COUNTY OF YOLO

Health and Human Services Agency

137 N. Cottonwood Street • Woodland, CA 95695
(530) 666-8940 • www.yolocounty.org

Local Mental Health Board Meeting

Wednesday, April 3rd, 2024, 6:00 PM–8:00 PM

Location: 137 N Cottonwood Street, Woodland, Bauer Bldg.
Walker/Thomson Conference Room

Hybrid Option through ZOOM:
https://yolocounty.zoom.us/j/84960787627
Meeting ID: 849 6078 7627

All items on this agenda may be considered for action.

LMHB CALL TO ORDER----------6:00 PM- 6:30 PM

1. Public Comment
2. Approval of Agenda
3. Approval of minutes from March 6th, 2024
4. Member Announcements
5. Chair Report-Jonathan Raven
6. Correspondence

TIME SET AGENDA----------6:30-7:15 PM

7. Strategic Planning Presentation & Discussion-Brittany Peterson

CONSENT AGENDA----------7:15 PM – 7:30 PM

8. Mental Health Directors Report-Karleen Jakowski
   - A) Current Request for Proposals (RFPs)
   - B) Public Guardian Presentation
   - C) Mental Health Services Act (MHSA) Community Engagement and Annual Update Process
   - D) Implementation of Behavioral Health Transformation (BHT) Due to the Passage of Proposition 1

If requested, this agenda can be made available in appropriate alternative formats to persons with a disability, as required by Section 202 of the American with Disabilities Act of 1990 and the Federal Rules and regulations adopted implementation thereof. Persons seeking an alternative format should contact the Local Mental Health Board Staff Support Liaison at the Yolo County Health and Human Services Agency, LMHB@yolocounty.org or 137 N. Cottonwood Street, Woodland, CA 95695 or 530-666-8516. In addition, a person with a disability who requires a modification or accommodation, including auxiliary aids of services, in order to participate in a public meeting should contact the Staff Support Liaison as soon as possible and preferably at least twenty-four hours prior to the meeting.

REGULAR AGENDA ----------7:30PM – 7:55 PM

9. Standing Committee Updates

Budget and Finance

Chair: Joe Galvan

Members: Meg Blankinship, Nicki King, Maria Simas

Communication and Education

Chair: Dee Olivarez

Members: Maria Simas, Kimberly Mitchell

Program

Chair: Sara Gaines

Members: Brad Anderson, Dee Olivarez, Meg Blankinship, Kimberly Mitchell

- Review and discuss Site Eval Guide and Site Visit Forms

10. Board of Supervisors Report
11. Criminal Justice Update- Chris Bulkeley
12. Public Comment- on tonight's agenda Items

PLANNING AND ADJOURNMENT ---------- 7:55PM – 8:00 PM

13. Future Meeting Planning and Adjournment

Next Meeting Date and Location
Wednesday, May 1st, 2024, at 6pm
Mary L. Stephens Davis Library
315 E 14th St, Davis CA 95616

I certify that the foregoing was posted on the bulletin board at 625 Court Street, Woodland CA 95695 on or before Friday, March 29th, 2024. Christina Grandison Local Mental Health Board Administrative Support Liaison Yolo County Health and Human Services

Local Mental Health Board Meeting

Wednesday, March 6th, 2024

In Person with Hybrid Option for Public

Members Present: Robin Rainwater, Nicki King, Jonathan Raven, Maria Simas, Dee Olivarez, Sara Gaines, Sue Jones, Melanie Klinkamon, John Archuleta, Brad Anderson, Kimberly Mitchell, Chris Bulkeley

Members Absent: Joe Galvan, Meg Blankinship

CALL TO ORDER

Welcome and Introductions: Meeting called to order at 6:08 pm by Jonathan Raven

Public Comment: none

Approval of Agenda: motion to approve Dee Olivarez, 2nd Chris Bulkeley

Yea "I"	Nay	Abstention
10	0	0

Motion: Approved

Approval of Minutes from February 7, 2024: motion to approve Chris Bulkeley, 2nd Dee Olivarez

Yea "I"	Nay	Abstention
10	0	

Motion: Approved with following addition: Strategic Planning-Need to plan, identify, and then schedule. Will cover at April meeting.

Chair Report:

- Jonathan Raven welcomes new Board Member, Melanie Klinkamon
- Melanie Klinkamon shared family experience and her work in legislation leading up to joining the board.

Time Set Agenda: Public Guardian Presentation

Board Comments on Time Set Agenda:

- **Jonathan Raven**-Clients per Public Guardian is noted, how are case managers factored in?

  Laurie Haas*-Grand Jury was considering the numbers prior to us hiring case managers. They can assist but not in the capacity of a deputized staff. They can do visits, run errands, provide transportation. Case managers are funded through MHSA. Conservatorship Officers cannot be funded through MHSA because of involuntary commitments. So, it's not a matter of salary but a funding source issue.*

- **Brad Anderson**-Are staff stepping away because of emotional issue or workload?

  Laurie Haas*-The level of responsibility, workload, and stress. It's more about having enough staff to have a manageable workload so they don't drop the ball on something serious. We have had 7 different deputies, people leaving due to burnout before they can get the two years of necessary training.*

- **Maria Simas**-Of the three folks, who is the most tenured?

  Laurie Haas*-The longest now has been there just under three years. The one who stayed the longest was here 5 years, the others 3 years or less. Big responsibility, and they need a lot of training.*

- **Jonathan Raven**-Look into MHSA funding because co-responders can place clients on involuntary hold, and they are funded by MHSA. So, it's possible condition that MHCS may not fund staff that can place individuals on involuntary holds may not apply.

  Karleen Jakowski*-MHSA funding is mostly allocated so looking to it to fund everything can't be the end all and be all. We will double check on the funding to see if MHSA can fund deputy PGs. I believe due diligence was done, but some of the components have changed so we will check into it.*

- **Jonathan Raven**-This is so shameful. What PG does is so critical, and real issue is how we prioritize our MHSA funding. We don't even know how successful some of these programs are that we are funding because we don't have measurable results. On one level I understand the challenges HHSA faces, but it's frustrating. I just don't know why more attention and advocacy hasn't been given to try to make a difference here. The numbers are staggering.

  Karleen Jakowski*-It's not for lack of trying. Every year Laurie requests additional staff, and every year she gets denied. This presentation will be going to board of supervisors. There hasn't been the willingness from leadership in the agency to take this information to the board. Challenge is that these are 100% general funded and HHSA gets a fraction of the amount of our budget.*

- **Jonathan Raven**-We can't leave it to someone at Laurie's level to advocate for the positions with the BOS and CAO. We need everyone to advocate for Public Guardian.

- **Nicki King**-Is the reason you haven't closed the cases is because staff don't have enough time to do clerical work?

  Laurie Haas*-That's one piece of it, but there is also a final court piece, final accounting, final expenses paid and not paid and where final money goes. Difference between someone who is getting off conservatorship or someone who has passed away. In some cases, the conservatorship officer is making end-of-life decisions. We don't want our staff to ever feel alone, stressed, or untrained. We may not be as visible, but what PG does is very important for this very special population.*

- **Chris Bulkeley**-We have people in diversion on full-service partnership, getting services from HOPE Cooperative, but they are not engaging. We are rooting for the Public Guardian to conserve them. We are looking at how we use our dollars when they are not engaging at that level. Money is not being efficiently used, because they can't make the right decision. So, there are a lot of resources wasted or not effectively used. We are hoping that they will get conserved. They are also committing new law violations, which creates other victimization. It's a systemic problem with the standard for the LPS. Lot of those resources aren't being effectively used because of the decision-making process. It's not so much that there is a staffing problem, but instead it's a problem with the LPS standard for conservatorship. If policy makers were aware of that so those dollars could be efficiently used, they might be better off.

  Laurie Haas*-PG is 100% General Funded and these other funding streams for serving mental illness, those funding streams have some limitations on staffing positions.*

- **Chris Bulkeley**-My point is that the policy decisions on the standards is where we need to try to make the difference.

- **Nicki King**-Sounds like LPS needs to be reviewed. It's been in place for 50 years.

  Laurie Haas*-That's exactly what SB 43 is aiming to do, and I will talk a little more about that later in presentation.*

- **Chris Bulkeley**-How do staffing numbers compare with Department of State Hospitals? DSH has 10 clients and there is a clinician case manager and psychiatric social worker when we are looking at that staffing level and severity of illness. Is it comparable with PG or is that comparing apples to oranges?

  Laurie Haas*-I'm guessing their staffing levels aren't 89 clients.*

  Karleen Jakowski*-FSP is highest level and ideally, they would have no more than 10 to 15 clients per worker. Intensive level of intervention. Placements are different, but it underscores how significantly high the caseloads are in the Public Guardian's office. We have Grand Jury saying 20-25 is manageable and Laurie is saying based on her experience, no more than 30. Even when we take away the cases waiting for closure, we are talking about double and that's unacceptable.*

  Laurie Haas*-What we do in Public Guardian's office is not clinical. We are addressing every aspect of their lives. We aren't providing specific services for their illness or diagnosis. Clothing, housing, property, funds, bills, we have a lot of responsibility to the court at every step of the way. We have had a marked uptick in referrals, and those are mostly LPS. It takes on average, depending on referral, 10-15 hours to investigate a referral while they carry their caseloads. As managers and supervisors, we are helping out with the referrals because it's just too much for the staff. When we accept a case, it takes 30-40 hours to get the client set up. Court forms to file, housing needs, benefits to*

set up, etc. We provide and arrange for whatever services they need. It's very comprehensive. We are providing and arranging whatever services they need.

- **Jonathan Raven**-Is it fair to say a probate client is less of an investment of time than LPS?

  ***Laurie Haas**-We are conservator of person and estate (both). For clients on LPS, there is a lot more work on person, more effort to placement and services around them. Probate is more time-intensive with estate.*

- **Jonathan Raven**-Probate less of an emotional investment than LPS?

  ***Laurie Haas**-No, they are all people. They aren't just their diagnosis. They have pasts, memories, trials, successes, and we want to engage with all of that. That they have their personal items around them as reminders of all those experiences. There is emotional connection and investment for all conservatees.*

- **Brad Anderson**-Can't a parent or a child be a conservator?

  ***Laurie Haas**-Most probate clients don't come through Public Guardian office. When they have no other relatives or family available due to proximity or ability to care for them, they are referred to Public Guardian. For 30 days, the public guardian can act as conservator. During those 30 days, we continue our investigation to determine whether they are improving, and we look into whether other people are able to take over. Some family opt out of being conservator and allow PG to deal with those responsibilities so they can focus on being a family to the conservatee.*

- **Kimberly Mitchell**-For people under LPS, what type of diagnosis do they have?

  ***Laurie Haas**-Most common are schizoaffective, bipolar, and schizophrenic, because those are the ones who are most impacted by not being able to care for themselves. They would also most benefit from medication, and conservators can enforce medication to help client make improvements.*

- **Maria Simas**-Are there counties out there that have data that we can benchmark against for caseloads?

  ***Laurie Haas**-I turned to CA Association of Public Guardian Administration and their data is that caseloads should be between 20-30 but never over 40.*

- **Maria Simas**-Is there information on outcomes? It needs to tie to outcomes. What are the successes following a best practice model? What are the outcomes with negative percentiles if you aren't staffed to the recommended model? That's the data that would be very effective in adding positions.

- **Nicki King**-That's difficult to do because you can't tell if the intervention prevented the worst thing from happening.

***Laurie Haas**-I can give you an example of where the Public Guardian made a big mistake, we caught it, and we were able to rectify it. We almost had a home go into foreclosure because the staff was carrying too high of a caseload, and we missed an important deadline.*

- **Dee Olivarez**-To piggyback off of what Maria Simas was speaking to in benchmarking, my brain went to when you're going to influence decision makers and ask for money, do we have a starting budgetary amount that we can tie those positions we accrue from that budgetary amount tie to caseload and be able to identify of the money we spent on this staff we were able to process 500 cases of the 1500 cases we received for the year?

  ***Laurie Haas**-I'd have to think about that. We are not allowed to say we have too many cases and not act on them. I think what's happened and why we burn out staff is that we get funding for the three positions, and they are going to do everything they can possibly do regardless of the number. They need to see the numbers and why it's important to protect the clients.*

- **John Archuleta**-Who determines the numbers? Does the budget determine any of it?

  ***Laurie Haas**-Research the grand jury did, and research the Public Guardian did. We pulled it from different counties, asking at what point do caseloads become so big that not everything can be addressed. We must accept referrals and are mandated to begin investigating within two days of receipt regardless of numbers and budget.*

  We would love to implement SB 43, but to implement it right now, there is no way the PG office has the capacity to process that many more referrals. There is no funding for staffing, no funding for facilities. By expanding the definition, we need to expand the number of staff and where conservatees will be living. There's no definition of how the laws will apply. We have facilities that treat people with severe mental illness, treatment programs to support them, but not the substance use disorder programs for people who don't have mental health issues. To my knowledge, there are no locked facilities for substance use disorder treatment. If we implement SB 43 without staffing, without facilities, it's going to crash and burn.

- **Dee Olivarez**-What will be the impact on the State Hospital System when it goes live?

  ***Laurie Haas**-It's going to have a big impact on facilities all the way from State Hospitals to community placements.*

- **Dee Olivarez**-If there is a lift and shift, will that be pushed back to the counties based on where they are conserved?

  ***Laurie Haas**-Yes, very much so. People in DSH receive the highest level of care.*

  Dee Olivarez-And then maybe a benchmark in preparation for larger discussion, assuming you can gather how many of those will be redirected to Yolo County and using

that as a starting point to project the impact that may have. Collectively here as a board, I would like to see you strengthen your presentation, so it does have the data and does justify the need.

Karleen Jakowski*-There is no magic number because it depends on the makeup of their needs, which can change from month to month. We just know that what we have right now is not manageable.*

Laurie Haas*-Last fiscal year, we had 28 referrals. So far, year to date, we have 32 referrals, and 25 have been LPS.*

- **Robin Rainwater**-From data perspective, BOS needs to see the liability side of it. Data to reflect the liability that exists when counties having bad outcomes or consent judgments. If there are counties out there, use those as data points. Those are the type of thing the board will want to avoid. It would be compelling to include those perspectives when it comes to the board.

- **Jonathan Raven**-Proposal for this board for LMHB Chair to go in front of the BOS to support this proposal. I know what it's like to have a family member be a conservatee. I'd be willing, if you'd like, to make that an action item right now.

- **Chris Bulkeley**-Interested in holding ad hoc to discuss and review updated presentation.

- **Dee Olivarez**-In agreement with Chris, though it may not need to be an ad hoc committee, per se. It would be in the best interest to get exposure to what that final delivery would look like, but I do agree.

- **Brad Anderson**-States he agrees with Dee and loves Jonathan's passion but would like to see what we are going to do before it goes before the board.

- **Jonathan Raven**-So the suggestion is to put this motion on hold.

  Karleen Jakowski*-I am not sure we are going to hold our timing on taking this to the board because we need to get this presentation to the board in time for them to approve our budget request. I can check in with Nolan on what our timing would be. We just need to create an agenda item and get this on the board agenda. There is some long-term planning to consider because they only accept so many presentations each board meeting. We need this information to get to the board before they approve the funding.*

- **Dee Olivarez**-That makes sense. This is already a vested interest in action for HHSA. In light of the considerations the board provided to Laurie today, will this lead to another discussion with a more intentional update to the PowerPoint with the statistical data we are encouraging that we can review and bless and another conversation before the Supervisors with Jonathan leading that would then be next.

- **Jonathan Raven**-Is there a timing issue?

  Karleen Jakowski*-Yes, Karleen believes they will have a timing issue, for sure. She will check to get a sense of when they want to take this to the BOS. Karleen's perspective is they would be happy to revise. They will refine the presentation further and are happy to send it out for review but doesn't know if time will allow them to bring it back before the LMHB. Only 2 meetings each month so it's not going to happen in March, perhaps target for April, but unsure. What she is hearing is resounding support and it's very meaningful and will make an impact. Even just a public comment from the board will be helpful and the BOS listens to those things.*

- **Nicki King**-There is a motion on the table, and it isn't asking Jonathan to do anything out of the ordinary and she is encouraging a "yes" vote because it will continue to move forward this presentation and they need to be out promoting it now.

- **Robin Rainwater**-Believes the motion was not the nitty gritty details at all. The motion is that, as a board, we support the Public Guardian's recommendation with a presentation to the board.

- **Brad Anderson**-We could hold a special meeting or come back more than once in a month, and he would be happy to do so.

- **Karleen Jakowski**-Received follow-up from Nolan and states that there needs to be a request for a presentation before it can be added to the BOS agenda. They aren't able to just add to the agenda.

- **Jonathan Raven**-Happy to draft a letter to BOS chair requesting they agendize a presentation from the Public Guardian.

Motion to Approve: That the board makes a recommendation to BOS in support of the Public Guardian presentation and the need for more staffing, moved by Robin Rainwater, 2nd Nicki King.

Yea "I"	Nay	Abstention
10	0	

Motion: Approved

Regular Agenda

Standing Sub-Committees:

Budget Finance-Chair: Joe Galvan, Members: Nicki King, Maria Simas

- Maria Simas-Nothing to report

Communications and Education-Chair: Dee Olivarez, Members: Maria Simas

- Dee Olivarez-Nothing to report
- Jonathan Raven-Kimberly Mitchell joining Communication and Education Committee

Program Committee-Chair: Sara Gaines, Members: Brad Anderson, Dee Olivarez

- Jonathan Raven-Appointed Sara Gaines as new Chair of Program Committee.
- Sara Gaines-Site visit form approval tabled until next meeting.
- Jonathan Raven-Kimberly Mitchell joining Program Committee.

Correspondence: resignation received from Christy Correa.

Member Announcements:

- **Brad Anderson**-States he is an employee at All Things Right and Relevant and was notified that by the end of the month the whole thrift store will no longer exist. He is sad and states the store has been in the community for 31 years and there are a lot of great people who work there.

Consent Agenda:

Mental Health Director's Report-Karleen Jakowski, Mental Health Director

- **Nicki King**-EVALCORP, what's the length of time involvement?

  Karleen Jakowski*-We have a contract with EVALCORP for the duration of our current three-year plan, and so the new three-year plan was already created before they came on board and they will be involved with the next. Generally, they are contracted for three years at a time.*

Public Comment on Mental Health Director's Report: None

Regular Agenda

Board of Supervisors Report: No representation from BOS.

Criminal Justice Update: Provided by Chris Bulkeley

The Public Guardian services are an important function for the county. Hopefully with that referral, the person won't come back to criminal justice system. Prop 47 *Connection to Care* is moving forward; still hiccups regarding the housing component. CommuniCare is taking referrals. There was a referral from West Sacramento for a person seeking services but who doesn't have an active criminal case. They are engaging services and seeking help, so I gave that referral. Moving forward. Managed by HHSA, we wrote the grant two years ago. In the previous grant we had, there were people seeking assistance in West Sacramento through Mark Sawyer, who oversees Homeless Service Program. They wanted to engage people seeking substance use disorder services but couldn't participate previously because they didn't have a current criminal justice case. So, in new grant, we wrote in the piece so there would be an

avenue for those without active criminal cases. Trying to focus on those who want services, to maximize the funding instead of forcing those who do not want it. We can get individuals who are asking for help into a program with case managers, housing, substance use programs, employment.

Mental Health Diversion graduation on the 20th at 10am, contact Chris for date and time. Couple of graduates and it's another great program.

Public Comment on Agenda Items:

- **Tony Kildare**-In regard to Public Guardian's presentation, he appreciates the input and request for additional data. Wants to point out, from his opinion, that the BOS are good people who want to help and do what is right. They have to have a balanced budget, so you have different stakeholders vying for what's important to them. I would encourage this board to encourage other people who are sympathetic to this cause to also show up. If there is going to be something to influence the board, it's not going to be just a presentation. It's going to be people who say this is important and we need to pay attention to it. It's a level of support that is invaluable. He believes the board will listen. It's important for the board to hear from constituents.
- **Jonathan Raven**-It's incumbent on HHSA to be a part of the process and feels it hasn't been done well enough. HHSA needs to advocate and rally the troops. It must be all of us doing this. BOS has a set budget that makes it challenging. We need to be the squeaky wheel. It will take all of us talking to our friends and people we know to support this.
- **Jen Danzer, Executive Director NAMI Yolo-**Appreciates the powerful and informative presentation from Laurie Haas on Public Guardian. She will be relaying the Public Guardian's request for additional support to the NAMI board of directors.

Future Meeting Planning and Adjournment:

Next Meeting: Wednesday, April 3rd at 6pm in Woodland at the Bauer Bldg. Walker/Thomson Room

Adjourned: 8:08 pm

Mental Health Director's Report
April 3rd, 2024

A) Current Requests for Proposals (RFPs)

- Children's System of Care- The RFP for the Children's System of Care, which includes children's Full-Service Partnership, Community Based Mental Health Programs, Therapeutic Behavioral Services, and Wraparound programs was released on January 25th and closed on February 29th. The panel is scoring proposals at this time and intent to award notifications are anticipated to be issued in the next week.
- Therapeutic Foster Care- The RFP for Therapeutic Foster Care will be released in Spring 2024.

B) Public Guardian Presentation

The Health and Human Services Agency (HHSA) will provide the Yolo County Board of Supervisors with an informational presentation of the Office of the Public Guardian and updates regarding referral, caseload, and staffing data, current challenges, and future needs at the April 9th Board meeting. The agenda item and presentation materials will be available once the final agenda is posted on April 4th.

C) Mental Health Services Act (MHSA) Community Engagement and Annual Update Process

Yolo MHSA is partnering EVALCORP to provide professional support services inclusive of research, analysis, community planning, facilitation, and technical writing in the development of upcoming MHSA plans (FY 24-25 Annual Update; FY 25-26 Annual Update; FY 26-29 Three Year Plan). EVALCORP has been conducting countywide needs assessments and evaluations of MHSA-funded projects throughout California since 2008.

To inform the annual update process, Yolo County used three approaches to engagement with the community: a community survey, key stakeholder interviews, and five community listening sessions. The community survey was distributed electronically and QR codes and physical copies of surveys were made available at a range of community locations (family resource centers, schools, libraries, etc.). Five (5) key stakeholder interviews were conducted with representatives from the Yolo County Office of Education, Yolo County Housing Authority, Yolo NAMI, the Yolo County Local Mental Health Board, and the Yolo County Mental Health Director.

While EVALCORP is working on a formal summary of the feedback from each of these approaches, a high-level, preliminary overview of themes is provided below. A more detailed summary of each of these themes is also included as an attachment to this report.

<u>Understanding Community Perceptions</u>

1. Community Mental and Emotional Well-being
    - Emotional Distress
    - Systemic Frustration
    - Survival Mode
2. Mental Health (MH) & Substance Use (SU) Misconceptions and Stereotypes
    - Cultural Perceptions of Mental Health
    - Educational Barriers and Misinformation
    - Stigma and Fear of Acknowledgment

<u>Identifying Needs</u>

1. Mental Health and Substance Use Challenges/Issues in the Community
    - Challenges in Engaging with Mental Health and Substance Use Treatment

- Family and Community Impact on Mental Health and Substance Use

2. Groups Needing Extra Support
    - Non-English Speakers (Cultural and Linguistic Barriers to Service Access)
    - Vulnerable Populations with Specific Needs
    - Systemic Issues in Continuity of Care

Access to Services

1. Accessibility of Support/Barriers
    - Systemic and Bureaucratic Challenges
    - Cultural and Language Disparities
    - Socioeconomic Constraints
    - Logistical Obstacles
    - Lack of Specialized Services and Providers
    - Lack of Effective Outreach and Public Education
2. Cultural Sensitivity in Services
    - Culturally Sensitive Education
    - Multilingual Service Provision
    - Inclusive Provider Representation
    - Reframing Terminology and Perceptions
3. Recommendations for Improved Access
    - Enhanced Educational Outreach
    - Community Outreach and Peer Support
    - Culturally Competent Services
    - Innovative Service Models
    - Integration of Services with Community Institutions
    - Technology and Information Dissemination

MHSA Fund Allocation

- Lobbying for Policy Changes
- Enhancing Support for Caregivers and Therapists
- Building Supportive Communities
- Comprehensive Continuum of Care

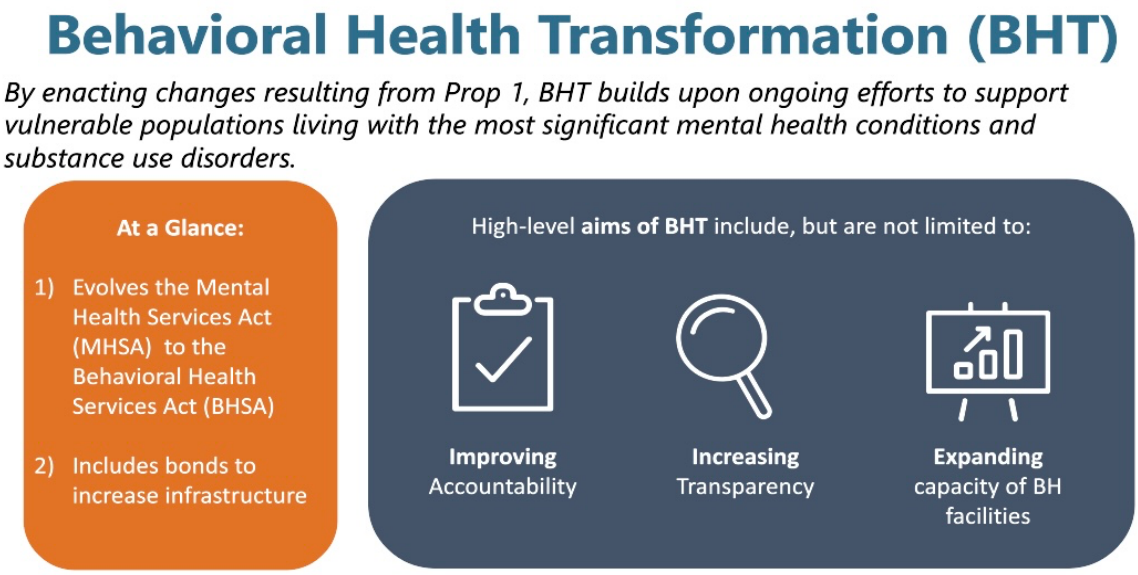
D) Implementation of the Behavioral Health Transformation (BHT) Due to the Passage of Proposition 1

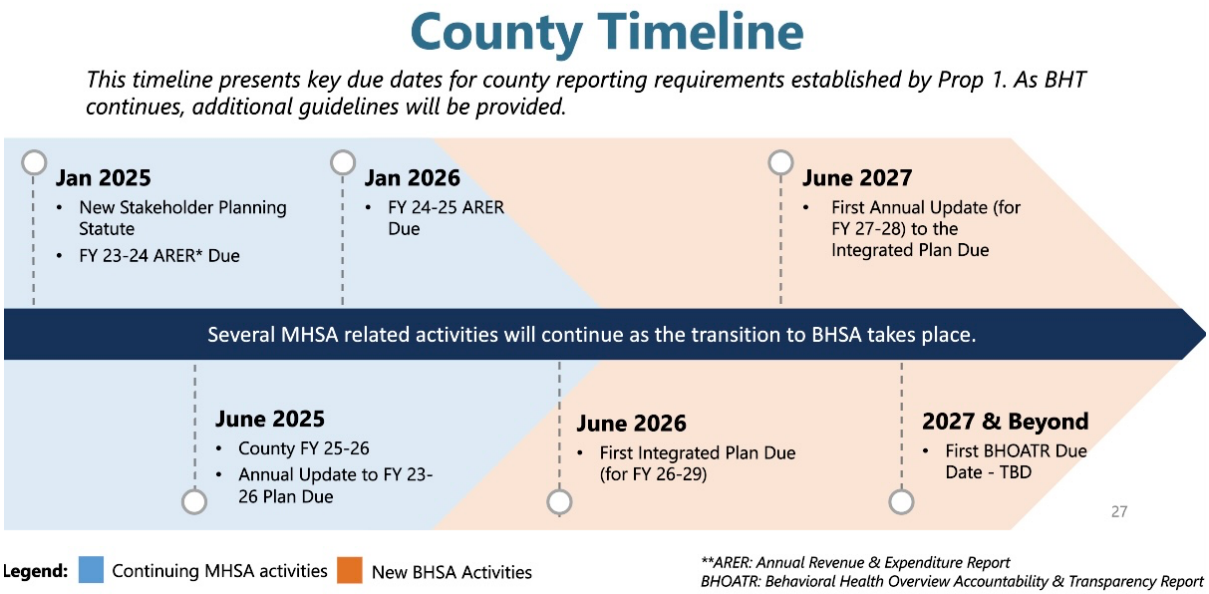
Behavioral Health Transformation (BHT) is the effort that will implement the ballot initiative known as Proposition 1. BHT complements and builds on California's other major behavioral health initiatives including, but not limited to, California Advancing and Innovating Medi-Cal (CalAIM) initiative, the California Behavioral Health Community-Based Organization Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration proposal the Children and Youth Behavioral Health Initiative (CYBHI), Medi-Cal Mobile Crisis, 988 expansion, and the Behavioral Health Continuum Infrastructure Program (BHCIP).

Californians voted to pass Proposition 1 to modernize the behavioral health delivery system, improve accountability and increase transparency, and expand capacity of behavioral health care facilities for California residents. The ballot initiative included allowance of up to $6.4 billion in bonds to build new supportive housing and community-based treatment settings. The Department of Health Care Services (DHCS) will enact changes resulting from Proposition 1 through the Behavioral Health Transformation (BHT) project. The two legislative bills that created the language in Proposition 1 are:

- Behavioral Health Services Act SB 326
- Behavioral Health Infrastructure Bond Act AB 531

Yolo County has been asked to participate in a statewide implementation workgroup and will be coordinating an internal workgroup to begin assessing the impacts to our currently funded programs through the Mental Health Services Act (MHSA) and to crosswalk the extensive new requirements.





Available Resources

The DHCS BHT website has been created to highlight additional information, updates, and resources related to BHT. Below outlines some of the key resources currently available on the BHT website.

A collection of **infographics** illustrate high-level objectives, changes and timelines related to BHT.

A **fact sheet** provides an overview of BHSA, and additional fact sheets will be created throughout the project.

A running list of public **stakeholder engagement forums and listening session recordings** will be maintained throughout the project.

SB 326 (Eggman) BHSA Timeline

March 5, 2024
Presidential Primary Election will be held, and voters will determine whether Prop 1 passes.

January 1, 2025 – June 30, 2026
New BHSA 18-month fiscal transition period begins

- Counties to start implementing new CPP process; e.g., engage expanded stakeholders; participate in MCPs and Public Health community assessments
- Begin developing new Integrated Plan for **ALL funding sources**.
- WIC 5963.03 related to stakeholders and local review process is operable January 1, 2025.
- Small rural counties may make requests for exemptions from 30% Housing allocation and FSP EBP but need to factor in a minimum of 30 days for DHCS to respond to request.
- Counties requesting to transfer funds between the BHSA categories you will need to build in 30 days for DHCS to approve the transfers.
- Counties will need to complete the local review process including stakeholder engagement, post Plan document for 30-day public comment, hold public hearing with local advisory board and get approval from the Board of Supervisors.

June 30, 2027
Submit first Annual Update under BHSA. June 30th will be the ongoing date Annual Updates and Three-Year Plans will need to be approved by the local county BOS for submission to the state.

March 2024 – July 1, 2026
DHCS will engage stakeholders regarding transition planning including:

- Developing state metrics
- FSP standards and levels of care
- EBP/CDEPs
- Template for new annual report
- Develop secondary guidance as

July 1, 2025
Counties can start using BHSA funds to pay for the new admin costs related to new BHSA functions up to 2% of their annual BHSA revenue received.

By June 30, 2026
The county BOS **must** approve the **BHSA Three-Year Integrated Plan for FYs 2026/27-2028/29** and counties must submit approved document to both DHCS and the BHSOAC.

July 1, 2026
Transition to new funding categories and new **BHSA Three-Year Integrated Plan FYs 2026/27- 2028/29** is in place. Counties will need to track local metrics and state metrics (if identified by this time), all expenditures and outcomes for each program included in the Plan and report out data in the Annual Update and new annual *County Behavioral Health Outcomes, Accountability, and Transparency Report.*

TBD 2028
Counties will submit first *County Behavioral Health Outcomes, Accountability, and Transparency Report* which replaces the ARER.

YOLO MHSA LISTENING SESSIONS - THEMATIC ANALYSIS

UNDERSTANDING COMMUNITY PERCEPTIONS

Community Mental and Emotional Well-being

- *Emotional Distress*

This theme encapsulates the high levels of psychological strain expressed by participants. The frequent use of words such as "anxious," "desperate," and "stressed" indicates a pervasive atmosphere of emotional distress.

- *Systemic Frustration*

Participants' frustration was not only personal but was deeply entwined with systemic issues. It's clear from the data that there's a significant challenge in how systemic structures impact individuals, particularly those in caretaking roles, leading to exhaustion that might not be immediately evident.

- *Survival Mode*

This theme reflects a state of basic existence or 'survival mode' that participants find themselves in, following a financial crisis precipitated by the COVID pandemic. The struggle to fulfill basic needs takes precedence over seeking additional services.

Supporting Quotes:

"Families have to live with other families to meet needs."

"Seeking services isn't the first thing. They need to fulfill basic needs first."

MH & SU Misconceptions and Stereotypes

- *Cultural Perceptions of Mental Health*

This theme refers to the varying perceptions and misconceptions about mental health within different cultural backgrounds. In some communities, discussing MH is considered a sign of weakness or is associated with a lack of strength, leading to a cultural stigma that prevents open dialogue and acknowledgment of mental health issues. The narrative across different cultural contexts, particularly within Latinx and Asian communities, illustrates a deep-rooted aversion to discussing and acknowledging MH issues.

Supporting Quotes:

"Growing up in a Hispanic community, you don't really believe in mental health."

"In the Japanese community it's shameful to express feelings, you hide it."

"Being that I come from a Hispanic background, we have this idea that we have to be strong."

- *Educational Barriers and Misinformation*

A lack of appropriate education and the presence of misinformation contribute to misconceptions about MH. Language barriers, insufficient information, and entrenched stereotypes, such as MH issues equating to 'craziness' or homelessness being seen merely as a problem rather than a symptom of larger issues, compound the stigma and prevent effective communication and understanding.

“Disinformation is a problem. Whether it’s about program elements or about mental health frameworks/perspectives."

"What they mistakenly think is that MH is what you see on the street, people walking on the street flailing their hands.”

- *Stigma and Fear of Acknowledgment*

Fear and shame surrounding MH contribute to a reluctance to acknowledge the need for help. Stigma attached to MH issues prevents individuals from seeking help or even having serious discussions about possible solutions, thereby inhibiting proactive approaches to MH and substance use issues.

Supporting Quotes:

"There’s a lot of fear and shame that keeps people from accepting help or following through with help."

"People are afraid to have a serious conversation about what we can do to solve the problem."

IDENTIFYING NEEDS

Mental Health and Substance Use Challenges/Issues in the Community

- *Challenges in Engaging with Mental Health and Substance Use Treatment*

Engagement with mental health and substance use treatment is complex, as individuals often exhibit resistance to acknowledging their problems and accepting help. This is compounded by societal stigma, a lack of trust in providers, and a general unwillingness to engage with services, whether due to addiction, mental illness, or the denial of issues.

Supporting Quotes:

"How do you engage people that aren’t cooperative?"

"What I see every day is the lack of willingness to engage in services."

"They don’t trust anybody."

- *Family and Community Impact on Mental Health and Substance Use*

The impact of mental health and substance use issues is not limited to the individual; it extends to their families and communities. There is a noticeable gap in family involvement in treatment, issues with parental rights, and community challenges like homelessness that intersect with mental health and addiction. Moreover, there is a need for targeted substance use treatment models, especially for youth, which are currently insufficient.

Supporting Quotes:

"Schools are very concerned about children using substances."

"There is a lack of providers that can provide a model of SUD treatment."

"There’s no parent component during treatment."

Groups Needing Extra Support

- *Non-English Speakers (Cultural and Linguistic Barriers to Service Access)*

This theme highlights the challenges faced by non-English speaking populations and those from diverse cultural backgrounds, including Latinx communities and undocumented individuals, in accessing mental health services. Language barriers and a lack of culturally sensitive services exacerbate these challenges, necessitating education and resources in native languages and culturally appropriate approaches. Participants pointed out that certain communities, particularly where there is a strong cultural stigma associated with mental health, or language barriers exist, require additional support to comfortably access services.

"Education is needed, preferably in their own language, where it can be broken down for them."

- *Vulnerable Populations with Specific Needs*

Specific groups such as seniors, transgender individuals, low-income families, and those experiencing housing instability have distinct needs that are not adequately met by current service structures. These populations require targeted support services that address not only their mental health needs but also the multifaceted aspects of their circumstances. Participants identified various vulnerable groups that struggle with unique challenges, such as isolation, gender identity, financial hardship, and the transition to adulthood, which necessitate tailored support strategies.

- *Systemic Issues in Continuity of Care*

This theme encompasses the systemic issues contributing to gaps in mental health service provision, such as the lack of follow-up care for those released from incarceration, the unhoused population, college students transitioning from high school, and new parents. The need for continuity of care is crucial to prevent further deterioration of mental health and substance use conditions. Participants expressed concern over systemic gaps that leave individuals without necessary support during critical transition periods, leading to a lack of continuity in care.

Supporting Quotes:

"Kids that are 5150, it’s very hard to find hospitals locally."

"Anyone being released from jail."

ACCESS TO SERVICES

Accessibility of Support/Barriers

- *Systemic and Bureaucratic Challenges*

This theme captures the structural and systemic hurdles within health care systems, including insurance complexities, limited-service capacity, and long wait times for appointments, which deter or delay individuals from receiving care. Participants have indicated that navigating the healthcare system is a formidable process, fraught with bureaucratic red tape that is particularly challenging for those unfamiliar with it.

Supporting Quotes:

"People don’t know how to fill out paperwork."

- *Cultural and Language Disparities*

This theme refers to the cultural stigmas and language barriers that prevent certain populations from accessing services. These include feelings of shame in discussing mental health in some cultures, the lack of multilingual services, and a general distrust of online resources among newcomers.

- *Socioeconomic Constraints*

Financial hardship and socioeconomic status are significant barriers to accessing mental health and substance use services. The costs associated with care, whether hidden or explicit, can make it unfeasible for those already under financial strain. Participants highlighted the economic challenges faced by individuals seeking mental health services, particularly those in lower socioeconomic brackets, undocumented populations, and those prioritizing basic needs over health care due to financial crises.

Supporting Quotes:

"Financial hardship for housing might be at the top of their list rather than paying for MH services."

"Hidden costs. People with SMI are already strapped financially."

"But we're on survival mode."

- *Logistical Obstacles*

Practical issues such as transportation difficulties and the availability of services pose important barriers as well. For some, physical access to services is a challenge, while for others, there is a lack of awareness or understanding of how to utilize telehealth options.

Supporting Quotes:

"There is a lack of transportation throughout the county."

"Telehealth is an option but what about the seniors that can't get on the internet?"

- *Lack of Specialized Services and Providers*

There is a reported shortage of specialized services and providers, especially for those with developmental issues, specific mental illnesses, or substance use disorders. The scarcity of qualified clinicians and targeted programs, such as those for substance use, exacerbates the difficulties faced by individuals in need of these services.

- *Lack of Effective Outreach and Public Education*

Another recurrent theme is the inadequate outreach and public education on mental health and substance use services. There is a need for better communication and dissemination of information to raise awareness and understanding of available services. Participants indicated that enhancing public education and outreach efforts could bridge the gap between services and those who need them but are unaware of how to access them.

Supporting Quotes:

"There's people that need help and those that can provide, but we need to have better outreach."

"We need more public education on existing resources."

"People want help, they're just not aware."

Cultural Sensitivity in Services

- *Culturally Sensitive Education*

This theme involves creating educational materials and programs in the native languages of the communities being served. It emphasizes the importance of cultural sensitivity and gradual familiarization processes, which respect the pace at which individuals become comfortable discussing mental health.

- *Multilingual Service Provision*

This theme stresses the need for mental health services to be available in multiple languages to address language barriers that can prevent non-English speakers from accessing care.

- *Inclusive Provider Representation*

The theme suggests that having service providers who represent or share the cultural and ethnic backgrounds of the clients they serve could lead to more inclusive and understanding care environments.

- *Reframing Terminology and Perceptions*

The recommendation here is to change the narrative around mental health and substance use by reframing the terminology used. By addressing the root causes (upstream) rather than just the symptoms (downstream), a more holistic and inclusive approach to care can be developed.

"Terminology is extremely needed."

"Our own language drives a narrative that might not be helpful."

- *Outreach to Marginalized Groups*

This theme identifies the importance of proactive outreach efforts targeted at marginalized groups, such as immigrants and those with uncertain immigration statuses, to prevent feelings of alienation and to avoid "dead ends" in service access.

Recommendations for Improved Access

- *Enhanced Educational Outreach*

Developing educational initiatives that effectively communicate the availability and benefit of mental health services to potential consumers, especially before they interact with the criminal justice system. Participants stressed the need for educational programs that can preemptively engage individuals and alter long-standing cultural mentalities towards mental health.

"The most challenging part is the educational component and how you get that out."

"We have to do a better job of educating the public."

- *Community Outreach and Peer Support*

Expanding outreach efforts and establishing peer-led support systems to provide relatable assistance and help overcome barriers of stigma and insight. Participants repeatedly highlighted the effectiveness of peer support and the necessity for better community outreach to bridge the gap between service providers and those in need.

- *Culturally Competent Services*

As previously mentioned, emphasizing the importance of cultural competence in service provision, including having staff from similar backgrounds as the patients to build trust and respect cultural nuances.

Supporting Quotes:

"Being patient in general... Having staff from a similar background will build trust."

- *Innovative Service Models*

Recommending the adoption of innovative models for mental health care, such as therapeutic communities or consistent long-term care teams that provide a holistic and integrative approach to mental health and substance use disorders.

Supporting Quotes:

"What I would like to see is a consistent therapist over a long period of time, consistent medical care."

"In Denmark they have villages for people with MH problems, what if we had something like that?"

- *Integration of Services with Community Institutions*

Integrating mental health services with other community institutions like schools or community-based organizations can help make these services more accessible and less intimidating for those in need.

Supporting Quotes:

"Having services on school grounds/site is important."

"We need to partner with organizations that have experiences with different populations."

- *Technology and Information Dissemination*

There is a necessity for leveraging technology to disseminate information about services more broadly and to create centralized information systems that compile service options.

MHSA FUND ALLOCATION

- *Lobbying for Policy Changes*

This theme encompasses the advocacy efforts aimed at influencing policy decisions, particularly concerning conservatorship laws. It reflects participants' considerations on how to balance individual freedoms with the need for a humane approach to care for those who might not engage voluntarily with services or who make choices that lead to instability.

Supporting Quotes:

"Lobby politicians over conservatorship laws. We see people who are stabilized, and they choose to do something that causes them to derail."

"Resources go to people not engaging in services/not accepting resources."

- *Enhancing Support for Caregivers and Therapists*

This theme identifies the need for bolstered support mechanisms for those who provide direct care and assistance, including caregivers and mental health professionals. It emphasizes the necessity of resources and education to decrease stigma and promote mental health proactively.

Certainly, let's identify another theme based on the fragmented text provided:

- *Building Supportive Communities*

This theme revolves around creating supportive structures within communities, emphasizing the role of schools and local organizations in fostering a supportive environment. It includes the integration of mental

health services in educational settings, outreach to undocumented populations, and the establishment of community resources for families and individuals facing mental health challenges.

Supporting Quotes:

“Establishing community-based support systems, with schools as central nodes for resources and mental health services.”

"We need collaborations with the county, and local non-profits. Specifically, the undocumented population, if funding was provided to those agencies, or even starting partnerships, would help that community."

Based on the fragments available, I can propose one more theme:

- *Comprehensive Continuum of Care*

This theme involves the development of a complete range of services that address the various needs of individuals with mental health issues. It highlights the necessity for a spectrum of resources, from educational programs to residential treatment facilities, and underscores the importance of easy access to and transition between services. Acknowledging the gaps in current services, stakeholders suggest the need for a more comprehensive continuum of care.

Supporting quotes:

“Developing a full spectrum of mental health services that are easily accessible and interconnected.”

Yolo County Local Mental Health Board
Program Committee Site Visit Guide

PURPOSE

Site visits provide an opportunity to "review and evaluate the community's mental health needs, services, facilities and special problems". *(Statutory Duties: WIC 5604.2)*

The purpose of this guide is to identify and evaluate behavioral health programs and services in Yolo County and identify areas of successes, opportunities for improvements and gaps to access to treatment. Findings and recommendations are presented to the Yolo County Local Mental Health Board by the Program Committee.

PROCEDURE

1. The Local Mental Health Board (LMHB) Administrative Liaison provides current facilities lists on an annual basis to be reviewed by the Program Committee. These lists will include both county run services and contracted services.
2. The Program Committee, with input from the LMHB, chooses which sites to visit and provides this list to the LMHB Administrative Liaison. Note: Additional sites can be considered throughout the year at the request of LMHB members and approval by the Program Committee.
3. The program Committee identifies targeted months that site visits could be held and canvasses which board members are available during those months. The Program Committee Chair then develops the schedule of annual site visits.
4. The site visit schedule for each year will be distributed during a LMHB meeting by the Program Committee Chair and posted to the LMHB webpage (listing the Program Committee Chair as main contact).
5. LMHB Administrative Liaison will provide (to Program Committee Chair):
    a. Site Contact (name/email/phone)
    b. Current Contract (to include Scope of Work and Budget) Information (to Program Committee).
    c. Copies of recent reports to the Yolo County HHSA BH Division (if any).
6. The Program Committee Chair will contact the Facility/Program contact to schedule the site visit. The coordination will be managed by the program Committee.
    a. The "Facility/Program Form" *Pre-Visit Questionnaire* section (sent to Facility/Program contact by Program Committee Chair) is to be completed prior to the visit by facility/program staff via phone or email. Note: the contractor is given the form for informational purposes. Contractors are welcome to offer information in advance if desired.
    b. Prior to the visit the Program Committee Chair will share all information with the Program Committee and prepare for the site visit.
7. After conducting the site visit, the Program Committee Chair will conduct a debriefing at the next Program Committee meeting and provide the Program Committee's completed findings and recommendations in a compiled "Facility/Program Observation Report" to the LMHB Chair and the Administrative Liaison to be included for review as an agenda item at the next LMHB meeting.
8. Concerns raised from site visits by the Program Committee should be addressed by the Mental Health Director and/or HHSA BH Division staff with follow-up information reported to the LMHB for inclusion in the LMHB Annual Report.

Yolo County LOCAL MENTAL HEALTH BOARD
FACILITY/PROGRAM OBSERVATION REPORT

By:_____
Board Member Name

This Report Is Based On A Personal Visit From One Or More Members Of The Yolo County Local Mental Health Board

Program/Facility Name:

Street Address:

Program Supervisor/Contact (name):
Title:
Email:
Phone #:

Pre-visit questionare:

What are the current contract terms and County funding source?

Brief description of services provided:

Number of staff having direct client contact:

What kind of training does your organization provide to staff, and how often?

What are the classifications which are directly involved with clients?

Are there education and support groups for clients?

What is the layout of the facility/program (attach)?

Is there a daily schedule for clients?

Date Of Site Visit:

Observations / Staff Interview

1. How does the staff interact with individuals? For example, does the staff appear compassionate, patient, caring, rushed, indifferent or perfunctory?

2. Are individual grievance procedures prominently posted? **Y/N** Are grievance forms readily available to the individual? **Y/N** Is the current Patients' Rights Advocate's contact information posted? **Y/N**

3. What are desired outcomes/treatment goals? How often are these achieved?

4. What are two or three obstacles your program, staff and individuals face which may make it difficult to achieve these outcomes/goals?

(Will not apply to all programs): Do some individuals require re-entry to the program/facility after discharge? If yes, what percentage return and why?

5. (Will not apply to all programs): How many individuals are engaged in your program? How often do they visit? What programs are the best attended?

6. What efforts are made to provide linguistically and culturally competent services/programs? Do the people you serve reflect the ethnic make-up of the community?

7. Does your agency's Board of Directors, owners or management include any mental health consumer members? **Yes / No**

8. Does your agency's staff include any peer providers? **Yes/No** Are peer providers consumers, family members or caretakers of adults with mental illness? Are they paid or volunteers?

9. How many people seeking services/involvement did your organization turn away over the course of a year? Why? (Qualifications? Behavioral? Medical? Waiting List? Other? – please specify)

10. Is there any other aspect of the program you'd like to share with us today?

SITE VISIT SUMMARY

MENTAL HEALTH BOARD MEMBERS TO COMPLETE THESE QUESTIONS AFTER VISITING THE PROGRAM

1. What Is Your Overall Impression Of The Facility/Program, Including Strengths And Limitations?

2. Any Recommendations For This Facility Or Program for the Mental Health Board to consider?