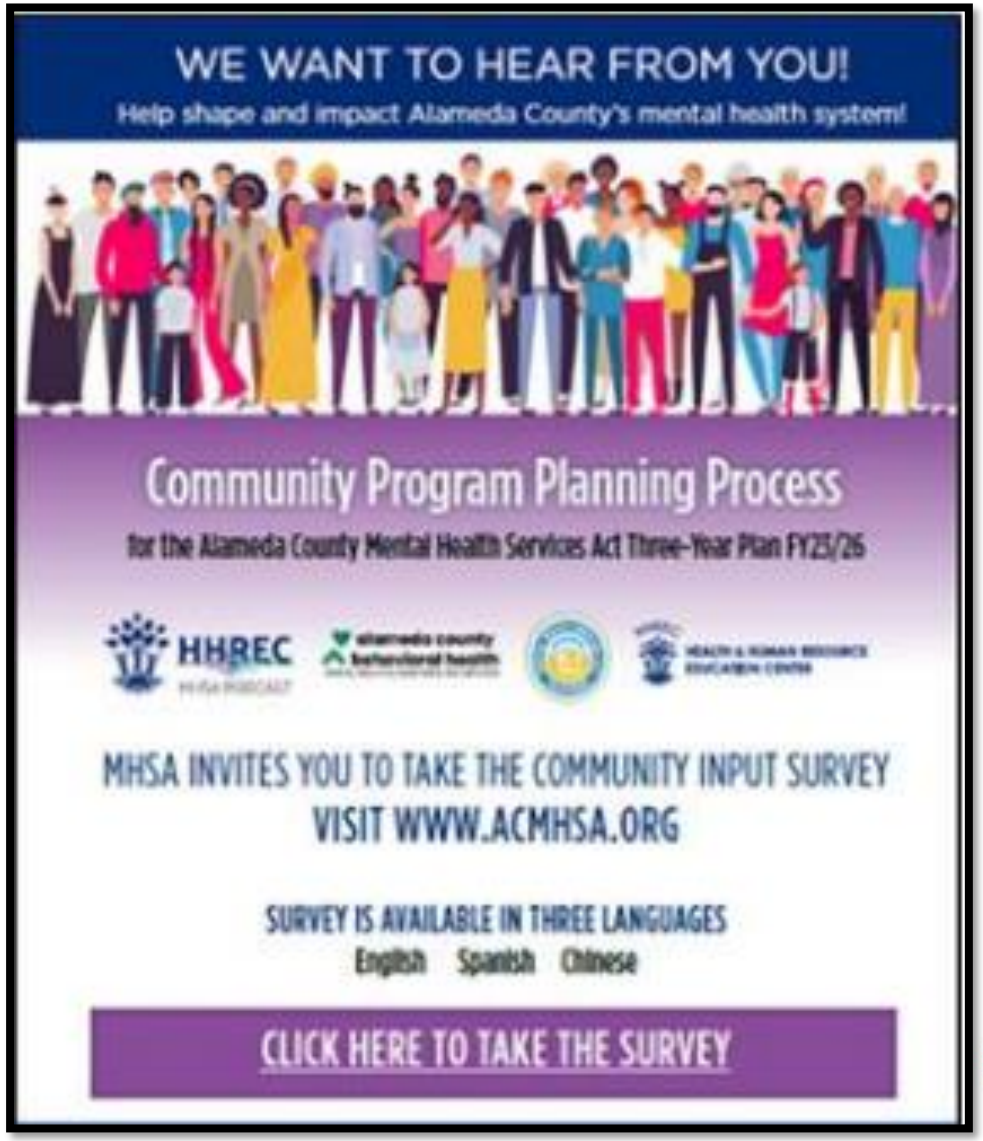
WELLNESS • RECOVERY • RESILIENCE

Community Input:

Counties conduct a **Community Program Planning Process (CPPP)** every 3 years. Alameda County chooses to gather additional data each Annual Update period.

A CPPP was held between October 28, 2022 through January 31, 2023:

- 13 listening sessions: 145 community stakeholders
- 581 surveys completed
- 100,000 community input invitations



WELLNESS • RECOVERY • RESILIENCE

Alameda County Three-Year Planning Process:

MHSA 3YR CPPP	2018-2020	2020-2023	2023-2026*
Outreach Timeline	September-October 2017	April-May 2020	Oct – Jan 2023
Outreach Summary	1,000+	14,069+	100,000+
Survey Responses	550	627	581
Focus Groups	18,138 participants	12,198 participants	13,145 participants
Public Comments	10	227	TBD

*This is the first year that providers were not over-represented in the survey responses. Of the survey responses: 51% identified as family members, 42% identified as Peers, 34% identified as Providers, 12% identified as the Faith Community, 3% Active Military/Veteran and 2% Law Enforcement agency.

CPPP Results:
Mental Health Issues Across the Age Span

<u>Social determinants of health focus</u>, with particular emphasis on:

- Housing/homelessness
- Community violence & trauma
- Family conflict & stress
- Employment

<u>Most pressing Behavioral Health Issues</u> (in addition to needs mentioned above):

- Suicide
- Depression
- Substance Use Disorders (SUD)
- Chronic Health Conditions

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*NOTE: *Issues in blue have been identified in several past CPPP*

WELLNESS • RECOVERY • RESILIENCE

Community Feedback Trends:

Improvement Needs & Recommendations:
Screening and assessment (especially for young children)
Service access and availability, with emphasis on culturally appropriate services, i.e.:
-Non-traditional/non-Western treatment and supports,
-Language capacity,
-LGBTQI services,
-Services for the African American community.

Community services (i.e. in-reach, mobile, field and home-based, non-traditional/ non-office settings)
System navigation & system coordinated care (i.e. medical/MH/SUD care coordination,
Coordinated continuum of care, 1-stop shop model/resource/wellness center

Top Five (5) Most Effective MHSA Service Areas:
Crisis services
Mental Health Outreach Teams (e.g. IHOT)
Suicide prevention (crisis hotline/training & educations)
Full Service Partnerships (FSPs)
Collaborative Courts

MHSA Components & Program Summaries:

Each MHSA component contains program summaries following this **standardized format**:

- *Page 1: MHSA component definition*
- *Client story (also known as vignettes or success stories)*
- *Program/project summaries*

MHSA **must** include all projects intended to be funded for the year in this plan. **Each program/project summary will include**:

- *MHSA Work Plan Budget identifier (e.g. OESD 33). This aligns with the Table of Contents*
- *Organization name*
- *Program/Project name*
- *The number of children, adults, and seniors to be served*
- *Results Based Accountability (RBA): Addresses 3 questions*

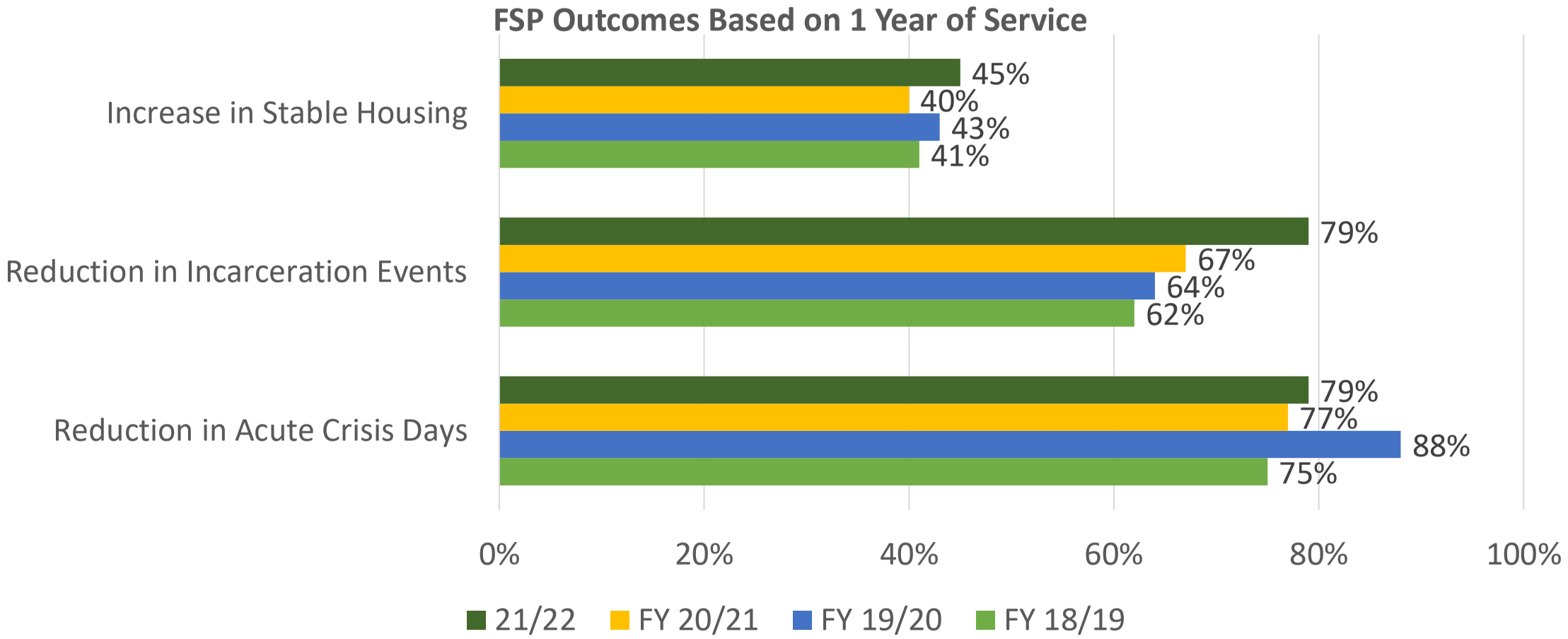
How Much Did We Do?

How Well Did We Do It?

Is Anyone Better Off?

Full Service Partnership (FSP) Program Highlights, Data Trends:

Is Anyone Better Off?? (Program Impact)



Quotes from the Annual FSP Fidelity Review Process:

"I have a lot of good experience with the BACS [HEAT] team. I really appreciate [them] helping me with my medications to stay healthy. [They] are really personable and flexible."

"I was always in the hospital before the program. Now I'm not."

"I receive numerous support and services [from CHANGES]. The big ones are getting a driver's license, going to school to get my GED, going to truck driving school. Better management of my money. Emotional, physical, and mental support."

"[CHANGES] is great. Basically, a life saver. I applaud them during the pandemic to come to our home. The home visits were on point. [The prescriber] comes and does home visits, maybe once a month. A phone call, and he gets on it right away. [My son] is actually back in school. [CHANGES] motivates him. It's teamwork."

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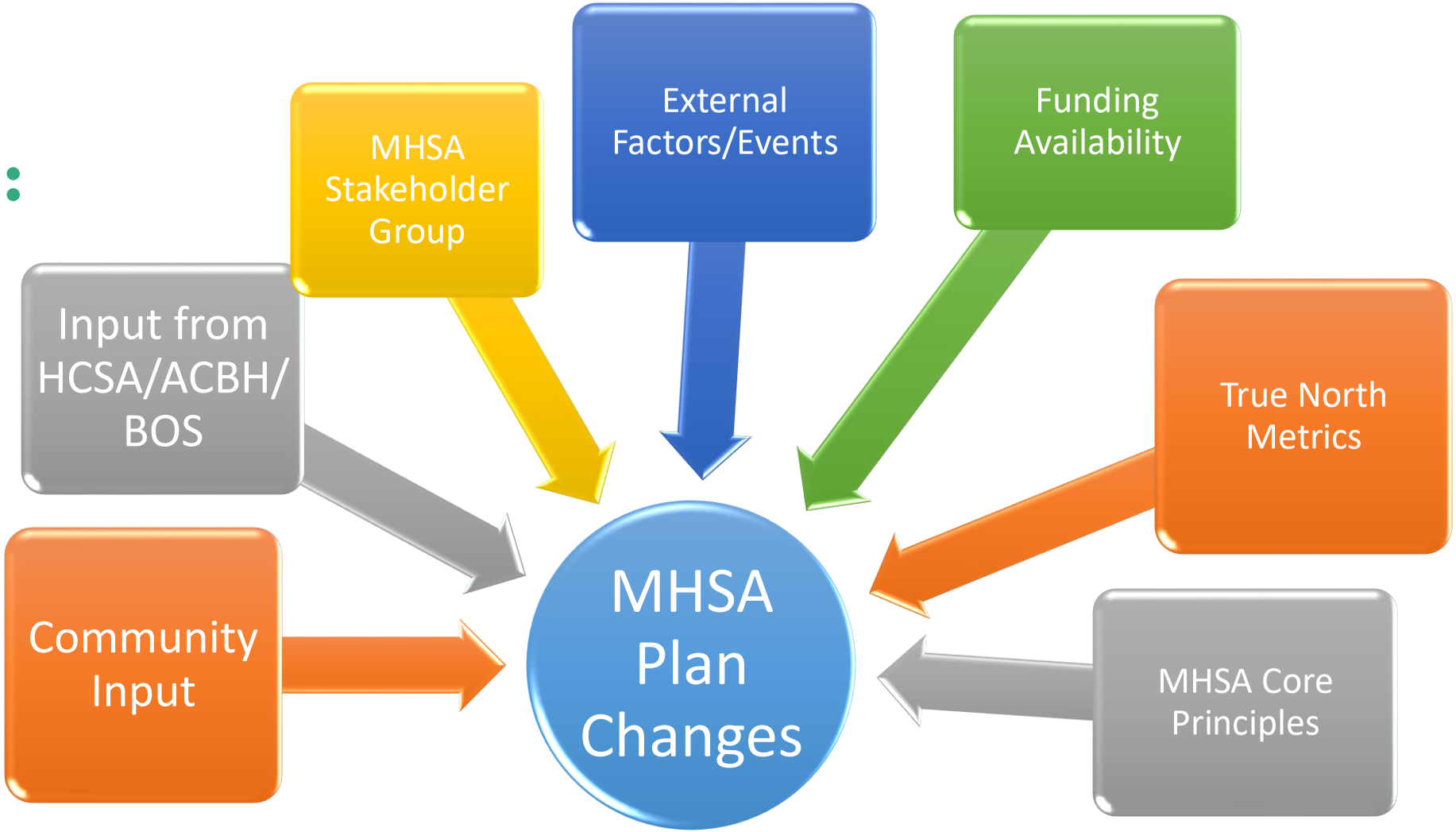
MHSA Change Process:



All community need information is shared with the ACBH Leadership and analyzed against the MHSA known budget information. After this review, the ACBH Director makes the final decisions on how to move forward with any new or expansion programming.

Proposed Programmatic Changes FY 23/24

MHSA Budget for FY 22/23 = **$176.2M**

- 1x capacity building grants to address the workforce crisis/Cal Aim implementation
- New Transition Age Youth (TAY) Forensic Focused Full Service Partnership
- New Early Childhood Mental Health Services and Consultation program
- Expansion of Asian American & Pacific Islander Older Adult treatment program with City of Fremont
- New PEI/CSS blended program for LGBTQI youth/TAY
- New PEI/WET blended program for the African American community
- Increase in Peer/Family Member Stipend Policy Update
- New program in WET Action 4: Residency/Internships ACBH-Stanford Public Psychiatry Training Partnership
- Funding for ACBH Forensic Plan (mainly for expansion of crisis services)

MHSA FY 23/24 Fiscal Overview Highlights

MHSA Funding *Estimates* (in Millions)

Source	All Components	CSS	PEI	INN	WET	CFTN
Unspent funds from prior FYs	109.50	81.40	6.07	17.63	.467	3.97
State Allocation FY 23/24	137.09	104.18	26.04	6.85		
Transfer to WET/CFTN	15.50	(15.50)			7.50	8.00
Available Funding	246.65	170.09	32.12	24.49	7.96	11.97
Projected Expenditures*	176.27	129.10	22.12	7.49	7.95	9.59
Carryover Funds	70.38	40.99	9.99	17.00	.170	2.37

*The above budget does not include the Prudent Reserve, estimated to be $14.59M in FY 23/24

2024 Ballot Initiative:
Modernizing Our Behavioral Health System & Building More Mental Health Housing

Governor Newsom has proposed a 2024 ballot initiative to improve how California treats mental illness, substance abuse, and homelessness. This initiative will cover three (3) areas:

- A **General Obligation Bond to build state-of-the-art mental health treatment residential settings** in the community to house Californians with mental illness and substance use disorders and to create **housing for homeless veterans**,
- **Modernize the Mental Health Services Act,** and
- **Increase Accountability and Fiscal Transparency** of all funding streams.

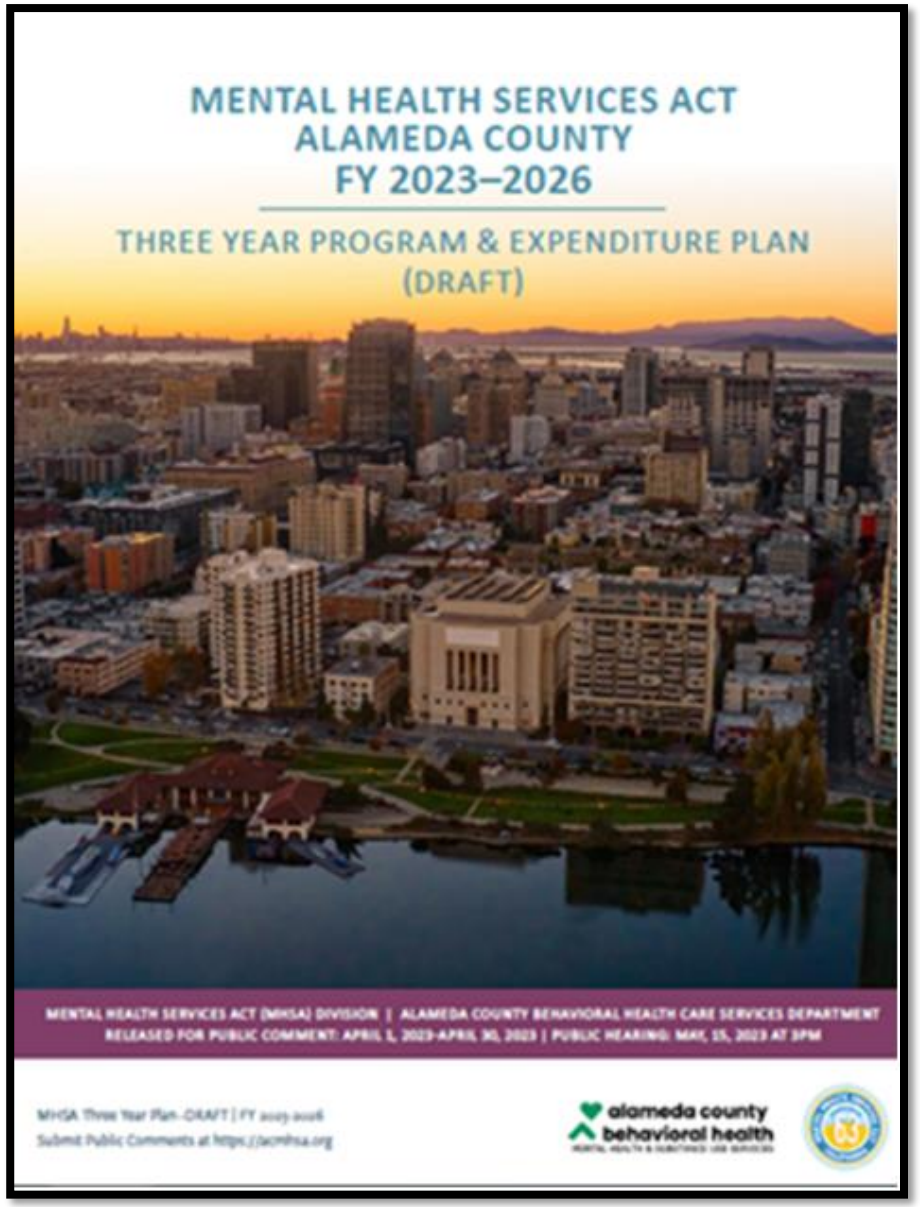
Public Comment Period:
April 1st-April 30th

All public comments are to be submitted in writing.

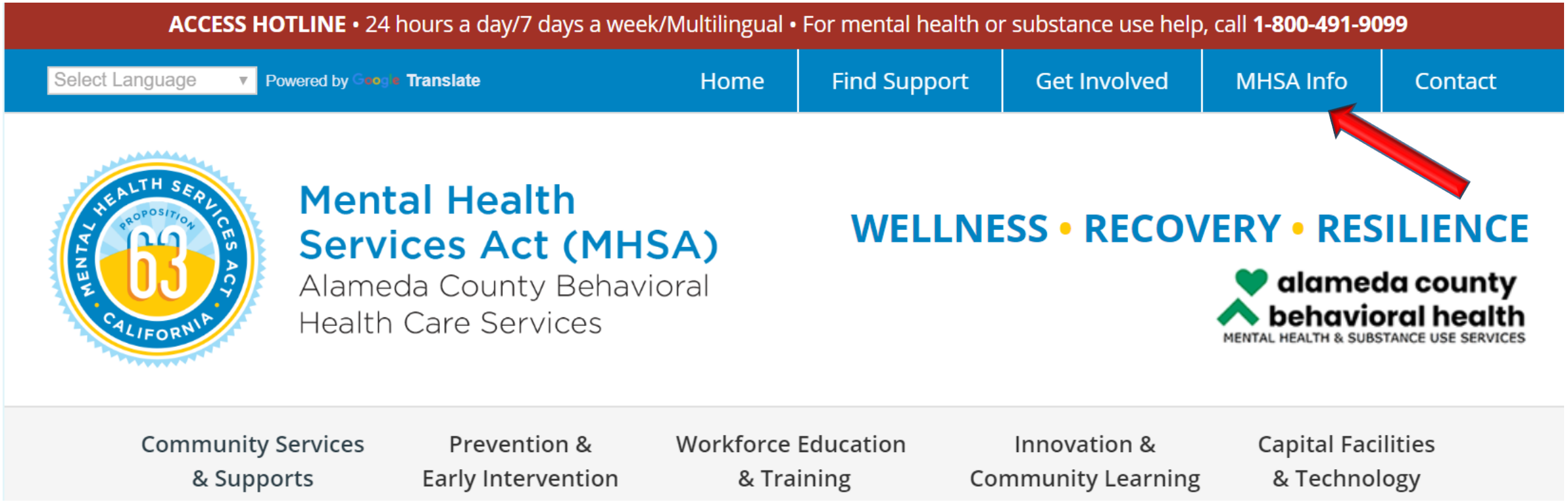
Comments can be submitted through:

- The website: https://ACMHSA.org and
- Comment cards if there is an in person meeting.

ACBH will be conducting outreach to community groups to highlight that the 30-day public comment period is now open and how to respond.



MHSA Website www.ACMHSA.org



For more information, contact our MHSA Staff at MHSA@acgov.org.

Questions & Discussion
Thank You

WELLNESS • RECOVERY • RESILIENCE

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Friday, April 7, 2023 12:44 PM
To: Works-Wright, Jamie
Subject: FW: CoB May 9, 2023 NOTICE OF PUBLIC HEARING and REQUEST FOR COMMENTS: Proposed Annual Action Plan (7/01/23-6/30/24)
Attachments: CoB-PHNotice-PY23AnnualActionPlan_FYLER.pdf

Please see the information

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: Oehler, Joshua
Sent: Friday, April 7, 2023 12:40 PM
To: Oehler, Joshua <JOehler@cityofberkeley.info>
Subject: CoB May 9, 2023 NOTICE OF PUBLIC HEARING and REQUEST FOR COMMENTS: Proposed Annual Action Plan (7/01/23-6/30/24)

Dear City Staffe,

This email contains important information regarding an opportunity for public comment on the City's expenditure of Housing and Urban Development (HUD) funds. **Please share, post and distribute the attached flyer regarding this public hearing and opportunity to comment.**

NOTICE OF PUBLIC HEARING
BERKELEY CITY COUNCIL
&
REQUEST FOR COMMENTS ON THE CITY'S ANNUAL ACTION PLAN

The Health, Housing, and Community Services Department (HHCS) will conduct a Public Hearing addressing the proposed **Annual Action Plan for Program Year (PY) 2023** (July 1, 2023 – June 30, 2024) which includes recommended allocations of Community Development Block Grant (CDBG), Emergency Solutions Grant (ESG), and HOME Investment Partnership Program (HOME) funds.

The hearing will be held on **Tuesday, May 9, 2023, at 6:00 P.M**. The hearing will be conducted in a hybrid model with both in-person attendance and virtual participation. For in-person attendees, face coverings or masks that cover both the nose and the mouth are encouraged. If you are feeling sick, please do not attend the meeting in person. The in-person meeting will be held at the **Berkeley Unified School District Board Room - 1231 Addison Street, Berkeley, CA 94702.**

A copy of the agenda material for this hearing will be available on the City Council agenda webpage at https://berkeleyca.gov/your-government/city-council/city-council-agendas in advance of the meeting. **Once posted, the agenda for this meeting will include a link for public participation using Zoom video technology. You may also attend virtually, at the teleconference location: 1404 Le Roy Avenue, Berkeley 94708.**

Accommodations Provided Upon Request. To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the Disability Services specialist at 981-6342 (V) or 981-6345 (TDD) at least three business days before the meeting date. Providing at least three working days' notice will help to ensure availability at the meeting.

The proposed **PY 2023 Annual Action Plan** required by the U.S. Department of Housing and Urban Development (HUD), outlines the City's housing and community development program for the period July 1, 2023 through June 30, 2024. The plan also outlines the proposed use of the estimated $3,361,202 in **Community Development Block Grant (CDBG)** funds available for housing related activities, improvement of public facilities, public services, and planning and administration. In addition, the plan outlines the proposed use of $232,452, the majority of which is used for rapid re-housing financial assistance, outreach and/or shelter for people who are homeless in Berkeley under the **Emergency Solutions Grant (ESG),** and the use of an estimated $749,633 in **HOME Investment Partnerships Program (HOME)** funds for affordable housing development and rehabilitation.

PUBLIC COMMENT PERIOD: The public also has from April 7, 2023 through May 9, 2023 to submit written comments on the PY2023 Annual Action Plan. **A draft of the Plan will be available for public review** on the web at https://berkeleyca.gov/community-recreation/community-services/hud-planning-performance-reports.

Physical copies of the public comment draft will be made available at the following locations:

- Berkeley Main Library: Reference Desk, on the 2nd Floor, 2090 Kittredge Street, Berkeley; and

- Health, Housing, and Community Services Department, 2180 Milvia Street, 2nd Floor, Berkeley.

All written comments must be either sent by email to both JOehler@berkeleyca.gov AND SFCPDMail@hud.gov, or by letter, or other legible written form, to Health, Housing, and Community Services Department, 2180 Milvia Street, 2nd Floor, Berkeley, and received no later than May 9, 2023, at 5:00 p.m.

For residents and groups that would like assistance in translating this report into another language, please contact HHCS at (510) 981-5400 or HHCS@berkeleyca.gov.

For general information, please contact Joshua Oehler (phone: (510) 981-5408 or email: JOehler@berkeleyca.gov) at HHCS 2180 Milvia Street, 2nd Floor, Berkeley, 94704.

Joshua Oehler
Pronouns: he/him
Community Services Specialist III
City of Berkeley
Housing and Community Services
2180 Milvia Street, 2nd Floor
Berkeley, CA 94704
(510) 981-5408 (office)
joehler@cityofberkeley.info

Please note: As a cost saving measure the City of Berkeley is closed the 2nd Friday of every month. Additional closures may occur. For the latest City Closures and Holidays please check the City of Berkeley Homepage at https://berkeleyca.gov/.

NOTICE OF PUBLIC HEARING
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For general information, please contact Joshua Oehler (phone: (510) 981-5408 or email: JOehler@berkeleyca.gov) at HHCS 2180 Milvia Street, 2nd Floor, Berkeley, 94704.

El Departamento de Servicios de Salud, Vivienda y Servicios Comunitarios llevará a cabo una audiencia pública para tratar el **Plan de Acción Anual para el Año (PY) 2023** (1 de julio de 2023 a 30 de junio de 2024), el cual incluye las asignaciones recomendadas de fondos de la Beca de Desarrollo del Bloque Comunitario (Community Development Block Grant-CDBG), Beca de Soluciones de Emergencia (Emergency Solutions Grant - ESG) y la beca HOME.

La audiencia se llevará a cabo el **martes, 9 de mayo de 2023 a las 6:00 P.M.** La audiencia está programada en forma presencial y virtual (modalidad hibrida). Para aquellas personas que asistan presencialmente mascarillas que cubran nariz y boca son recomendadas. Si se está sintiendo enfermo por favor no venga a la audiencia. La audiencia presencial se llevará a cabo en el **Berkeley Unified School District Board Room** localizado en **1231 Calle Addison, Berkeley, CA 94702**.

Una copia de la agenda para esta audiencia estará disponible en la página electrónica https://berkeleyca.gov/your-government/city-council/city-council-agendas antes de la audiencia. **Una vez que la agenda sea publicada, esta incluirá un enlace (link) para la participación pública usando la tecnología de Zoom.**

Para solicitar adaptación especial debido a una discapacidad por favor contactarse con el Especialista de Servicios para Discapacitados al 510.981.6342 o al (TDD) 510.981.6345. Por favor contactarse con el especialista por lo menos 3 días antes de la junta para asegurar que su pedido sea atendido.

El **Plan de Acción Anual PY 2023** que cubre el período a partir del 1ro de julio de 2023 hasta el 30 de junio de 2024 es un requisito del Departamento de Vivienda y Desarrollo Urbano de los E.E. U.U. (HUD por sus siglas en inglés) y resume los programas de vivienda y desarrollo comunitario. El plan también enumera la distribución de aproximadamente $3,361,202 que la Ciudad recibirá por medio de la de la Beca de Desarrollo del Bloque Comunitario (Community Development Block Grant - CDBG) para financiar programas de vivienda, mejoras de infraestructura de edificios públicos, servicios públicos y la administración y planificación de los mismos. Además, el plan también explica el uso propuesto de aproximadamente $232,452 que en su gran mayoría será usado para la relocalización rápida de vivienda dando ayuda financiera, información y/o refugio a las personas desamparadas de Berkeley, estos fondos son parte de la Beca de Soluciones de Emergencia (Emergency Solutions Grant - ESG). También explica cómo se usarán los fondos de la Beca HOME, aproximadamente $749,633 que se usarán para el desarrollo y rehabilitación de viviendas.

PERIODO DE COMENTARIO PÚBLICO: A partir del 7 de abril de 2023 hasta el 9 de mayo de 2023, el público podrá presentar comentarios por escrito sobre el Plan de Acción Anual PY 2023**.** Un borrador del **Plan está disponible al público** en el Internet en la página electrónica https://berkeleyca.gov/community-recreation/community-services/hud-planning-performance-reports.

Copias impresas del borrador estarán disponibles en los siguientes lugares:

- En el escritorio de referencia de la Biblioteca Pública de Berkeley localizada en Calle Kittredge 2090, y
- En el escritorio de recepción del Departamento de Salud, Vivienda y Servicios Comunitarios de la ciudad de Berkeley localizado en la Calle Milvia 2180, 2do Piso,

Cualquier comentario escrito tiene que ser enviado a JOehler@berkeleyca.gov Y SFCPDMail@hud.gov o enviarlos por correo regular al Health, Housing & Community Services Department, 2180 Milvia Street, 2nd Floor, Berkeley, CA 94704. Todos los comentarios deben ser recibidos antes o a más tardar el 9 de mayo de 2023 hasta las 5:00 p.m.

Residentes y grupos que necesiten servicios de interpretación o traducción en otro idioma por favor contactarse con el Departamento de Salud, Vivienda y Servicios Comunitarios al 510.981.5400 o por correo electrónico a HHCS@cityofberkeley.info

Para información general, por favor contactarse con Joshua Oehler al 510.981.5408, por correo electrónico a JOehler@berkeleyca.gov o por correo regular enviando sus comentarios a HHCS 2180 Milvia Street, 2nd Floor, Berkeley, CA 94704.

伯克萊市
公眾視訊聽證會通知
及
計劃評論徵求
關於市政府的年度行動之綜合計劃書

伯克萊市房屋及社區服務部門(HHCS)將提出公開聽證會針對市政府的 **2023 服務行動計劃年度 (PY2023) (07/01/2023-06/30/2024) 行動之綜合計劃書**. 伯克萊市政府將邀請公眾人仕對伯克萊市政府的年度行動之綜合計劃書加以檢討及評論。該計劃書將提出對於社區發展經費（CDBG），緊急解決方案撥款（ESG）和房屋投資合作計劃（HOME）的資金分配建議。

此次聽證會將在 2023 年 5 月 9 日，星期二，下午 6:00 舉行。此次聽證會將以現場出席和虛擬參與的混合模式進行。 對於現場與會者，我們鼓勵大家佩戴面罩或同時遮住鼻子和嘴巴的口罩。 如果您身體不適，請不要親自出席會議。 面對面會議將在伯克利聯合學區董事會會議室 - 1231 Addison Street, Berkeley, CA 94702 舉行。

本次聽證會的議程材料副本將在會議召開前在市議會議程網頁 https://berkeleyca.gov/your-government/city-council/city-council-agendas 上提供。 一旦發布，本次會議的議程將包括一個使用 Zoom 視頻技術的公眾參與鏈接。 您也可以在電話會議地點, 1404 Le Roy Avenue, Berkeley 94708 虛擬參加。

市政府將根據要求提供視聽支持。如果您需要有關於殘障人士的技術協助，包括輔助工具或服務，請至少在會議開始前三個工作日致電(510) 981-6342（V）或 (510)981-6345（TDD）與殘疾服務專員聯繫。如能在會議日期前三個工作日發出技術協助通知，我們將盡力確保您毫無困難地參加會議。

此 **PY 2023 服務行動計劃年度之綜合計劃書**擬議計劃是根據住房和城市發展部門 (HUD) 財務資助接受者所提出的流程。此計劃書概述了伯克萊市政府的城市住房和社區發展計劃。該計劃書有效運轉期為 2023 年 7 月 1 日至 2024 年 6 月 30 日。該計劃還概述了在**社區發展經費（CDBG）**中分配的$3,361,202 美元（估計），用於與住房有關的活動，公共設施的改善，公共服務以及規劃和管理。此外，該計劃還概述了大約$232,452 美元（估計）的擬議用途，其中大部分用於根據**緊急解決方案撥款（ESG）**為伯克利無家可歸者提供快速重新安置的財政援助，外展和/或庇護，以及動用約$749,633 美元（估計）的 HOME 資金用於經濟適用房的開發和修復。

公共評論期：公眾可以在 2023 年 4 月 7 日至 2023 年 5 月 9 日之間提交書面評論。該計劃的草案可在以下網站上進行公開審查：

https://berkeleyca.gov/community-recreation/community-services/hud-planning-performance-reports

公眾意見草案的紙質副本將在以下地址提供：

- 伯克利主圖書館：2090 Kittredge Street, Berkeley 諮詢台，二樓
- 伯克萊市房屋及社區服務部門(HHCS)：2180 Milvia Street, Berkeley，二樓

所有書面評論必須通過電子郵件同時發送至 JOehler@cityofberkeley.info 和 SFCPDMail@hud.gov ，或通過信件或其他清晰的書面形式發送至伯克萊市房屋及社區服務部门 (HHCS)，2180 Milvia Street, 2nd Floor, Berkeley，並於 2023 年 5 月 9 日下午 5:00 之前收到這種類型的書面交流。

對於需要幫助將本報告翻譯成另一種語言的居民和團體，請致電 (510) 981-5400 或發送電子郵件至 HHCS@cityofberkeley.info 聯繫 HHCS 以獲得技術支持。

请仅在需要更多有关此主题信息时，联系伯克莱市房屋及社區服務部门的 Joshua Oehler 先生(电邮：JOehler@cityofberkeley.info)，地址: 2180 Milvia St., 2nd Floor, Berkeley, CA 94704。

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Monday, March 20, 2023 2:07 PM
To: Works-Wright, Jamie
Subject: FW: Mental Health Advisory Board Meeting (March 20, 2023)
Attachments: MHAB Main Board Agenda (March 2023).pdf; MHAB Meeting Minutes (UNAPPROVED) 02.21.2023.pdf; ACBH Director Presentation (March 2023).pdf; MHAB Recruitment (DRAFT) 03.13.2023.pdf

Internal

Please see the information below.

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office

From: MHB Communications, ACBH <ACBH.MHBCommunications@acgov.org>
Sent: Friday, March 17, 2023 3:40 PM
Subject: Mental Health Advisory Board Meeting (March 20, 2023)

Good afternoon,

Please see attached agenda/materials for the Mental Health Advisory Board (MHAB) meeting scheduled for Monday, March 20, 2023.

Reminder: Effective March 2023, all MHAB Members will be attending the MHAB Main Board meetings in person. Members of the public are invited to observe and participate in person at the location stated on the agenda or participate remotely via Zoom. The meeting link is below:

Topic: **Mental Health Advisory (Main) Board Meeting**
Time: 3:00 PM – 5:00 PM Pacific Time (US and Canada)
Location: 2000 Embarcadero Cove, Suite 400 (Gail Steele Room), Oakland CA 94606

Join from PC, Mac, Linux, iOS or Android:
https://us06web.zoom.us/j/87366080958?pwd=YWZaQkd5RWEwZW1sbjRTVTh4Q3pNUT09
Password: 774947

Or Telephone:

One tap mobile:
+14044436397,,,937417# US Toll
+18773361831,,,937417# US Toll-free

Dial:
USA 404 443 6397
USA 877 3361831 (US Toll Free)
Conference code: 937417

Find local AT&T
Numbers: https://www.teleconference.att.com/servlet/glbAccess?process=1&accessNumber=4044436397&accessCode=937417

Alameda County
Mental Health Advisory Board

Mental Health Advisory Board Agenda

Monday, March 20, 2023 ◊ 3:00 PM – 5:00 PM

2000 Embarcadero Cove, Suite 400 (Gail Steele Room), Oakland, CA

This meeting will also be conducted through videoconference and teleconference

https://us02web.zoom.us/j/87366080958?pwd=YWZaQkd5RWEwZW1sbjRTVTh4Q3pNUT09

Teleconference: (877) 336-1831 | Meeting ID: 873 6608 0958 | Code: 937417

MHAB Members:			
Brian Bloom *(Interim Chair, District 4)*	**Thu Quach** *(District 2)*	**Juliet Leftwich** *(District 5)*
Warren Cushman *(Interim Vice Chair, District 4)*	**Loren Farrar** *(District 3)*	**Amy Shrago** *(BOS Representative)*
Christina Aboud (*District 1*)	**Ashlee Jemmott** *(District 3)*	
Terry Land *(District 1)*	**Anh Thu Bui** *(District 5)*	

Committees

Adult Committee
Thu Quach, Chair

Children's Advisory Committee
Vacant

Criminal Justice Committee
Brian Bloom, Co-Chair
Juliet Leftwich, Co-Chair

MHAB Mission Statement

The Alameda County Mental Health Advisory Board has a commitment to ensure that the County's Behavioral Health Care Services provide quality care in treating members of the diverse community with dignity, courtesy and respect. This shall be accomplished through advocacy, education, review and evaluation of Alameda County's mental health needs.

3:00 PM Call to Order _____ **Brian Bloom**

3:00 PM I. Roll Call

3:05 PM II. Approval of Minutes

3:10 PM III. Announcements from MHAB Members

3:15 PM IV. Interim Chair's Report
- A. Santa Rita Jail Update
- B. County Administrator Office's Report to Board of Supervisors
- C. MHAB's Annual Report Recommendations
- D. Mobile Crisis (MET, CATT, MACRO, etc.)
- E. John George Psychiatric Hospital Tour

3:25 PM V. ACBH Director's Report

3:50 PM VI. Committee Reports
- A. Adult Committee
- B. Criminal Justice Committee
- C. MHSA Stakeholders Committee
- D. Care First, Jail Last Task Force
- E. Ad Hoc Data Committee
- F. Ad Hoc Legislative Committee
- G. Children's Advisory Committee

4:00 PM VII. Discussion and Action Items
- A. Reschedule Next Month's Meeting
  1. MHAB Executive Committee to 4/6/23 (*Action Item*)
  2. MHAB Regular (In-Person) Meetings to 4/10/23 (*Action Item*)
- B. Recruitment
  1. Recruitment Flyer Review (*Action Item*)
  2. Overview of Current MHAB Composition and Criteria
  3. Recruitment Strategies (*Action Item*)

4:45 PM VIII. Public Comment

5:00 PM IX. Adjourn

Contact the Mental Health Advisory Board at ACBH.MHBCommunications@acgov.org

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Mental Health Advisory Board UNAPPROVED Minutes
Tuesday, February 21, 2023 ◊ 3:00pm-5:00pm

Meeting Conducted Exclusively through Videoconference and Teleconference

Alameda County Mental Health Advisory Board

MHAB Members:	☒ **Brian Bloom** *(Interim Chair, District 4)* ☐ **Christina Aboud** *(District 1)* ☒ **Terry Land** *(District 1)*	☒ **Thu Quach** *(District 2)* ☒ **Warren Cushman** *(Interim Vice-Chair, District 3)* ☐ **Loren Farrar** *(District 3)*	☒ **Ashlee Jemmott** *(District 3)* ☒ **Anh Thu Bui** *(District 5)* ☐ **Juliet Leftwich** *(District 5)*
ACBH Staff:	☒ **Dr. Karyn Tribble** *(ACBH Director);* ☒ **James Wagner;** ☒ **Asia Jenkins;** ☒ **Dainty Castro** *(Administrative Liaison);*		
Unexcused Absences:			

Meeting called to order at 3:03 PM by **Interim Chair Brian Bloom**

ITEM	DISCUSSION	DECISION/ACTION
Roll Call / Introductions	Roll Call completed.	
Approval of Minutes	Minutes from the last month's meeting approved.	
Interim Chair's Report	Interim Chair Bloom acknowledged the passing of Board of Supervisor Richard Valle, and the service he rendered to Alameda County, particularly related to the jail population. A moment of silence was taken in his memory. **MHAB Retreat** One of the topics discussed at the MHAB retreat dealt with recruitment for MHAB members. A document is being created and hopefully available in March to be used as a recruitment tool. The goal is to have three MHAB members per district, including a representative from the Board of Supervisors. Since the retreat, Amy Shrago from Supervisor Carson's office has agreed to be the MHAB liaison. The MHAB Children's Committee has not been active in recent years. However, discussion took place to revisit the issue.	

ITEM	DISCUSSION	DECISION/ACTION
	Short Term Goals and Priorities: 1) ACBH's response to the MHAB Recommendations 2) Recruitment 3) Lifting of the State of Emergency **Summary of the Brown Act** County Counsel distributed materials regarding the Brown Act. HCSA Policy Director, Eileen Ng has been available to answer questions and provided assistance in understanding the content of the material. It was also stated that even the various committees are not meeting in accordance with the Brown Act, i.e., in-person. He further illuminated various conditions and/or restrictions that must be implemented when virtual meetings are taking place. **Executive Committee** The Executive Committee meeting for March will be virtual. The Board meeting for March 20th will be further decided before the adjournment of this meeting.	
Director's Report	**Departmental Update** A presentation was provided by ACBH Director, Dr. Tribble that addressed the California State Budget & Impacts to Counties' Behavioral Health Care Delivery System, the CARE Courts Update and the IMD Waiver. *IST Programs* Clarification was asked if programs would be used for involuntary participants, or on a voluntary basis only. It was stated that this would be a compelling opportunity for someone who is not able to participate by virtue of their mental health condition. They can be found unable to participate without volunteering. Allocations are available for WET, and it has been moved to the Office of the Agency Director (OAD). Grant allocations have been given in order to make changes to contracts, along with incentives to encourage workers to remain as workers in the jail. Hiring bonuses are also being paid between $6,000 and $15,000, depending upon the classification. The OAD's goal is to prevent the end consumer from being impacted by working with other departments so that there will be cross-strategies to make sure the end consumer does not fall through the cracks, while serving as many people as possible. *MHSA Funding* The need for prioritizing the next MHSA 3-year plan was discussed. MHSA requires portions of the funds to be used for treatment, prevention, and intervention. We are	

ITEM	DISCUSSION	DECISION/ACTION
	examining and steadily closing the gap between the budget and the expenses, and closely looking at the expenditure of the funds.	
Committee Reports	**Adult Committee** A meeting was held in January. The committee reached out to Tracy Hazelton and will be at the February meeting to provide an overview regarding MHSA. In the March meeting, the focus will be on CalAIM, and will focus primarily on language access for the month the April. Meetings are held on the 4th Thursday of each month at 4:00 p.m. **Criminal Justice Committee** The CJC met in February and discussed the IST Diversion program in Alameda County. There has been written response and communication since the meeting. Penny Bernhisel, ACBH's Forensic, Diversion, Re-Entry System of Care Supervisor, was available to answer questions from the attendees. There have been three deaths at Santa Rita Jail this year, and all of the individuals died within 4-5 days of intake, including one by suicide. **MHSA Stakeholders Committee** The meeting for February was cancelled, so the next meeting is scheduled for March. The results from the Community Planning Service survey will be discussed. **MHAB Legislative Ad Hoc Committee** No report. **Children's Advisory Committee** On hiatus. **Quality Improvement Committee** No report. Loren Farrar explained the purpose of this committee. **MHAB Data Ad Hoc Committee** No specific information to report, as the committee is on hiatus. **Care First, Jails Last Taskforce** This committee meets the 4th Thursday of each month. Progress is being made and the other members are being gathered to discuss specific recommendations from all of the agencies going forward.to address the Care First, Jails Last philosophy.	

ITEM	DISCUSSION	DECISION/ACTION
Discussion Items	**MHAB Meetings after State of Emergency Ends** Discussion took place regarding the potential in-person meeting location. It was stated that having the option to meet virtually will continue, however some MHAB members are not able to meet in-person at this time. Dr. Tribble was asked if the Cove might be available for in-person meetings that would accommodate both in-person and hybrid conditions. It was stated that 2000 Embarcadero Cove would be able and available to host meetings. In any event, the MHAB wants the meetings to also be available to the public virtually. Warren made a motion was made to allow the Executive Committee to determine whether the March 9 meeting can and will be held virtually or in-person. The motion was amended to ask the Cove to reserve a room for the March 20 meeting in the event the meeting will be held in-person at the Cove. Terry seconded the motion. Motion was approved unanimously. **MHAB Membership Attendance** The MHAB Bylaws state that if a member misses three consecutive meetings without notice, the recommendation is that that person will be removed from the Board. Based on Section 15 of the MHAB Bylaws, Member Christina Aboud should be removed from the MHAB by recommendation to the Board of Supervisors. Interim Chair Bloom made the motion, and it was seconded by Interim Vice Chair Cushman. Motion carried.	
Public Comment	Public Comment given.	
Adjournment	Adjourned at 5:02 p.m.	

Alameda County Behavioral Health Care Services

Community Assistance, Recovery and Empowerment: The CARE Act/ CARE Court Update

Mental Health Advisory Board Meeting Presentation: March 20, 2023

Presenter:
Karyn L. Tribble, PsyD, LCSW
ACBH Director

CARE Court

Overview: SB 1338

Community Assistance, Recovery, and Empowerment (CARE) Court Program

Community Assistance, Recovery and Empowerment Act

- Based in Law (SB1338)
- **California Health & Human Services Agency (CalHHS) – Lead** coordination efforts with Department of Health Care Services (DHCS) & the Judicial Council
- An "**Upstream Diversion** to prevent more restrictive conservatorships or incarceration"
- Based on "evidence which demonstrates that many people **can stabilize, begin healing, and exit homelessness in less restrictive, community-based care settings**"
- Legislation governs actions by Courts, Behavioral Health Departments & Holds Local Government Entities Accountable

Key Source: CalHHS

How is **CARE Court** *Different?*

Community Assistance, Recovery and Empowerment Act

- CARE is different from LPS Conservatorship in that **it does not include custodial settings or long-term involuntary medications**
- CARE is **different than LPS/Laura's Law** in several important ways:
  - May be initiated by a petition to the Court from **a variety of people known to the participant** (family, clinicians/ physicians, first responders, etc.) and only credible petitions are pursued
  - **Multiple prior negative outcomes** (incarceration, hospitalizations, etc.) **are not required** to be considered
  - **Local government and participants work together** and are both held to the CARE plan
  - **Client may have a "Supporter"** to assist in identifying, voicing, and centering the individual's CARE decisions in their CARE plan and graduation plan, including preparing a Psychiatric Advanced Directive, if desired

Key Source: CalHHS

CARE Court

State Budget Proposals

Community Assistance, Recovery and Empowerment Act

- January Budget proposes placeholder amounts for CARE Court implementation funding to continue ongoing conversations and negotiations between counties and State
  - Proposed $16.5 million for FY 23-24 for county costs on implementing CARE Court
  - Proposed $66.5 million for FY 24-25
  - Proposed $108.5 million FY 25-26

Key Source: cbhda COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION CALIFORNIA

Community Assistance, Recovery and Empowerment Act

CARE Court

Timing

- All counties will participate in the CARE Court Program through a phased-in approach.
- **Cohort 1 counties start October 1, 2023**: Glen, Orange, Riverside, San Diego, Stanislaus, Tuolumne, and San Francisco; and Los Angeles County by December 2023. **All other counties (Cohort 2) are required to implement by December 2024.**
- Counties **will not have the option to "opt-out."**

Key Source: CalHHS

CARE Court

Implementation

- SB 1338, Community Assistance, Recovery, and Empowerment (CARE) Court Program:
  - Requires the counties of Glenn, Orange, Riverside, San Diego, Stanislaus, Tuolumne, and the City and County of San Francisco to implement the program as of October 1, 2023. Los Angeles County has also opted in, with plans to implement by December 2023. All other counties required to implement by December 31, 2026.
  - **CARE Act Working Group** Established. CARE Act Working Group - California Health and Human Services (NOTE: Working Group to end no later than December 2026)
  - **UPDATE**: Lawsuit filed by several advocacy organizations, including, Disability Rights California, Western Center on Law and Poverty, and the Public Interest Law Project – which asked the California Supreme Court to block the initiation of CARE Court in January 2023. The matter is pending in the Court System. An additional "WRIT of Mandate" legal filing was submitted to the California Supreme Court on February 21, 2023.

CARE Court

Major Themes

- SB 1338, Community Assistance, Recovery, and Empowerment (CARE) Court Program:
  - Authorizes specified adult persons to petition a civil court to create a **voluntary CARE agreement or a court-ordered CARE plan and** implemented services by county behavioral health agencies to provide stabilization medication, housing, and other services.
  - Adults currently e**xperiencing severe mental illness** and have a diagnosis identified in the disorder class such as; **schizophrenia and other psychotic disorders** (and other criteria).
  - Local governments may be imposed **fines** of up to $1,000 per day if the court finds persistent noncompliance (for the provision of services).
  - ***Housing** will pay an important role in CARE Court Programs statewide.

Care Court Intersections with "Bridge Housing"?

Behavioral Health Bridge Housing (BHBH) Overview & Requirements:

- **Behavioral Health Bridge Housing RFA (Requests for Applications) Due no later than April 28, 2023**

- **Administrative Requirements:**
  - ✓ Designate a **program director, project lead**, or other point of contact.
  - ✓ **Coordinate** with local or regional California Continuums of Care (CoCs) and other homeless service efforts within the county.
  - ✓ Include people with lived experience of homelessness and serious behavioral health conditions—**both SMI and SUD as part of BHBH programmatic planning, implementation, and quality improvement.**
  - ✓ **Submit policies and procedures** for Participant Assistance Funds, Rental Assistance, and/or Landlord Outreach and Mitigation Funds, as applicable.
  - ✓ Certain uses of bridge housing startup infrastructure funding **will also require documentation** of site control; insurance; compliance with federal, state, and local laws; and other certifications, as applicable.
  - ✓ **Submit and update a BHBH Program Plan**, using a template to be provided, that describes how the county BHA will use the BHBH Program funds.

Key Source: DHCS California Department of HealthCareServices

Care Court Intersections with "Bridge Housing"?

Behavioral Health Bridge Housing (BHBH) Overview & Requirements *Continued*:

- Alameda County Allocation is expected to be approximately $46 Million Dollars (Spent by 06/30/2027);
- **At least 75% of BHBH funds** towards costs of operating bridge housing that **serves people with serious behavioral conditions who are also experiencing homelessness**;
- Bridge housing will be established and provided **based on community needs and Housing First principles** and will include voluntary supportive services for individuals experiencing both homelessness and serious behavioral health conditions;
- **County BHAs must maximize all other funding sources and BHBH funds may not be used to pay for existing services or housing supports** that are currently reimbursed or eligible for reimbursement through MediCal, MHSA funded programs, or other federal or local programs.
- Complete ALL bridge start-up infrastructure activities and make beds available **within 1 year of contract execution**.

Key Source: DHCS California Department of HealthCareServices

Care Court Intersections with "Bridge Housing"?

Behavioral Health Bridge Housing (BHBH) Overview & Requirements *Continued*:

- **County BHAs may claim up to 10% of indirect costs**
- **Applicants must be able to process a contract for final execution/ approval within 660 days of receipt of the initial contract.**
- **Allowable Uses:**
  - County BHA BHBH Program Implementation
  - Bridge Housing Outreach and Engagement
  - Bridge Housing
    - ✓ Shelter/ Interim Housing
    - ✓ Rental Assistance
    - ✓ Auxiliary Funding in Assisted Living Settings
    - ✓ Housing Navigation
  - Bridge Housing Start-Up Infrastructure
- https://bridgehousing.buildingcalhhs.com/

CARE Court

Client & Systems

CARE Court Eligibility & Individual Accountability

5972. An individual shall qualify for the CARE process only if all of the following criteria are met:

a) The person is **18 years of age or older**.

b) The person is currently experiencing a severe mental illness…and has a diagnosis identified in the disorder class: **schizophrenia spectrum and other psychotic disorders**.

c) The person is **not clinically stabilized in on-going voluntary treatment**.

d) (1) The person is **unlikely to survive safely** in the community without supervision and the person's condition is substantially deteriorating; **and/or** (2) The person is **in need of services and supports in order to prevent a relapse or deterioration** that would be likely to result in grave disability or serious harm to the person or others, as defined in Section 5150.

e) Participation in a CARE plan or CARE agreement would be **the least restrictive** alternative necessary to ensure the person's recovery and stability.

f) It is likely that the person **will benefit** from participation in a CARE plan or CARE agreement.

Key Source: Indigo Project

CARE Court Jurisdiction

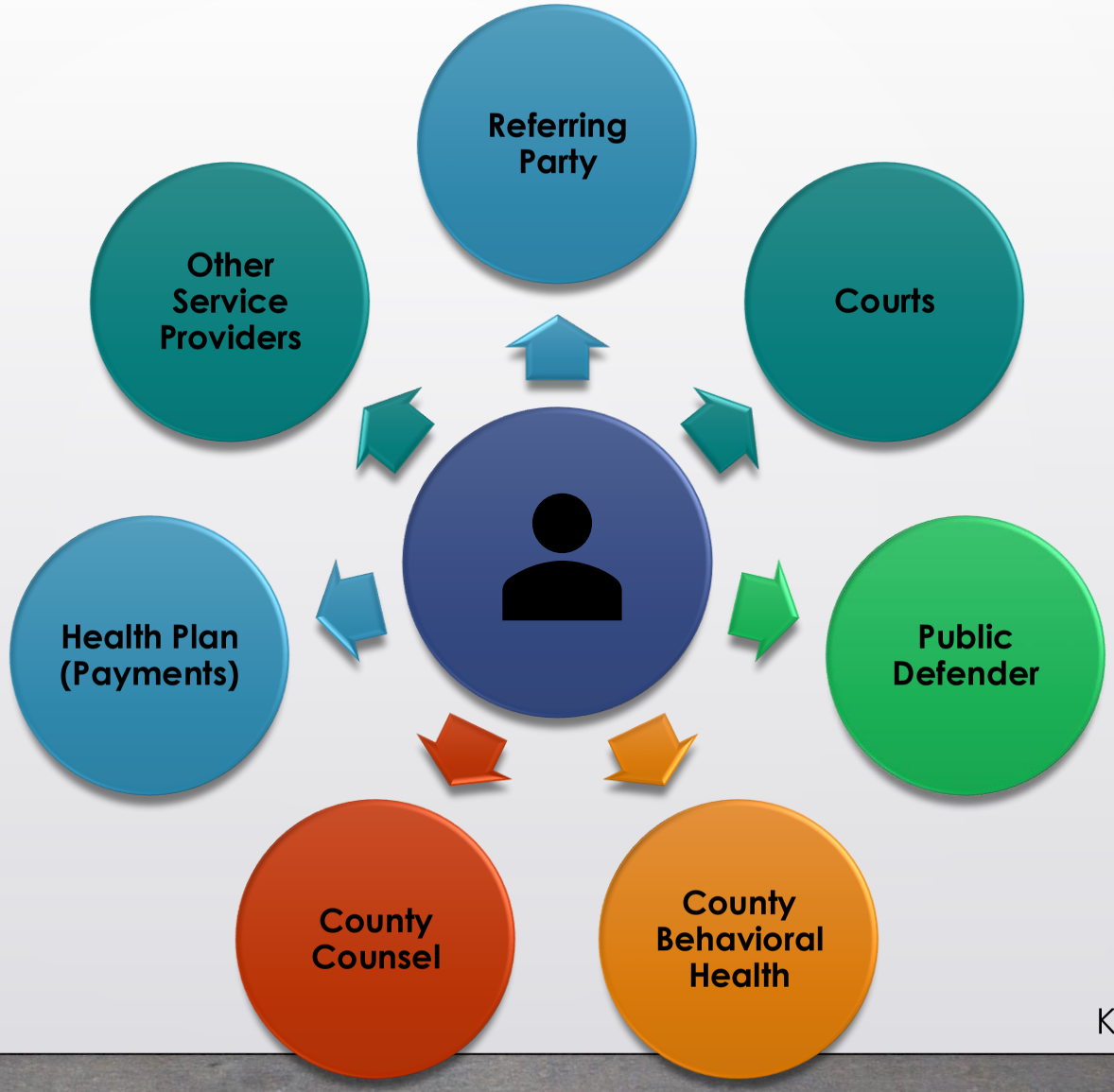
5973. (a) Proceedings under this section may be commenced in any of the following:

1) The county in which the **respondent resides**.
2) The county where the **respondent is found**.
3) The county **where the respondent is facing criminal or civil proceedings**.

5973. (b) If the respondent ***does not reside in the county*** in which proceedings are initiated under this subdivision…the proceeding shall, with the respondent's consent, be transferred to the county of residence as soon as reasonably feasible. Should the respondent not consent to the transfer, the proceedings shall continue in the county where the respondent was found.

Key Source:

KEY CARE Court Participants & Stakeholders



Key Source: Indigo Project

Eligibility to <u>make</u> Referrals to CARE Court

5972. The following adult persons may file a petition to initiate the CARE process:

a) A person **with whom the respondent resides**.

b) A **spouse, parent, sibling, child, or grandparent or other individual** who stands in loco parentis to the respondent.

c) The **Director of a hospital**, or their designee, in which the respondent is hospitalized, including hospitalization pursuant to Section 5150/5250.

d) The **Director of a Public or Charitable organization, agency, or home**, or their designee, who has, within the previous 30 days, provided or who is **currently providing behavioral health (BH) services** to the respondent or in whose institution the respondent resides.

e) A **licensed BH professional**, or their designee, who is, or has been **within the previous 30 days**, either supervising the treatment of, or treating the respondent for a mental illness.

f) A **first responder**, including a peace officer, firefighter, paramedic, emergency medial technician, mobile crisis response worker, or homeless outreach worker, who has had repeated interactions with the respondent in the form of multiple arrests, multiple detentions and transportation pursuant to Section 5150, multiple attempts to engage the respondent in voluntary treatment or other repeated efforts to aid the respondent in obtaining professional assistance.

Eligibility to <u>make</u> Referrals to CARE Court

5972. The following adult persons may file a petition to initiate the CARE process:

g) The **Public Guardian or Public Conservator**, or their designee, of the county in which the respondent is present or reasonably believed to be present.

h) The **Director of a County Behavioral Health** agency, or their designee, of the county in which the respondent resides or is found.

i) The **Director of County Adult Protective Services**, or their designee, of the county in which the respondent resides or is found.

j) The **Director of a California Indian Health Services Program**, **California Tribal Behavioral Health Department**, or their designee.

k) The **Judge of a Tribal Court** that is located in California, or their designee.

l) The **Respondent**.

Community Assistance, Recovery and Empowerment Act

CARE Court

Process

Court Filing → Written Report within 14 Days → Initial Hearing for Petition → Care Management Hearing → Ongoing Review

Key Sources:

CARE Court

Key Considerations

Community Assistance, Recovery and Empowerment Act

- **Bridge Housing**
- **Incompetent to Stand Trial (IST)**
- **CARE Services, CARE Plans, etc.**
- **Client Accountability**
- **Health Care Plans (Insurance Code)**
  - ✓ ***1374.723.*** *(a) A health care service plan…shall cover the cost of developing an evaluation pursuant to Section 5977.1 of the Welfare and Institutions Code and the provision of all health care services for an enrollee when required or recommended for the enrollee pursuant to a CARE agreement or a CARE plan approved by a court regardless of whether the service is provided by an in-network or out-of-network provider.*
  - ✓ *(b) (1) A health care service plan shall not require prior authorization for services, other than prescription drugs, provided pursuant to a CARE agreement or CARE plan approved by a court…*
- **CARE Act Reporting**
- **CARE Act Outcome Evaluation**

Key Source: CalHHS

Community Assistance, Recovery and Empowerment Act

CARE Court

Departmental Expertise & Consultation

- GSA Release of Bid for ACBH Consultation
- Stakeholder Planning & Engagement
- Strategy: Client, Programs, System, Requirement, & Implementation
- Implementation & Capacity Review

Summary:

- County Behavioral Health Planning Dollars – Operations & Stakeholder Input Planning (Community Assistance, Recovery, and Empowerment (CARE) – FAQ)
- Local Systems Coordination (ACBH Forensic, Diversion, & Re-Entry System of Care; HCSA Housing; Agency Partners)
- CARE Court Implementation for Alameda County: "Begin Implementation by December 2024"
- CARE Act Working Group & Stakeholder Voices (CARE Act Working Group - California Health and Human Services)
- For More Information: PowerPoint Presentation (ca.gov) & CARE Act - California Health and Human Services


THANK YOU

BOARD APPLICANTS WANTED

What is the Mental Health Advisory Board (MHAB)?

Every California county is required by state law to have a mental health advisory body. In Alameda County, members of the board are appointed by the Alameda County Board of Supervisors (BOS) for a three-year term. The MHAB's charge is to review and evaluate Alameda County's mental health needs, facilities, services and special problems; advise the BOS and the Alameda County Mental Health Director on any aspect of the local mental health programs; review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council; provide input into the development of the county's Mental Health Services Act (MHSA) plan; and submit an annual report to the BOS on the needs and performance of the county's mental health system.

Looking for passionate and dedicated team players to join the board!

Alameda County is seeking Alameda County residents who are passionate about ensuring and advocating for responsive, equitable mental health prevention, intervention and treatment services, who want to use their voice and expertise towards this end. Qualifying board members include consumers of mental health services and their family members, as well as community members and individuals who have experience with and knowledge of mental health systems.

In order to ensure diverse perspectives and round out current MHAB membership, individuals representing the following groups are particularly desired:

- Have expertise and/or a strong interest in children and youth-related issues
- Identify as Latinx
- Have worked in the field, lived in the field, or have special knowledge of the field
- Are interested in and/or have expertise in local or state legislation
- Have experience working in county or city services or government

What does serving on the MHAB involve?

As a board member, you will be required to:

- Work in collaboration with other board members to fulfill the responsibilities of the MHAB
- Attend 10 regular in-person monthly board meetings each year
- Attend Special Meetings from time to time
- Serve on at least one committee and/or serve as a Board Liaison to another entity or organization (usually monthly meetings)

Interested in joining? Next Steps

For more information about the MHAB and how to apply click here. You can also email ACBH.MHBCommunications@acgov.org.

Interested individuals are encouraged to attend at least one board meeting prior to application.

Works-Wright, Jamie

From: Pedro Hernandez <pehernandezjr@gmail.com>
Sent: Thursday, March 16, 2023 4:37 PM
To: Manager, C
Cc: Vance-Dozier, Okeya; Mariscal, Cecelia; Castrillon, Richard; Allen, Shallon L.; Terrones, Roberto; Burns, Anne M; May, Keith; Slaughter, Kieron; Zoning Adjustments Board (ZAB); Heath, Julia; Bryant, Ginsi; Javandel, Farid; Hollander, Eleanor; RPSTF Commission; Office of the Director of Public Accountability; Planning Commission; Kouyoumdjian, Aram; Miller, Roger; FCPC (Fair Campaign Practices Commission); Berkeley/Albany Mental Health Commission; Crane, Fatema; Katz, Mary-Claire; Housing Advisory Commission; Homeless Services Panel of Experts; Romain, Billi
Subject: Timely Posting of Minutes
Attachments: 20230316 PH Letter re Posting of Minutes.pdf

Dear City Manager Williams-Ridley, and Commission Secretaries,

Attached please see my letter regarding the timely posting of commission meeting minutes. This is a matter that was brought to the Open Government Commission. I've pasted the text without citations below. Thank you for your attention to this matter.

Sincerely,
Pedro Hernandez

--

Dear City Manager Williams-Ridley, and Commission Secretaries,

First, I first want to thank you and acknowledge the incredible work you do in providing vital and important services to the Berkeley City Government. Your work and support makes it possible for the people of Berkeley to participate in important city matters.

I am writing to you because it has been brought to the attention of the Open Government Commission that there have been several instances where meeting minutes have not been posted on the city's website in a timely fashion. It is a duty of the Open Government Commission to advise the City Council as to any other action or policy that it deems advisable to enhance open and effective government in Berkeley. I am writing to you as a commissioner asking that these minutes, which provide the people of Berkeley important information, be posted in a timely fashion that align with the timely posting of minutes we see with Berkeley's legislative bodies.

I understand that the Brown Act defines a "legislative body" as the governing body of a local agency or a commission, committee, board or other body of a local agency, whether permanent or temporary, decision making or advisory, created by resolution or formal action of the legislative body. Section 2.06.140 of the Berkeley Municipal Code states agendas and minutes of "all Legislative bodies" must be provided through the City's website. However, Section 2.06.140 does not indicate a timeline for the posting of minutes, and the Brown Act notes in the case of Emergency Meetings, minutes should be taken and must be posted for a minimum of 10 days "as soon after the meeting as possible."

Because commission decisions are important matters that residents have an interest in, I am respectfully requesting that secretaries post commission meetings as soon as possible, and no later than the 11th day following a commission meeting.

Thank you for your attention to this matter.

Sincerely,

Pedro Hernandez
pehernandezjr@gmail.com

Pedro Hernandez
phone: (415) 613-2363

To: Berkeley City Manager, Commission Secretaries
From: Pedro Hernandez
Subject: Posting of Meeting Minutes
Date: March 16, 2023

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Thank you for your attention to this matter.

Sincerely,

Pedro Hernandez
pehernandezjr@gmail.com

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[1]Berkeley Municipal Code, 2.06.190, *available at* https://berkeley.municipal.codes/BMC/2.06.190.
[2] Cal. Gov. Code 54952 et seq.
[3] Berkeley Municipal Code, 2.06.140, *available at* https://berkeley.municipal.codes/BMC/2.06.140. Also, according to a June 1, 2021 staff memo, there are three groups of City Legislative bodies: City Council; City Council Policy Committees; and Boards and Commissions. While the Charter and Municipal Code does not declare which committees are "legislative bodies", in March 2020, the city adopted Resolution 69,331-N-S, which declared that certain bodies may continue to meet ("certain legislative bodies must continue for time-sensitive, legally mandated actions." Those commissions included the Design Review Committee, the Planning Commission, and the Personnel Board.
[4] Cal. Gov. Code 54956.5 (e).

JAMA Psychiatry: No Evidence that Psychiatric Treatments Produce “Successful Outcomes”

In a viewpoint article in JAMA Psychiatry, researchers reveal that psychiatry is unable to demonstrate improving patient outcomes over time.

By
Peter Simons

-
March 27, 2023

36

In a viewpoint piece published in *JAMA Psychiatry*, researchers write that there is no evidence that psychiatric interventions lead to “successful” outcomes. Successful outcomes, they write, include **“the prevention of undesirable events, such as death and disability, and the achievement of desirable ones, such as remission.”**

Psychiatry, unlike other medical specialties, has not developed efforts to investigate this question. They write:

“Despite advances in measurement-based psychiatric care, clinical [success rate] reporting systems do not exist for most psychiatric services. This applies to all psychiatric treatments, including pharmacotherapy, psychotherapy, and neuromodulation.”

The viewpoint was written by Kenneth Freedland and Charles Zorumski at Washington University School of Medicine in St. Louis, Missouri.

One way to measure “successful outcomes” is to assess whether current treatments are more effective “for a variety of clinically important outcomes” than previous treatments. Other medical specialties can point to such progress.

Freedland and Zorumski write, “Cardiologists, oncologists, and other medical specialists can point to temporal trends in success rates for a variety of clinically important outcomes to confirm that current treatments are more effective than the ones that were available 20 or 30 years ago.”

Yet, they note, “Similar data are hard to find for psychiatric disorders.”

This is the very data that the public wants to know. They want to know that a medical treatment leads to “successful outcomes” and that outcomes have improved over time.

“Patients with serious illnesses care about their chances of having successful treatment outcomes. They also expect to receive more effective treatments than the ones that were available to their parents or grandparents, and they hope that even more effective treatments will be available for their children and grandchildren,” Freedland and Zorumski write.

If this assessment is applied to psychiatry, it raises this question: Are mental health outcomes today—in this era of Prozac, ECT, CBT, and so forth—better than they were in the era of, say, insulin coma therapy and lobotomy? Or even better than in the early 1800s, when Quakers introduced "moral therapy"?

According to Freedland and Zorumski, there is an absence of "successful outcomes" data that could answer that question.

The authors focus on the need for psychiatry to develop such measurements, focusing on the "success rate" of new psychiatric treatments compared to existing treatments.

They write:

"If psychiatric treatment success rate data systems were available, they would show us that it is difficult to improve clinical [success rates] by devising new interventions for patients who are potentially responsive to existing ones."

The two authors don't delve into the outcomes data that do exist, which tell of a public health failure in psychiatric care. Instead, all the data today tells of worsening mental health in the United States, particularly among the young. For instance, new data from the CDC found that 57% of teen girls feel "persistently sad and hopeless," and 30% "seriously considered attempting suicide."

And the data also shows that current interventions may contribute to that decline. For instance, researchers have warned that well-intentioned "mental health awareness" campaigns may be worsening outcomes. Antidepressants have been shown to increase the risk that depression will run a more chronic course, and they increase the risk of diabetes, hypertension, and other evidence of poor health.

In the long term, antipsychotics—on the whole—lead to worse outcomes for people diagnosed with schizophrenia and other psychotic disorders, including worse work functioning, even when comparing people with similar baseline symptom severity.

While the authors have pointed out the absence of successful outcome data for psychiatric treatments, they then jump to this conclusion, which nevertheless presents psychiatric care in a positive light: If systemic measurements were created for assessing "successful outcomes," they write, this could ensure that psychiatry "continues" to improve:

“The development of well-designed, sustainable success rate data systems would facilitate this kind of progress and help ensure that psychiatric treatment outcomes continue to improve in the decades ahead.”

That sentiment suggests that psychiatric treatments have been shown in the past to lead to successful outcomes; yet, as they write here, there is no data on whether medical treatments for psychiatric disorders, past or present, produce that bottom-line result. As such, this paper highlights the fact that there is no evidence that psychiatric interventions do more good than harm.

Freedland, K. E. & Zorumski, C. F. (2023). Success rates in psychiatry. JAMA Psychiatry. Published online March 22, 2023. doi:10.1001/jamapsychiatry.2023.0056 (Link)