Public Notice
County of Shasta

Mental Health, Alcohol and Drug Advisory Board (MHADAB)

Regular Meeting Agenda

Wednesday, January 10, 2024, 5:30 pm
Mae Helene Bacon Boggs Conference Center
2420 Breslauer Way, Redding, CA 96001

Members of the public may attend via GoToMeeting
You can also dial in using your phone.

United States: +1 (408) 650-3123
Access Code: 510-166-341
This meeting will be audio recorded.

Board Members

Kalyn Jones, *Chair*

Heather Jones, *Vice Chair*

Alan Mullikin

Angel Rocke

Cindy Greene

Connie Webber

David Kehoe

Jo-Ann Medina

Mary Rickert

Ron Henninger

Samuel Major

I. Call to Order & Welcome

II. Public Comment

Members of the public will have the opportunity to address the Board on any issue within the jurisdiction of the Board. *Speakers will be limited to three minutes.*

III. Announcements and Staff Updates

Staff will address Public Comment, if needed, to follow up from the previous meeting.

IV. Consent Calendar

The following Consent Calendar items are expected to be routine and non-controversial. They may be acted upon by the Board at one time without discussion. Any Board member or staff member may request that an item be removed from the Consent Calendar for discussion and consideration. Members of the public may comment on any item on the Consent Calendar before the Board's consideration of the Consent Calendar. Each speaker is allocated three minutes to speak.

A. Approval of Meeting Minutes

Board members will review and approve minutes from the November 1, 2023, Regular Meeting

B. Membership Committee's Nomination

Consider recommending to the Board of Supervisors the Membership Committee's nomination of the following new members to fill the vacant MHADAB positions: Matilda Grace (Marlar) – term to expire 12/31/2025, Laurie Hicks (Menoher), Wesley Tucker (Stewart), Erin Dooley (Prielipp) – terms to expire 12/31/2026.

V. Regular Calendar

Public Comment will be invited prior to the close of each item.

VI. Presentations

A. Shasta Triumph And Recovery, Mey Chao-Lee, BHSS Clinical Program Coordinator
B. Warm Line, Kalyn Jones, MHADAB Chair

VII. Discussion Items

A. Board members may ask questions about the Director's Report.
B. Board members may make suggestions for future agenda consideration.
C. Ad Hoc Committee MHADAB Annual Report 2023
D. Ad Hoc Committee Update: Annual Report 2022
E. Ad Hoc Committee Update: Bylaws
F. New Board Member Biography
G. MHADAB New Member Orientation
H. MHADAB Application and Interview Questions
I. Woodlands Update
J. 2024 Special Meetings (Site Visits)
K. Board Member Committee Assignment
L. 2024 Executive Committee Meeting Dates
M. Data Notebook 2023

   Review the 2023 Shasta County Data Notebook as presented in written form and consider voting to approve for submission to the Board of Supervisors

VIII. Board Member Committee Reports

Board members will report committee meeting updates.

IX. Adjourn

MHADAB Meeting
February 14, 2024, 5:30 pm
Location: TBD
Redding, CA 96001

Executive Committee Meeting
TBD, 11:00 am
HHSA BHSS Services Branch, Administrative Conference Room
2640 Breslauer Way,
Redding, CA 96001

Committees

Shasta Substance Use Coalition
January 9, 2024, 10:30 am
Virtual via Zoom
jill@shastatraining.org

Shasta Suicide Prevention Collaborative
January 9, 2024, 2:30 pm
For location, please email
sstinger@co.shasta.ca.us

Stand Against Stigma
February 13, 2023, 1:30 pm
Sunrise Mountain Wellness Center
1300 Hilltop Drive Suite 200
Redding, CA 96001
cdiamond@co.shasta.ca.us

ADP Provider Meeting
February 28, 2024,
10:00 am
Location: Boggs Conference Center
2420 Breslauer Way,
Redding, CA 96001
kcassidy@co.shasta.ca.us

MHSA Stakeholder Workgroup
February 29, 10:00 am
Boggs Building
2420 Breslauer Way
Redding, CA 96001
mhsa@co.shasta.ca.us

"The County of Shasta does not discriminate on the basis of disability in admission to, access to, or operation of its buildings, facilities, programs, services, or activities. The Shasta County Mental Health, Alcohol and Drug Advisory Board will make available to any member of the public who has a disability a needed modification or accommodation including an auxiliary aid or service, in order for that person to participate in the public meeting. A person needing assistance should contact Jacquelynn Rose by telephone at (530) 229-8266, or in person 2640 Breslauer Way, Redding, or by mail at P. O. Box 496048, Redding CA 96049-6048, or by e-mail at MHADAB@co.shasta.ca.us at least two (2) working days in advance. Accommodations may include, but are not limited to, interpreters, assistive listening devices, accessible seating, or documentation in an alternate format. If requested, this document and other agenda materials may be made available in an alternative format for persons with a disability who are covered by the Americans with Disabilities Act. Questions, complaints, or requests for additional information regarding the Americans with Disabilities Act (ADA) may be forwarded to the County's ADA Coordinator: Monica Fugitt, Director of Support Services, County of Shasta, 1450 Court Street, Room 348, Redding, CA 96001-2676 Phone: (530) 225-5515 Fax: (530) 225-5345 California Relay Service: 711 or 1-(800)-735-2922, E-mail: adacoordinator@co.shasta.ca.us.

Public records which relate to any of the matters on this agenda (except Closed Session items), and which have been distributed to the members of the Advisory Board, are available for public inspection at Shasta County Health and Human Services Agency, 2640 Breslauer Way, Redding, CA 96001. This meeting may be recorded. If there are any questions regarding this agenda, please contact Jacquelynn Rose at 530-229-8266, or via e-mail at MHADAB@co.shasta.ca.us.

Shasta County Health and Human Services Agency
SHASTA COUNTY Mental Health, ALCOHOL AND DRUG ADVISORY BOARD (MHADAB)
REGULAR Meeting
Wednesday, November 1, 2023

Attendees:

Ron Henninger	√	Anne Prielipp		Connie Webber	√	Mary Rickert	√
Kalyn Jones	√	Charlie Menoher	√	David Kehoe		Samuel Major	
Alan Mullikin		Christine Stewart		Heather Jones	√		
Angel Rocke	√	Cindy Greene	√	Jo-Ann Medina	√		

Shasta County Staff: Miguel Rodriguez, Jackie Rose, Ashley Saechao, Amber Brock, Adam Hilton, Genelle Restivo, Rachel Ibarra, Shawnna Flanigan, katie Cassidy, Marie Marks, Kristin Wilson, Katie Nell, Mey Chao – Lee
Community Members: 32 members including those on GoTo Meeting

Agenda Item	Discussion/Conclusions/ Recommendations	Action/Follow-Up	Date Due/Status	Individual/ Department Responsible
I. Call to Order	Ron Henninger called meeting to order at 5:34 pm	No action required.	N/A	Ron Henninger
II. Public Comment	Danny Medina from Camhpro shared the Superior Region Peer Leadership Forum event was happening on November 10, 2023 at the McConnell Foundation. He provided a flyer.	No action required.	N/A	N/A
III. Announcements and Staff Updates	None.	No action required.	N/A	N/A
IV. Consent Calendar	A. Approval of Previous Minutes The minutes from October 4, 2023 were presented in written form.	Meeting minutes approved with nine (9) ayes, zero (0) nays, and zero (0) abstentions.	N/A	Motion: Heather Jones Second: Charlie Menoher
	B. Ad Hoc Nominating Chair/Vice Chair Consider approving the Ad Hoc Nominating Committee's recommendation for 2024 Mental Health, Alcohol and Drug Advisory Board Chair and Vice Chair. Ron Henninger – Chair gave Ad Hoc Nominating Committee's recommendation for Chair and Vice Chair positions: Kalyn Jones and Heather Jones	Approve the Nominating Committee's recommendation for 2024 MHADAB Chair Kalyn Jones and Vice Chair, Heather Jones	N/A	Motion: Cindy Greene Second: Charlie Menoher
	C. Board Member Reappointments: Recommendations to the Shasta County Board of Supervisors for 2024 Mental Health, Alcohol and Drug Advisory Board Chair and Vice Chair were approved with 9 ayes and 0 nays. D.	Recommend the Board of Supervisors reappoint Angel Rocke to three-year terms to MHADAB.	12/19/2023	Motion: Cindy Greene Second: Kalyn Jones

Agenda Item	Discussion/Conclusions/ Recommendations	Action/Follow-Up	Date Due/Status	Individual/ Department Responsible
V. Presentations	A. Psychiatric Advance Directives Michelle young -Sambajon and Gail DiRaimonda from Chorus provided a Powerpoint presentation about an app that can be utilized to help individuals in crisis for professionals who have been grated access.	No action required	N/A	N/A
	B. 5150 Holds Adam Hilton gave a PowerPoint presentation about what a 5150 hold is, who is authorized to write a 5150 hold, what the criteria is for 5150, and Shasta County's evaluation process including after the 5150 hold is written.	No action required	N/A	N/A
	C. Shasta Triumph and Recovery Team (STAR) Mey Chao-Lee provided a PowerPoint presentation on the voluntary program that focus on wellness, recovery and resiliency. The social workers, clinicians and one nurse who make up this team practice the "whatever it takes' model to provide access services to those in need.	No action required	N/A	N/A
	D. Kingsview Assisted Outpatient Treatment Program Genell Restivo provided a PowerPoint presentation on Kingsview Assisted Outpatient Treatment. This is a community based mental health service under court order to individuals with severe mental illness who have demonstrated adhering to prescribed treatment on a voluntary basis.	No action required	N/A	N/A
VI. Regular Calendar	No regular calendar items were discussed.	N/A	N/A	N/A
VII. Discussion Items	A. Director's Report No questions were asked about the Director's report.	No action required	N/A	N/A
	B. Future Agenda Items Board members were invited to participate in meeting planning by attending Executive Committee meetings. It is asked if you ask for a specified agenda topic to attend the Executive meeting to provide additional clarification on special interests.	No action required	N/A	N/A
	C. Meeting Minutes 6/9	No action required	N/A	Motion: Kalyn Jones

Agenda Item	Discussion/Conclusions/ Recommendations	Action/Follow-Up	Date Due/Status	Individual/ Department Responsible
	The minutes from June 9, 2023 Special Meeting presented in written form was approved. D. <u>Ad Hoc MHADAB Annual Report</u> Ron stated that progress toward the 2022 Annual report is being made.	Ad Hoc MHADAB Annual Report committee will continue working on the annual report for 2022.	January 10, 2024 an update will be provided	Second: Angle Rocke Ron Henninger, Chair
VIII. Board Member Reports	No reports from members of the board.			
IX. Adjournment		Adjournment 7:25 pm	N/A	Motion: Charlie Menoher Second: Kalyn Jones

Next Regular Meeting is scheduled on: January 10, 2024

Ron Henninger
MHADAB Chair

Date

Shasta County
Health & Human Services Agency | Behavioral Health & Social Services Branch

Shasta Triumph And Recovery (STAR)

Mey Chao-Lee, LCSW, Clinical Program Coordinator

STAR Funding

- Funded by Proposition 63-Mental Health Services Act (MHSA)
  (Proposition 63 approved by California voters November 2004 and became law January 2005. It places a 1% tax on personal income above $1 million)
- Medi-Cal

“Whatever It Takes”

- STAR is a voluntary, Full-Service Partnership Program that focuses on wellness, recovery, and resiliency.
- We practice “whatever it takes” model to provide access to services.
- We focus on meeting our partners where they’re at to increase engagement and provide a pathway to improve their mental health at the lowest level of care possible. These field locations may include but are not limited to emergency department, shelters, encampments, under the bridge, Native Reservations, “mountains/wooded areas,” out in the community, in their homes, and at different times of the day and hour (after hours, weekends and holidays).
- Provides non-traditional treatment and engagement. Engaging partners by having a cup of coffee, assisting and ensuring partner has access to food, assessing and discussing partner’s needs using non-clinical terms to build rapport, trust, and increase engagement. Treatment is usually out of the office and coordinated at a location of the partner’s preference.
- STAR Team is creative and adapts to the partner’s needs by providing different series of treatment modality and engagement while encouraging the partner’s natural support systems to be part of the partner’s journey to their mental health wellness.
- STAR Team is available to our FSPs 24/7.

Barriers

While partner care and treatment is our goal, we prioritize safety for our partners, community members and staff. This can at times limit our ability to safely, legally or ethically practice and utilize “whatever it takes” model. Some of these challenges are:

- Partner decline treatment or engagement
- Partner does not give us permission to exchange information with their support system and/or family
- Can’t force partners to engage in treatment, including medication and therapy
- Partner is not at appropriate level of care
- Lack of resources, such as limited board and care beds, inpatient beds, housing options in the community

Criteria for services

- Must be a Shasta County Resident and have Shasta County Medi-Cal
- Severe and persistent mental illness
- Unsheltered or risk of homelessness and/or incarceration due to their mental illness
- Multiple inpatient psychiatric hospitalizations and/or emergency department contacts due to their mental illness
- At risk of being conserved or already on LPS conservatorship
- Difficult to engage or not in treatment
- Multiple functional impairments, struggles to complete Activities of Daily Living (ADLs) tasks without support or prompts from intensive case management
- Step Down from State Hospitals and Institutions for Mental Disease (IMD)

Tiers of Services

- Level I (Primary Outreach Phase)-Not an active client of HHSA, BHSS/STAR Team
- Level II (Partners)-Open to services with HHSA, BHSS/STAR Team, minimal service engagement
- Full-Service Partners (FSP)-Open to services with HHSA, BHSS/STAR Team, fully engaged with multiple services from STAR Team (therapy, case management, medication management, both individual and group rehabilitation services).

STAR Team

- Two Clinicians, Four Social Workers, One Nurse
- Team members are diverse
- Services in three different Languages (English, Hmong and Mien)
- Collaborate with CIRT, Peer Support, IHSS, VA, NVCSS, Hill Country and Kingsview AOT to provide wrap around services to our partners for the best quality of care
- Serves up to 50 FSP/Partners

What Does STAR Team Do?

- We provide intensive (daily or weekly) services to our partners who suffer from chronic and severe mental illness.
- Our goal is to assist our partners with maintaining or reaching their goal to live independently in the community and improving their quality of life.
- We assist with accessing resources, learning independent living skills, completion of Activities of Daily Living (which many of our partners can not maintain), and provide opportunities for positive social support and social rehabilitation.
- Many of our partners continue to experience psychotic symptoms despite medication compliance and we have found that social support and social rehab interventions are crucial to their success. This has been evidenced by our observations of clients' decompensation and increase in symptoms (such as paranoia and hallucinations) since the COVID-19 quarantine.

STAR Partners

- Total of 68 FSP/Partners/Outreach: 61 FSP, 2 Partners (Level II) and 5 Outreach (Level I)
- 26 conserved FSP and 42 non-conserved FSP/Partners/Outreach
- 11 FSP (previous and active FSP) at Woodlands
- 4 current FSP at the Woodlands
- 9 FSP graduated from STAR
- 3 FSP Unsheltered, 5 Outreach Unsheltered, 2 partners Motel, 16 FSP/Partners Independent Living, and 42 FSP Board and Cares

CA PEER RUN WARM LINE

Kalyn
Jones (She/Her/Hers)
Assistant Manager WL Programs

THE CALIFORNIA PEER RUN WARM LINE

The Peer-Run Warm Line–which began operation in 2014–is a non-emergency resource for anyone in California seeking mental and emotional support. We help via phone, SMS and web chat on a nondiscriminatory basis to anyone in need. Some concerns callers share are challenges with interpersonal relationships, anxiety, pain, depression, finances, alcohol/drug use, etc. We service the entire state of California.

The role as a Warm line is, we support callers having thoughts of suicide by exploring the caller's resources and tools, holding space without judgement, and scheduling follow-up calls for ongoing supporting

WHAT IS THE DIFFERENCE BETWEEN THE WARM LINE AND 988?

Warm Line:

- Program designed and delivered by peers with lived experience
- Nonclinical, values-based Peer Support Model (with link to Peer Values page on new website if possible)
- You don't have to be in crisis to call the Warm Line. In fact, we know that immediate access to self-determined support can prevent challenges from escalating to crisis
- Voluntary Services Only (no non-consensual active rescue)

988:

- Call takers are not peers
- Clinical model
- Designed to intervene in crisis
- May call emergency services regardless of a caller's knowledge or consent

HOW DOES THE WARM LINE AND 988 INTERACT?

Referrals in both directions – sometimes callers to 988 want person-centered peer support from a Warm Line, some Warm Line callers want crisis-intervention support from 988.

Good to know:
Referrals to 988 from the Warm Line are done through a warm handoff and with informed consent

The Warm Line can schedule a follow-up call to check in after the call with 988

IN PERSON INTERVENTIONS?

MANDATED REPORTERS

There are some urgent situations were in-person intervention could be more immediately helpful than a phone conversation to help the person stay alive.

- CPS
- APS
- Tarasoff

COMMUNITY-BASED SUPPORT

- First option of support for staff
- Mobile/ Crisis Response Teams

EMERGENCY SERVICES

- Last resort for staff
- Consent is Key
- Work with local Police Departments

IS NON-CONSENSUAL ACTIVE RESCUE A NECESSARY OPTION?

- Calls to the Warm Line where someone is at "imminent risk" of suicide by our definition are extremely rare (0.004%)
- Warm Line counselors have supported 100% of these calls without the use of nonconsensual active rescue
- When needed these services were requested or consent was consistently granted
- The California Peer Run Warm Line does not practice non-consensual active rescue. We will not call emergency services unless the caller says it's ok.

Why a "Warm Line" and no a "Hotline"?

Imagine a pot left unattended and beginning to boil over. One must act IMMEDIATELY to prevent additional damage. Distress left avoided for too long is like a boiling pot.

The Warm Line aims to be a HIGHLY ACCESSIBLE, LOW-THRESHOLD MENTAL HEALTH RESOURCE people can use for support BEFORE they've reached their boiling point, with the hope immediate support will PREVENT CRISIS later.

QUESTIONS?

THANK YOU

Kalyn@mentalhealthsf.org

CMPSS, #MPSS-MVPAOB

THE CALIFORNIA PEER RUN

WARM LINE

HERE TO HOLD SPACE

Our free, peer run phone and chat line is available 24/7/365 across California for warm, non-crisis emotional support.

SCAN HERE

CALL OR TEXT TO CONNECT WITH A PEER COUNSELOR NOW

MENTALHEALTHSF.ORG **1-855-845-7415**

THE WARM LINE PROVIDES ACCESSIBLE MENTAL HEALTH SUPPORT BY USING THE WISDOM OF LIVED EXPERIENCE TO CONNECT, INSPIRE HOPE, AND EMPOWER OUR COMMUNITY TOWARD UNLIMITED RECOVERY.

Mental Health, Alcohol and Drug Advisory Board (MHADAB)

DIRECTOR'S REPORT

January 10, 2024.

Mental Health, Alcohol & Drug Advisory Board Previous Meeting Documents | Shasta County California

Shasta County
Health & Human
Services Agency

Board of Supervisors Updates – August & September

October 17, 2023 BOS Meeting Legal Minutes

No contract updates

October 24, 2023 BOS Meeting Legal Minutes

No contract updates

October 31, 2023 BOS Meeting Legal Minutes

- **C7** Approve a retroactive amendment to the agreement with Cascades Management LLC, dba Ridgeview Residential Care Home, for adult residential care home services which increases rates and compensation for a new maximum compensation of $2,198,323.20.

- **C8** Approve a retroactive renewal agreement with Shasta County Child Abuse Prevention Coordinating Council, dba Pathways to Hope for Children for the Community Based Child Abuse Prevention Program.

- **C9** Approve a retroactive renewal agreement with Shasta County Child Abuse Prevention Coordinating Council, dba Pathways to Hope for Children, for Parent Learning, Supportive Services, and Prevention and Early Intervention.

October 31, 2023 continued...

- **C10** Approve a renewal agreement with Northern Valley Catholic Social Service for youth mental health services in an amount not to exceed $1,875,000 and designate authority to terminate the agreement.

November 7, 2023 BOS Meeting Legal Minutes

No contract updates

December 5, 2023 BOS Meeting Legal Minutes

- **C18** Adopt a resolution which authorizes acceptance of the County's allocation award under the California Department of Housing and Community Development for the Transitional Housing Program and the Housing Navigation and Maintenance Program.

- **C19** Approve a retroactive agreement with the State of California Department of Health Care Services, in an amount not to exceed $118,236,000, for covered Drug Medi-Cal Organized Delivery System services.

December 5, 2023 continued...

- **C20** Approve a retroactive renewal agreement with Northern California Youth and Family Programs for an Independent Living Program and designate authority to terminate the agreement.

- **C21** Approve an agreement with His Ideas, Inc., dba Children First Foster Family Agency, in an amount not to exceed $1,200,000, for youth mental health services and therapeutic foster care.

December 19, 2023 BOS Meeting Legal Minutes

- C6 Adopt a resolution which defers implementation of the changes to Welfare and Institutions Code Section 5008 by Senate Bill 43.

MH & SUD Services Update

Crisis Services (ER) Activity Report November 2023

ER/ED Activity: There were **125** crisis evaluations performed at the Emergency Departments. Shasta Regional Medical Center had **80** evaluations, while Mercy Medical Center had **45** evaluations in November 2023.

Percentage of visits by hospital:

Shasta Regional Medical Center	64%
Mercy Medical Center	36%
Mayers Memorial Hospital	0%

Diagnosis:

Depressive Disorders	14%
Psychotic Disorders (not Schizophrenia)	14%
Bipolar Disorders	17%

Toxicology:

THC	68%
Amphetamines/Meth	39%
Fentanyl	6%

5150s Upheld:

- Of clients 5150'd, 28% were ultimately upheld and hospitalized.
- Of clients initially designated 1799.111 then became a 5150, 63% were upheld and ultimately hospitalized.
- Of 5150s to be released, 91% were reported as "Does not Meet Criteria."

MH & SUD Services Update

Notice of Adverse Benefit Determinations (NOABDs)

Quarterly reports detail Notice of Adverse Benefit Determinations (NOABDs) for both Adult and Children's Services Branches. NOABDs are issued when the plan decides to deny or terminate treatment.

In November 2023, 6 NOABDs were issued to Adult Services clients, and 9 NOABDs were issued to Children's Services clients.

MH & SUD Services Update

Notice of Adverse Benefit Determinations (NOABDs)

Delivery System Notices & Terminations 300

Most Common Reasons Cited for NOABDs in November 2023	Total Adult (6)	Total Child (9)
Not able to contact client, various reasons.	**3 (50%)**	**9 (100%)**
Mental health condition would be responsive to treatment by a physical health care provider.	**0 (N/A)**	**0 (N/A)**

MH & SUD Services Update

Mental Health Services Act (MHSA) Annual Update

The Mental Health Services Act (MHSA) provides approximately 25% of California's Mental Health services funding. The 3-Year Plan outlines available county mental health services and goals. MHADAB was created, in part, to oversee and guide the use of MHSA funding.

For an overview of current MHSA programs, look through Shasta County's most recently published 3-Year Plan.

The Annual Update to our current 3-Year Plan is in progress, your feedback on these programs is valued. Please reach out to our MHSA team with any commentary or suggestions regarding the Annual Update at mhsa@co.shasta.ca.us.

Learn more about Shasta County's MHSA activities at www.ShastaMHSA.com.

HHSA BHSS Branch Updates

Mobile Crisis Medi-Cal Benefit:

On December 21, 2023 the Center for Applied Research Solutions (CARS), the organization reviewing county implementation plans for Mobile Crisis for DHCS, approved Shasta County delaying the start of the Medi-Cal Mobile Crisis Benefit.

- the policy and procedure for Mobile Crisis was in the review process
- workforce shortage
- staff formalized a complaint to their union reps citing safety and exiting job duty concern in the process of expanding the Mobile Crisis service with Hill Country to include all ages and a 24/7 response

HHSA BHSS Branch Updates

SB 43 (Senator Eggman) expands the gravely disabled criteria to allow for the involuntary detention and conservatorship of individual on the basis of a "severe" substance use disorder or co-occurring mental health disorder.

- On December 19, 2023 the BOS approved delayed implementation until January 1, 2026.
- Delayed implementation will allow for the development of an extensive workforce and treatment capacity

HHSA BHSS Updates

New Bills:

- AB 702 - Local Government Financing Juvenile Justice
- AB 1047 - Firearms Purchase Notification Registry

New Resource:

- Opioid resource website created by the state, OPIOIDS.CA.GOV

"Engaging individuals, families and communities to protect and improve health and wellbeing."

Miguel Rodriguez, *LCSW, Behavioral Health and Social Services Branch Director*
Katie Cassidy, *Behavioral Health and Social Services Deputy Branch Director*
Laura Stapp, *Behavioral Health and Social Services Deputy Branch Director*
Health & Human Services Agency | Shasta County California

Mental Health, Alcohol and Drug Advisory Board

Annual Report 2022

Shasta County
Health & Human Services Agency

Our Membership

Ronald Henninger (Chair)
Kalyn Jones (Vice Chair)

Alan Mullikin
Angel Rocke
Anne Prielipp
Charles Menoher
Christine Stewart
Cindy Greene
Connie Webber
Dale Marlar
David Kehoe
Heather Jones
Jo-Ann Medina
Mary Rickert
Sam Major

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Dear Shasta County Board of Supervisors:

The members of the Shasta County Mental Health, Alcohol and Drug Advisory Board (SCMHADAB) are pleased to present to you the SCMHADAB 2022 Annual Report.

Sincerely,
Ron Henninger
Shasta County Mental Health, Alcohol and Drug Advisory Board Chair

Board Mission and Responsibilities

The mission of the Board is to inform and educate the public on alcohol, drug and mental health issues as well as to advise the Shasta County Mental Health Plan on program development, availability of services and planning efforts as established by Welfare and Institutions Code Section 5604.2. This includes the following responsibilities:

1. Review and evaluate the community's mental health, alcohol and/or drug treatment needs, services and special problems as related to the above.
2. Review performance contracts.
3. Advise the Board of Supervisors, the Shasta County Director of Mental Health Services and the County Alcohol and Drug Program Administrator to any aspect of Shasta County's mental health, alcohol and drug treatment and prevention services.
4. Ensure citizen, consumer and professional involvement in the Shasta County Mental Health Plan's delivery planning efforts.
5. Submit an annual report to the Board of Supervisors on the needs, challenges and performance of Shasta County's mental health, alcohol and drug treatment and prevention services.
6. Review, interview and make recommendations on applicants for appointment of the Director and Administrator.
7. Review and comment on Shasta County's performance outcome data and communicate its findings to the State of California Mental Health Planning Council and/or other appropriate entities.
8. Assess the impact of the realignment of services from the State of California on mental health services delivered to clients and within the Shasta County community.
9. Review draft Mental Health Services Act (Proposition 63, General Election of November 2004) plans and annual updates, make recommendations to the Director regarding the plans and updates, and make recommendations to the County Mental Health Department for revisions, as needed (per Welfare and Institutions Code Section 5848(b)).
10. Conduct public hearings on draft Mental Health Services Act plans, annual updates and other matters as appropriate.

Meetings: Action Items and Presentations

January

Discussions and Actions:

- Approved the Shasta County Data Notebook 2021

Presentations:

- **Adult Services ACCESS to Mental Health and Substance Use Disorder Services** – A PowerPoint presentation was presented by Deidra Ward, Mental Health Clinician. She provided an overview of services offered to clients and different avenues of treatment through the ACCESS Clinicians and County programs. ACCESS Clinicians are available to see walk-in clients between 8:00 and 3:30 p.m.

- **Children's Services Branch Behavioral Health Clinical Services** – A PowerPoint presentation was presented by Children's Services Branch Director Miguel Rodriguez, Deputy Branch Director Dwayne Green, HHSA Program Managers Cindy Lane, Tara Shanahan, Mary Jane Mathis, Pamela Ottinger, Laura Stapp, and Kiley Castaneda**.** They talked about different services that Children's branch offers including investigations and detentions, after hours response and family urgent response services, court interventions, intensive services, collaboration with local partners.

March

Discussions and Actions:

- The board welcomed new members Angel Rocke and Anne Prielipp
- Announcement of HHSA Director Donnell Ewert will retire in April of 2022. Donnell was with the county for 23 years.
- Presentation guidelines were sent out to all board members.

Presentations:

- **MORS II Outcome Data Tracking** – A PowerPoint presentation was presented by Paige Greene, Adult Services Branch Director. The Milestone of Recovery Scale (MORS) was created to capture aspects of recovery from the agency perspective such as client engagement and measurable progress.

- **Full-Service Partnership** – A PowerPoint presentation was presented by Genell Restivo, Clinical Division Chief of the Adult Services Branch. She described that Full-Service Partnership is a comprehensive and intensive program for adults with severe and persistent mental illness. This takes a "business as usual" approach away and utilizes a "whatever it takes" field-based approach using innovative interventions to help people reach their recovery goals.

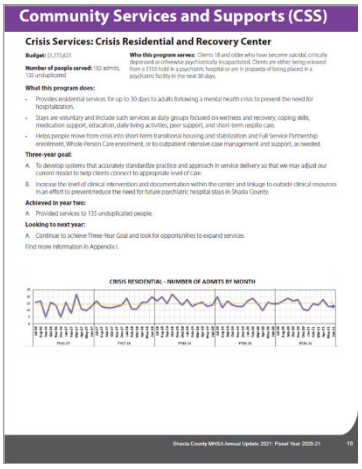
- **Continuation of Children's Services Branch Behavioral Health Clinical Services**– Laura Stapp, Clinical Division Chief and Kiley Castaneda, Clinical Division Chief presented on the remaining children services from the prior month.

May

Discussion and Action Items:

- Approval of the MHADAB 2021 Annual Report for Submission to the Shasta County Board of Supervisors.
- Ron Henninger, MHADAB Chair discussed security issues and the cost of security staff during a recent meeting at Woodlands Apartment Complex.

Presentations:



- **MHSA Annual Update Presentation** – A PowerPoint presentation was presented by Kerri Schuette, Deputy Branch Director. The update included the second and final updated for the current three-year program and expenditure plan. Changes to the report format based on recommendation to make it more clear, concise and easy to read.
- **Youth Innovation Toolkit** – A PowerPoint presentation was presented by Kalyn Jones, MHADAB Vice-Chair. The presentation included a guide to increase youth engagement and provide a tangible guild to self-advocacy, development tools, and youth-led labs to inform computer resources.
- **California Peer-Run Warming Line** – Kayln Jones Kalyn Jones, MHADAB Vice-Chair, described the Warming Line as a nonemergency resource call line and web chat for Californians seeking mental health and emotional support, where counselors are peers. The line provides 24/7 immediate support to help prevent mental health crisis.

June (Special Meeting)

Discussion and Action Items:

- Approved 2022 Mental Health Services Act Annual Update to the Three-year Program and Expenditure Plan, which covers Fiscal Years 2020-21. Recommend that Shasta County Board of Supervisors approve the plan as well.

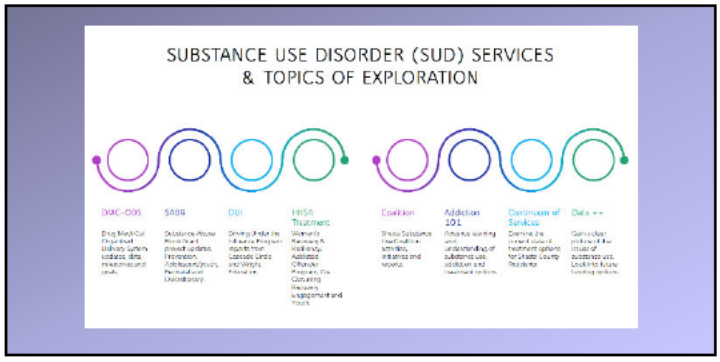
July

Discussion and Action Items:

- Updated members on meetings to discuss shared goals with Shasta County Board of Supervisors
- Establish a subcommittee to complete the Shasta County 2022 Data Notebook and Survey for Behavioral Health Boards and Commissions
- Establish a subcommittee for Substance Use Disorder in collaboration with Shasta Substance Use Coalition, with board assignment and committee reports.
- **Case Manager Services Upon Release from County Jail** – Board member Dale Marlar provided a discussion about Discharge planning is active in the jail. With 9,000 bookings per year, each is assessed by medical personnel upon entry and again prior to release. Limitations imposed by current law and case law dictate the role of law enforcement in determining release and services upon release. Public commentary spoke to frustrations with 5150 detainment protocols related to their use as a default means to access services on behalf of someone with SMI who is unwilling or unable to do so themselves. Lieutenant Marlar noted that it is more difficult to initiate the conservatorship process from jail than from a hospital or mental health facility. Members of the public wishing to provide medication history or other pertinent information on behalf of someone who has been booked may call the jail and request to speak with Lieutenant Marlar directly.

Presentations:

- Substance Use Disorder (SUD) Services and Topics of Exploration – A PowerPoint presentation was presented by Katie Cassidy, Adult Services Program Manager. Several areas were highlighted of exploration relevant to current issues, including the Drug Medi-Cal Organized Delivery System (DMC-ODS), Substance Abuse Block Grant (SABG) funding, current SUD research, and more.



- **Shasta County's Rising Fentanyl Problem Story Map** – A storymap presentation was presented by Jacob Hahn, Agency Staff Services Analyst. Fentanyl is synthetic opioid that is 80-100 times stronger than morphine and is commonly found mixed with other drugs. Statistics were shown about Shasta County's problem.

August (Special Meeting)

- Tour of Visions of the Cross

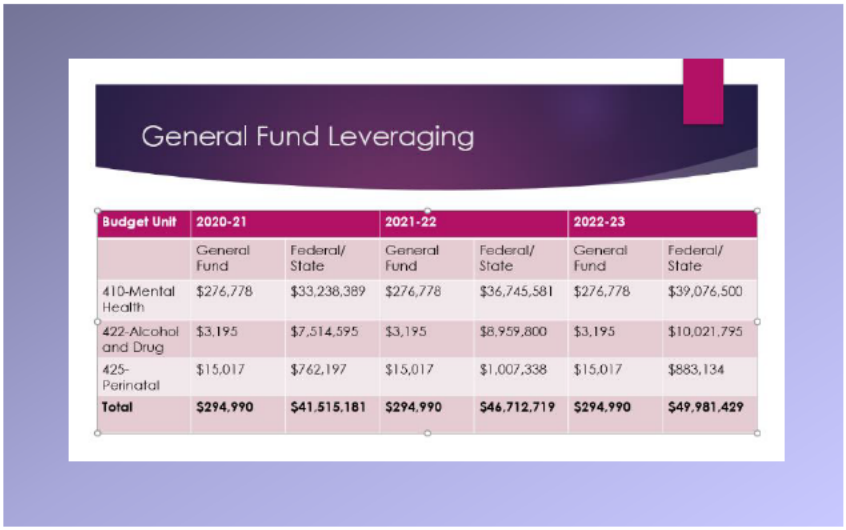
September

Discussion and Action Items:

- Approve 2023 MHADAB meeting dates
- Approve Substance Use Disorder (SUD) Subcommittee
- The 4th Annual Recovery Happens "Fun in Recovery" Event was be held Saturday, September 10, 2022.
- Adult Services hosts its Open House September 21, 2022
- Approved teleconferencing meetings in the form of hybrid meetings considered under emergency circumstances.

Presentation:

- Mental Health Services Budget – A PowerPoint presentation from Megan Dorney, Business and Support Services Branch Director was provided. The presentation included an overview of Mental Health Finances including upcoming changes to CalAIM Implementation, CARE Court, mobile services and increased collaboration with county partners.



Budget Unit	2020-21		2021-22		2022-23	
	General Fund	Federal/ State	General Fund	Federal/ State	General Fund	Federal/ State
410-Mental Health	$276,778	$33,238,389	$276,778	$36,745,581	$276,778	$39,076,500
422-Alcohol and Drug	$3,195	$7,514,595	$3,195	$8,959,800	$3,195	$10,021,795
425-Perinatal	$15,017	$762,197	$15,017	$1,007,338	$15,017	$883,134
Total	**$294,990**	**$41,515,181**	**$294,990**	**$46,712,719**	**$294,990**	**$49,981,429**

October (Special Meeting)

Discussion and Action Items:

- 2022 Assignment and Committee schedule was provided

Presentations:

- Brown Act training was provided to the Board Members from Rubin Cruse Jr., County Counsel

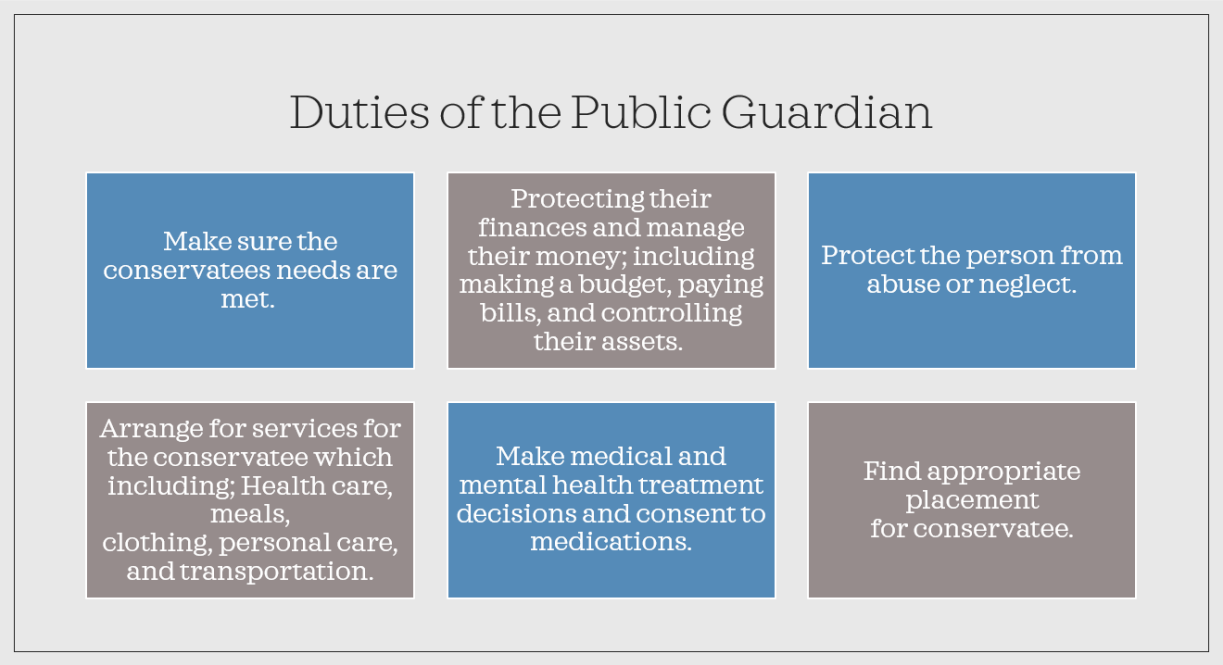
November

Discussions and Action items:

- Discussion of HHSA Director and Acting Mental Health Director appointments of Laura Burch and Miguel Rodriguez
- Approved three-year reappointments for MHADAB members Ron Henninger, Kayln Jones, Dale Marlar, Jo-Ann Medina and Connie Webber
- Approved the Shasta County Data Notebook 2022

Presentation:

- Public Guardian Conservatee Data – A PowerPoint presentation was provided by Supervising Deputy Public Guardian Shonda Cannelora. The presentation consisted of what Public Guardian is and what they do for members in the community. They also talked about involuntary mental health treatment (5150), conservatorship referral process, court process, placements, budget and how many clients are served.



November (Special Meeting)

Discussions and Action items:

- Matthew McOmber, County Counsel was introduced and provided details on meeting instructions.

  The Mental Health, Alcohol and Drug Advisory Board voted to recommend to the Shasta County Board of Supervisors the appointment of Miguel Rodriguez, LCSW as Director of Mental Health Services and authorize public disclosure of this recommendation.

Committees & Workgroups

Board members serve on various community and agency committees to share input, gather information and bring that knowledge back to their fellow board members. Committees include:

- Mental Health, Alcohol and Drug Advisory Board Executive Committee | Meet the 3rd Monday of every even month
  Board Member Assignment: Ron Henninger, Kalyn Jones, Sam Major

- California Association of Local Behavioral Health Boards and Commissions
  Board Member Assignment: All MHADAB Members

- Stand Against Stigma Committee (SASC)| Meet 2nd Tuesday ever other even month
  Board Member Assignment: Connie Webber, Kalyn Jones

- Mental Health Services Act Stakeholder Workgroup| Meet quarterly
  Board Member Assignment: Charlie Menoher, Christine Stewart, Kalyn Jones, Alan Mullikin

- Shasta Suicide Prevention Collaborative: | Meet the 3rd Thursday of every odd month
  Board Member Assignment: Kalyn Jones

- Continuum of Care (CoC) | Meet the 2nd Tuesday of each month
  Board Member Assignment: Ron Henninger, Alen Mullikin

- 2022 Shasta County Data Notebook Workgroup | October 2022
  Board Member Assignment: Connie Webber, Kalyn Jones, Ron Henninger

- ADP Provider Meeting | Meet quarterly
  Board Member Assignment: Christine Stewart, Cindy Greene, Jo-Ann Medina

Join us!

The Mental Health, Alcohol and Drug Advisory Board meets at 5:15 p.m. the first Wednesday of every other month - January, March, May, July, September, and November - with occasional special meetings in alternating months. The board is always looking for new members. For more information, go to www.shastahhsa.net. In the right-hand column under "Advisory Boards," click "Mental Health, Alcohol and Drug."

Summary

SHASTA COUNTY MENTAL HEALTH, ALCOHOL AND DRUG ADVISORY BOARD (MHADAB) BYLAWS

GENERAL PROVISIONS
MISSION STATEMENT

It is the mission of the Shasta County Mental Health, Alcohol and Drug Advisory Board (MHADAB) to inform and educate the public on alcohol, drug, and mental health issues and to advise the Department on program development, availability of services, and planning efforts. Further, to assure that staff complies with duties established by Welfare and Institutions Code Section 5604.2.

ARTICLE I - NAME

The name of this organization shall be the Shasta County Mental Health, Alcohol, and Drug Advisory Board, hereinafter referred to as MHADAB.

ARTICLE II - AUTHORITY

The authority for establishment of the MHADAB is set forth in Sections 5604 through 5607 of the Welfare and Institutions Code and by Shasta County Board of Supervisors (BOS) Resolutions.

ARTICLE III - PURPOSE

The purpose of the Mental Health Alcohol Drug Advisory Board are to:

a. Review and evaluate the community's public mental health, alcohol and/or drug treatment needs, services, and special problems in any facility within the county or jurisdiction where mental health evaluations or services are being provided, including, but not limited to, schools, emergency departments, and psychiatric facilities.

b. Review performance contracts and make recommendations to Board of Supervisors regarding concerns identified within these contracts.

c. Advise the Board of Supervisors, the County Director of Mental Health Services (hereinafter referred to as Director), and the County Alcohol and Drug Program Administrator as to any aspect of the County of Shasta's mental health, alcohol and drug treatment and prevention services.

Review draft Mental Health Services Act (Proposition 63, General Election of November 2004) plans and annual updates, make recommendations to the Director regarding the plans and updates,

and make recommendations to the County Mental Health Department for revisions, as needed (per Welfare and Institutions Code Section 5848(b)).

d. Conduct public hearings on draft Mental Health Services Act (MHSA) plans, annual updates, and other matters as appropriate.

e. Ensure citizen, consumer, and professional involvement in the County of Shasta's mental health, alcohol, and drug programs service delivery planning efforts. Involvement shall include individuals with lived experience of mental illness and their families, community members, advocacy organizations, and mental health professionals. It shall also include other professionals that interact with individuals living with mental illnesses on a daily basis, such as education, emergency services, employment, health care, housing, law enforcement, local business owners, social services, seniors, transportation, and veterans.

f. Submit an annual report to the BOS on the needs, challenges, and performance of the County of Shasta's mental health, alcohol, and drug treatment and prevention services.

g. Review, interview, and make recommendations on applicants for appointment of the Director of Mental Health Services, and the Alcohol and Drug Program Administrator.

h. Review and comment on County of Shasta's performance outcome data and communicate its findings to the State of California Mental Health Planning Council and/or other appropriate entities.

i. Assess the impact of the realignment of services from the State of California to the County of Shasta on mental health services delivered to clients and within the Shasta County community.

j. Recognize that the BOS can transfer additional duties or authority to the MHADAB.

ARTICLE IV-MEMBERS OF MHADAB

1. **Number of Members of the Board** The MHADAB shall consist of 15 members, however, initial membership of the Mental Health, Alcohol, and Drug Advisory Board may exceed this number. All members shall be appointed by the BOS. Members of this MHADAB shall serve at the discretion of the BOS and may be removed at any time with or without cause. One member of this MHADAB shall be a member of the BOS.

Pursuant to Section 5604(a)(1) of the Welfare and Institutions Code, the MHADAB shall reflect the ethnic diversity and demographics of the client population in the county.

2. Direction of MHADAB Required. The activities and affairs of individual members of the Mental Health Board, acting as Board members, shall be conducted, and powers exercised, by and under the direction of the Mental Health Board and these Bylaws.

3. Terms of Office Pursuant to Welfare and Institutions Code Section 5604(b) each member of the MHADAB shall be appointed for a term of three years. Initial appointments shall be staggered at one-, two- or three-year terms so that approximately one-third of the appointments expire each year. When a vacancy occurs or a term expires, the MHADAB may make recommendations of candidates for appointment to the BOS. A person appointed to fill a vacancy shall serve out the remainder of the original term.

4. Requirements Applicable to all Members. A member of MHADAB must:

    a. Be appointed by the Shasta County Board of Supervisors

    b. Take the Oath of Office Administered by the Clerk of the Shasta County Board of Supervisors

    c. Serve on at least one Committee or Work Group of the Mental Health Board or serve as a Mental Health Board representative on a designated local, regional or state committee/commission or professional/service organization as approved or excused by the Executive Committee for good cause shown

    d. Maintain a satisfactory meeting attendance record to Mental Health Board meetings and other assignments as defined in Article VII of these Bylaws.

    e. Keep any confidential information obtained while performing duties as a MHADAB member confidential.

    f. Participate in site visits of a mental health facility or program, at least once per year, unless excused by the Executive Committee.

ARTICLE V – QUALIFICATIONS OF MEMBERS

1. Qualification of Members. In accordance with WIC 5604.5, the composition of the Mental Health Board should represent and reflect the diversity of the demographics of the county as a whole to the extent feasible. The members of

the Mental Health Board shall be composed of the following:

a. One member of the Shasta County Board of Supervisors.

b. Fifty percent of the Board membership shall be consumers, or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least twenty percent of the Board membership shall be consumers. At least twenty percent of Board membership shall be families of consumers.

c. In counties with a population of 100,000 or more, at least one member of the board shall be a veteran or veteran advocate. A veteran advocate means either a parent, spouse or adult child of a veteran, or an individual who is part of a veteran's organization, including the Veterans of Foreign Wars or the American Legion

   To comply with clause, a county shall notify its county veterans service officer about vacancies on the board, if a county has a veteran's service officer.

d. Of the remaining members, the MHADAB shall recommend individuals for appointment who have experience with and knowledge of mental health system. Recommended are those who engage with individuals living with mental illness such as representatives from the education community, the law and justice community (including, but not limited to, law enforcement, probation department, and officers of the court), the health community (including, but not limited to, representatives from local hospitals, clinics, or individual healthcare providers), representatives of community partners (programs serving individuals with mental health, alcohol and/or drug disorders), and the community at large.

2. Residents of the County Required, Exceptions. Members appointed should be residents of Shasta County. No member of the MHADAB or his or her spouse/registered domestic partner or immediate family member shall be a full-time or part-time employees (except as noted below*) of Shasta County Health and Human Services Agency, or be an employee of, or a paid member of the governing body of a contract agency with the Agency. *Section 5604 of the California Welfare and institutions Code (3) (d) (1) and (2) states that Consumers may be employed by county mental health services or mental health contract agency as long as they don't have any financial or contractual interest and are not allowed to vote on any financial or contractual issues concerning their employer that may come before the Board.

ARTICLE VI – RECRUITMENT OF MEMBERS

1. Recruitment Criteria An effort will be made to recruit individuals who have experience with and knowledge of the mental health system. This would include members of the community that engage with individuals living with mental illness in the course of daily operations, such as representatives of county offices of education, large and small businesses, hospitals, hospital districts, physicians practicing in emergency departments, city police chiefs, county sheriffs, and community and nonprofit service providers.

2. Recruitment by MHADAB Board. Interview and Recommendation. Applicants selected through a screening process will be interviewed by at least two members of MHADAB. Names of the applicants recommended shall be presented to the full Mental Health, Alcohol and Drug Advisory Board for its consideration. Those applicants recommended by MHADAB shall then be referred to the Board of Supervisors with a recommendation they be appointed to Mental Health, Alcohol and Drug Advisory Board

ARTICLE VII – ATTENDANCE & VACANCIES ON THE BOARD

1. All MHADAB members are required to contact the Mental Health Board Chair or Secretary prior to a meeting if they are unable to attend. Failure to do so will result in an unexcused absence.

2. In the event that a member of the MHADAB is absent from three consecutive regular meetings, a letter shall be sent by the Chair of the MHADAB requesting confirmation of the member's interest in continuing to serve on the MHADAB. If the Chair determines that the member is no longer interested in serving on the MHADAB, or if the Chair determines that there is no valid reason for the absences, the position may be declared vacant by the Chair in the Chair's sole discretion.

3. In the event that A vacancy on the MHADAB shall be filled by appointment by the BOS upon recommendation by the MHADAB.

4. The MHADAB may recommend to the BOS that a member be removed for cause. This action shall require the concurrence of two-thirds of the current MHADAB members.

ARTICLE VIII – RESIGNATIONS AND LEAVES OF ABSENCE

1. Any member may resign effective upon giving written notice to the Chair, the Vice Chair or the Secretary of the Mental Health Board. A notice which specifies a later time shall be effective upon the date of the resignation set forth in said notice.

2. A Board member, who does not wish to resign and who needs leave from board commitments, may request a leave of absence for personal reasons. The Chair

may grant a MHADAB member a leave of absence, not to exceed four consecutive regular MHADAB meetings. To grant such a leave, the Chair shall announce it at a MHADAB meeting. The leave may become effective at the meeting at which it is announced. When a person is on a leave of absence, they will not be counted as part of the membership for the purpose of achieving a quorum.

ARTICLE IX – OFFICERS

1. The officers of this MHADAB shall consist of Chair and Vice Chair.

2. The Chair and Vice Chair shall be elected at the last regular meeting of the MHADAB each calendar year. The term of the officers shall be one year but no more than two consecutive terms. It is the non-binding policy of MHDAB that the Vice-Chair will be the person that will normally be elected to serve as Chair in the year following service as Vice-Chair.

3. Nominations for the officers shall be made by an Ad Hoc Nominating Committee appointed by the Chair at least 60 days prior to the last regular meeting of the MHADAB each calendar year. Recommendations from the Ad Hoc Nominating Committee shall be presented at the last regular meeting of the calendar year. Additional nominations shall be accepted from the floor. Voting shall be by public ballot with a plurality of those members voting being sufficient to elect an officer. However, if there is only one candidate for each position, he or she may be declared elected by voice vote. The elected officers shall assume office at the following regular meeting.

4. The Chair or Vice Chair may be removed from office and relieved of duties by a majority vote of the members casting public ballots at any meeting of the MHADAB. Reasonable notice, in writing or in person by any member of good standing, must be given to an officer of such an impending removal action.

5. In the case of a vacancy in the position of Chair, the Vice Chair shall immediately assume the office of Chair and a new Vice Chair shall be elected. An Ad Hoc Nominating Committee for a Vice Chair shall be appointed by the Chair and nominations from the Ad Hoc Nominating Committee shall be presented at the next regular meeting of the MHADAB. Additional nominations may be presented from the floor. Voting shall be by public ballot with a plurality of those members voting being sufficient to elect the new Vice Chair. However, if there is only one candidate, he or she may be declared elected by voice vote. The new Chair and Vice Chair shall serve out the remainder of the original terms.

6. In the case of a vacancy in the position of Vice Chair, an Ad Hoc Nominating Committee shall be appointed by the Chair and nominations from the Ad Hoc Nominating Committee shall be presented at the next regular meeting of the

MHADAB. Additional nominations may be presented from the floor. Voting shall be by public ballot with a plurality of those members voting being sufficient to elect the new Vice Chair. However, if there is only one candidate, he or she may be declared elected by voice vote. The new Vice Chair shall serve out the remainder of the original term.

7. The Chair shall be the principal executive officer of the MHADAB, shall preside over all meetings of the MHADAB, and shall carry out the policies and directives of the MHADAB.

8. The Vice Chair shall assist the Chair in the performance of the Chair's responsibilities and in the event of the absence of the Chair, the Vice Chair shall exercise all the powers of the Chair.

ARTICILE X – COMMITTEES

Standing Committees

1. Executive Committee There shall be a standing Executive Committee which consists of the Chair, the immediate past Chair, the Vice Chair, and the Chairs of any standing committee(s). Meetings of the Executive Committee shall be called, noticed, and conducted in accordance with the Brown Act and shall be presided over by the Chair, and in the absence of the Chair, by the Vice Chair. The Executive Committee is to advise the Director on matters which may arise between regular meetings of the MHADAB. In addition, the Executive Committee may act on behalf of the full MHADAB if deemed necessary by the Chair, provided that any action taken by the Executive Committee requiring approval of the full MHADAB must be ratified by the MHADAB at the next regular meeting following the action.

   The Executive Committee or Chair of the MHADAB shall set the agenda for meetings of the MHADAB.

2. Alcohol and Drug Committee The Alcohol and Drug Committee's focus is to become knowledgeable about alcohol and drug services available in Shasta County and to advise the Alcohol and Drug Program Administrator in areas of planning and service delivery. The Chair of the Alcohol and Drug Committee shall be appointed by the Chair of the MHADAB and is responsible for setting the date, place, and agenda for meetings.

   Meetings of standing committees shall be called, noticed, and conducted in accordance with the Brown Act.

Other Committees

Additional committees may be established as deemed appropriate by the

MHADAB as either standing or ad hoc committees. Ad hoc committees shall focus on a single topic and shall be time limited. The chair of each committee shall be appointed by the Chair of the MHADAB.

Meetings of any committees formed under this Section shall comply with all applicable provisions of the Brown Act.

ARTICLES XI - MEETINGS

Meetings of the MHADAB shall be called, noticed, and conducted in accordance with the provisions of the Ralph M. Brown Act (Brown Act) (commencing with Section 54950 of the Government Code). Except as may otherwise be provided in the Brown Act, meetings of the MHADAB shall be governed by the latest edition of Robert's Rules of Order.

Governing bodies are encouraged to provide a budget for the local mental health board, using planning and administrative revenues identified in subdivision © of Section 5892 [see below], that is sufficient to facilitate the purpose, duties, and responsibilities of the local mental health board.

> WIC 5892 (c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process ...

The BOS may pay from any available funds the actual and necessary expenses of the members of the MHADAB incurred during the performance of their official duties and functions. Such expenses may include travel, lodging, childcare, and meals for the members of the MHADAB as budgeted by the BOS and approved by the Director.

1. Regular Meetings. Other regular meetings of MHADAB may be held at such time and place as is established by the annual meeting schedule.
    a. At the last regular meeting, of MHADAB, the time and date of the regular meetings for the ensuing calendar year shall be established.
    b. A minimum of five regular meetings of the MHADAB shall be held each calendar year.
    c. The agenda for regular meetings shall be set by the MHADAB's Executive Committee or Chair and distributed to each MHADAB member at least three days prior to the meeting. Copies of the agenda shall be made available for the public at each meeting.
2. Notice of Meeting Schedule. Notice of schedule shall be given to each member of MHADAB by one of the following methods: (a) personal delivery of written

notice; (b) e-mail of written notice. Notice given by personal delivery, e-mail shall occur at least 72 hours before the time set for the meeting. All such notices shall be given or sent to the e-mail addresses as shown on the records of the Board.

3. Special Meeting Special meetings of this MHADAB may be called at any time by the Chair or by a majority of the members of this MHADAB.
    a. The notice of the special meeting shall specify the time, place, and business to be transacted. No other business shall be acted upon. Special meetings shall be conducted in accordance with the Brown Act.

4. Notice of Special Meeting. Notice of special meetings shall be given by delivering written notice to each member of MHADAB and to each local newspaper of general circulation and radio or television station. The notice shall be emailed and shall be received at least 24 hours before the time of the meeting specified in the notice. The notice shall specify the time and place of the special meeting and the business to be transacted or discussed. No other business shall be considered at these meetings by the Board. The notice shall be posted at least 24 hours prior to the special meeting in a location that is freely accessible to members of the public.

5. A quorum shall consist of 50 percent plus one of the current active membership of the MHADAB. Members who are on an approved leave of absence will not count toward establishing a quorum.

6. Meetings of the Mental Health Board shall be governed by The Standard Code of Parliamentary Procedure (Sturgis 4th Edition) as modified to allow open participation of the Chair and to comply with the Brown Act.

Article XII
Miscellaneous Provisions

Amendment of Bylaws

These Bylaws may be amended at any regular or special by a two-thirds vote of a quorum of the members provided that such proposed amendment has been presented in writing to all MHADAB members at least two weeks prior to the meeting at which the amendment(s) is/are to be considered.

The Mental Health Board shall use the following procedure when amending the Bylaws.

A. Proposals for change shall be noticed on the MHADAB agenda and a written copy sent to all Shasta County MHADAB members a minimum of five days prior to the meeting date on which proponents wish consideration and a vote on the change.

B. The MHADAB must approve the change by a two-thirds majority of those members in attendance at a regular or special meeting at which a quorum is present.

C. The change, as approved, is to be signed and dated by the MHADAB Chair.

D. The changed and revised copy of the Bylaws is then forwarded to the Shasta County Board of Supervisors for their review and approval/disapproval and signature by the Board of Supervisors Chair or designated representative.

E. A copy of approved changed Bylaws is to be provided to each Shasta County MHADAB member at the next regularly scheduled meeting.

F. An original copy, signed by the MHADAB Chair and the Board of Supervisors, of the approved changed Bylaws is to be filed with the MHADAB Secretary. Additionally, an appropriate historical log of all Bylaw changes and the date of the change are to be maintained by the MHADAB Secretary. The historical log is to be distributed to all Mental Health Board members whenever "Proposals for Changes" are distributed.

G. All members will be provided with a set of the current MHADAB Bylaws, Policies and Procedures.

ARTICLE XIII – POLCIES AND PROCEDURES

The Mental Health, Alcohol Drug Advisory Board may establish Policies and Procedures on matters not covered by these Bylaws.

Shasta County Mental Health, Alcohol Drug Advisory Board

By: _____
[Insert First and Last Name], Chair

Date of Mental Health, Alcohol Drug Advisory Board Approval:

MHADAB Presentation Ideas

Restpadd
Woodlands
Sunrise Wellness Center
Empire
Write Roads
Martin/Janet Place
About Time Recovery
North Valley Social Services
Children's First

Site Visits

Shasta County Jail
CRRC
Anderson Creek?
Youth Program (LS)
River's Edge Academy

January	
Special Meeting: February	Jail
March	
Special Meeting: April	CRRC
May	
Special Meeting: June	Anderson Creek
July	
Special Meeting: August	
September	
Special Meeting: October	
November	
December	NO MEETING

MHADAB | Board Member Assignments & 2024 Committee Schedule – *DRAFT*

Stand Against Stigma Committee (SASC) | TBD **|** 1:30 – 3:00
Board Member Assignment: Connie Webber, Kalyn Jones
For information, please contact Christopher Diamond at 229-8484 or cdiamond@co.shasta.ca.us.

Shasta Suicide Prevention Collaborative | TBD **|** 2:30 – 3:30
Board Member Assignment: Kalyn Jones
For information, please contact Sydney Stinger at 229-8426, or via e-mail at sstinger@co.shasta.ca.us.

ADP Provider Meeting | TBD **|** 10:00 – noon
Board Member Assignment: Cindy Greene, Jo-Ann Medina
For information, please contact Katie Cassidy at 225-5997, or via e-mail at kcassidy@co.shasta.ca.us.

2022 Shasta County Data Notebook Workgroup | TBD **|** 1:00 – 2:30
Board Member Assignment: Connie Webber, Kalyn Jones, Ron Henninger
For information, please contact Dominic Evanzia at devanzia@co.shasta.ca.us.

MHSA 3-Year Plan and Annual Update Committee | TBD |
Board Member Assignment: Heather Jones, Ron Henninger
For information, please contact Melissa Field at mfield@co.shasta.ca.us.

MHSA Stakeholder Workgroup | TBD|
Board Member Assignment: Kalyn Jones, Alan Mullikin
For information, please contact Melissa Field at mfield@co.shasta.ca.us.

DATA NOTEBOOK 2023

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

Prepared by California Behavioral Health Planning Council, in collaboration with:
California Association of Local Behavioral Health Boards/Commissions

The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies, and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally, and linguistically responsive and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness.

For general information, you may contact the following email address or telephone number:
DataNotebook@CBHPC.dhcs.ca.gov
(916) 701-8211

Or, you may contact us by postal mail at:

Data Notebook
California Behavioral Health Planning Council
1501 Capitol Avenue, MS 2706
P.O. Box 997413 Sacramento, CA 95899-7413

For questions regarding the SurveyMonkey online survey, please contact Justin Boese at Justin.Boese@cbhpc.dhcs.ca.gov

NOTICE:

This document contains a textual **preview** of the California Behavioral Health Planning Council 2023 Data Notebook survey, as well as supplemental information and resources. It is meant as a **reference document only**. Some of the survey items appear differently on the live survey due to the difference in formatting.

DO NOT RETURN THIS DOCUMENT.

Please use it for preparation purposes only.

To complete your 2023 Data Notebook, please use the following link and fill out the survey online:
https://www.surveymonkey.com/r/DP8XG65

Please note, if you are working from a PDF, scanned image or photocopy, you will need to Copy/Paste or type the above address into your browser bar.

Table of Contents

CBHPC 2023 Data Notebook: Introduction

What is the Data Notebook? Purpose and Goals

The Data Notebook is a structured format to review information and report on aspects of each county's behavioral health services. A different part of the public behavioral health system is addressed each year, because the overall system is very large and complex. This system includes both mental health and substance use treatment services designed for individuals across the lifespan.

Local behavioral health boards/commissions are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council). To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for local behavioral health boards to complete and submit to the Planning Council. Discussion questions seek input from local boards and their departments. These responses are analyzed by Planning Council staff to create annual reports to inform policy makers and the public.

The Data Notebook structure and questions are designed to meet important goals:

- To help local boards meet their legal mandates[1] to review and comment on their county's performance outcome data, and to communicate their findings to the Planning Council;
- To serve as an educational resource on behavioral health data;
- To obtain opinion and thoughts of local board members on specific topics;
- To identify unmet needs and make recommendations.

In 2019, we developed a section (Part I) with standard questions that are addressed each year to help us detect any trends in critical areas affecting our most vulnerable populations. These include foster youth, homeless individuals, and those with serious mental illness (SMI) who need housing in adult residential facilities (ARFs) and some other settings. These questions assist in the identification of unmet needs or gaps in services that may occur due to changes in population, resources, or public policy.

What's New This Year?

The topic selected for the 2023 Data Notebook is stakeholder engagement. The Planning Council has long supported upholding the principles of the Mental Health Services Act (MHSA) and encourages consumer and family member participation in the

[1] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

stakeholder process for behavioral health services through the Community Program Planning (CPP) process, as well as other stakeholder engagement activities.

How the Data Notebook Project Helps You

Understanding data empowers individuals and groups in their advocacy. The Planning Council encourages all members of local behavioral health boards/commissions to participate in developing the responses for the Data Notebook. This is an opportunity for local boards and their county behavioral health departments to work together to identify important issues in their community. This work informs county and state leadership about local behavioral health (BH) programs, needs, and services. Some local boards use their Data Notebook in their annual report to the County Board of Supervisors.

In addition, the Planning Council will provide our annual 'Overview Report', which is a compilation of information from all of the local behavioral health boards/commissions who completed their Data Notebooks. These reports feature prominently on the website[2] of the California Association of Local Mental Health Boards and Commissions. The Planning Council uses this information in their advocacy to the legislature, and to provide input to the state mental health block grant application to SAMHSA[3].

Example of Statewide Data for Specialty Mental Health and Access Rates

Tables 1-A and 1-B on the next two pages shows typical data and demographics for California recipients of Specialty Mental Health Services (SMHS) for fiscal year (FY) 2021-2022. These are the most recent data available at the time this document was prepared. SMHS are intended for adults with serious mental illness (SMI) and for children with serious emotional disorders (SED). The category of 'certified eligibles' means those persons (also called beneficiaries) who are eligible and approved to receive Medi-Cal benefits for health care.

These metrics are from datasets developed in accordance with California Welfare and Institutions code § 14707.7 (added as part of Assembly Bill 470 on 10/7/17). Due to recent changes in how AB 470 data is presented by DHCS in the Behavioral Health Demographic Dashboard[4], demographic metrics presented are not exact, as the dashboard rounds them to the nearest .1 thousand (k) or million (M).

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[2] See the annual Overview Reports on the Data Notebook posted at the California Association of Local Mental Health Boards and Commissions, https://www.CALBHBC.org.
[3] SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For reports, see www.SAMHSA.gov.
[4] AB 470 Mental Health Services Demographics Dashboards, published by California Department of Health Care Services (DHCS) at: https://behavioralhealth-data.dhcs.ca.gov/

Table 1-A. California Children and Youth: Access Rates for Specialty Mental Health Services,[5] Fiscal Year 2021-22.

	Specialty Mental Health Services		
	FY 21-22		
	Number of Clients with MH Visits	Certified Eligibles	Rate
Children 0-2	6.8k	740.9k	0.9%
Children 3-5	15.9k	802.6k	2.0%
Children 6-11	68.5k	1.7m	4.0%
Children 12-17	119.2k	1.8m	6.7%
Youth 18-20	35.1k	79.1k	4.4%
Alaskan Native or American Indian	1k	12.3k	5.5%
Asian or Pacific Islander	7.4k	359.6k	2.0%
Black	23.7k	378.7k	6.3%
Hispanic	146.3k	3.3M	4.4%
Other	12.8k	445.5k	2.9%
Unknown	128.k	548.5k	2.5%
White	40.6k	750.3k	5.4%
Female	130.1k	2.8M	4.6%
Male	114.4k	3M	3.9%
Totals and Average Rates	244.5k	5.8M	4.3%

Notes: The first column presents the demographic groups of interest. Next there are three columns. The first column of numbers shows the number of clients who received one or more services, described as Specialty Mental Health Visits. The second column of numbers is labeled 'Certified Eligibles', which is the number of clients who were deemed eligible and approved to received health care paid by Medi-Cal. The third column of numbers represents the service penetration rates. These penetration rates are taken as one measure of Access. They are calculated by dividing the total number

[5] In contrast, non-specialty Mental Health Services (i.e., Managed Care (MC), Fee-for-Service (FFS), etc), services generally designed for people with mild-to-moderate mental health needs.

of Clients with MH visits by the total number of Medi-Cal Eligibles, multiply by 100 to express the result as a percentage; this is taken as the “Access Rate.”

Table 1-B. California Adults and Older Adults, Access Rates for Specialty Mental Health Services, Fiscal Year 2021-22.[6]

	Specialty Mental Health Services		
	FY 21-22		
	Number of Clients with MH Visits	Certified Eligibles	Rate
Adults 21-32	102.2k	2.8M	3.6%
Adults 33-44	88.2k	2.3M	3.9%
Adults 45-56	71.5k	1.7M	4.1%
Adults 57-68	6.5k	1.6M	4.1%
Adults 69+	14.6k	1.1M	1.30%
Alaskan Native or American Indian	2.1k	38.8k	5.5%
Asian or Pacific Islander	19.4k	1.1M	1.8%
Black	50.3k	706.3k	7.1%
Hispanic	103.9k	4.1M	2.5%
Other	36.9k	977.8k	3.8%
Unknown	29.8k	684.6k	4.4%
White	99.1k	1.9M	5.1%
Female	177.3k	5.3M	3.3%
Male	164.2k	4.2M	3.9%
Totals and Access Rates	341.5k	9.5M	3.6%

Notes: The data for Adults and Older Adults were calculated similarly to the data for Children and Youth in Figure 1-A. For example, out of all Adult 9.5M Medi-Cal eligibles, a total of 341.5k individuals, i.e. 3.6% received Specialty Mental Health Services (SMHS).

[6] For comparison, the population of the state of California was **39,029,342** on April 1, 2020, according to the U.S. Census Bureau. https://www.census.gov/quickfacts/CA. Of those residents,24.3% of Californians were adults (age 21 and above) receiving Med-Cal benefits. Also, 14.9 % of Californians were children or youth < 20 who received Medi-Cal benefits. These numbers show that 39.2 % of all Californians of all age groups received Medi-Cal in FY 2021-22.

CBHPC 2023 Data Notebook – Part I:

Standard Yearly Data and Questions for Counties and Local Boards

In recent years, changes in data availability permit local boards and other stakeholders to consult some Medi-Cal data online that is provided by the Department of Health Care Services (DHCS). These data include populations that receive Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) treatment. Standard data are analyzed each year to evaluate the quality of county programs and those reports can be found at www.CalEQRO.com. Additionally, Mental Health Services Act (MHSA) data are found in the 'MHSA Transparency Tool' presented on the Mental Health Services Oversight and Accountability Commission (MHSOAC) website.[7]

The Planning Council would like to examine some county-level data that are not readily available online and for which there is no other public source. Please answer these questions using information for fiscal year (FY) 2022-2023 or the most recent fiscal year for which you have data. Not all counties will have readily available data for some of the questions asked below. In that case, please enter N/A for 'data not available.' We acknowledge and appreciate the necessary time and effort provided by local boards and their behavioral health departments to collect and discuss these data.

Adult Residential Care

There is little public data available about who is residing in licensed facilities listed on the website of the Community Care Licensing Division[8] at the CA Department of Social Services. This lack of data makes it difficult to know how many of the licensed Adult Residential Facilities (ARFs) operate with services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. In 2020, legislation was signed that requires collection of data from licensed operators about how many residents have SMI and whether these facilities have services to support client recovery or transition to other housing. The response rate from facility operators does not provide an accurate picture for our work.

The Planning Council wants to understand what types of data are currently available at the county level regarding ARFs and Institutions for Mental Diseases (IMDs)[9] available to serve individuals with SMI, and how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs. 'Bed day' is

[7] www.mhsoac.ca.gov, see MHSA Transparency Tool, under 'Data and Reports'
[8] Link to Licensed Care directory at California Department of Social Services. https://www.ccld.dss.ca.gov/carefacilitysearch/
[9] Institution for Mental Diseases (IMD) List: https://www.dhcs.ca.gov/services/MH/Pages/IMD-List.aspx

defined as an occupancy or treatment slot for one person for one day. One major difference is that IMDs offer mental health treatment services in a psychiatric hospital or certain types of skilled nursing home facilities. In contrast, a non-psychiatric facility such as an ARF is a residential facility that may provide social support services like case management but not psychiatric treatment.

The following is a text summary of the survey questions for Part I of the 2023 Data Notebook. Please note that the questions are presented here in a different format than the finalized SurveyMonkey online survey.

Questions:

1) **Please identify your County / Local Board or Commission.**

   Shasta

2) **For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Care Facility (ARF), during the last fiscal year? 129**

3) **What is the total number of ARF bed-days paid for these individuals, during the last fiscal year? 35,803**

4) **Unmet needs: how many individuals served by your county behavioral health department need this type of housing but currently are not living in an ARF? N/A**

5) **Does your county have any 'Institutions for Mental Disease' (IMD)?**
   Yes, Shasta has 1 facility within the County.

6) **For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during the last fiscal year?**
   In-county: **23** Out-of-county: **39**

7) **What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during the same time period?**
   13,940 (4,880 in county, 9,060 out of county)

Homelessness: Programs and Services in California Counties

The Planning Council has a long history of advocacy for individuals with SMI who are homeless, or who are at-risk of becoming homeless. California's recent natural disasters and public health emergency have exacerbated the affordable housing crisis and homelessness. Federal funding was provided to states that could be used for temporary housing for individuals living on the streets as a method to stop the spread of the COVID-19 virus. Additional policy changes were made to mitigate the rate of evictions for persons who became unemployed as a result of the public health crisis.

Studies indicate that only one in three individuals who are homeless also have serious mental illness and/or a substance use disorder. The Planning Council does not endorse the idea that homelessness is caused by mental illness, nor that the public BH system is responsible to fix homelessness, financially or otherwise. However, we do know that recovery happens best when an individual has a safe, stable place to live.

The issue of homelessness is very complex and involves multiple systems and layers of interaction. Therefore, the Council will continue to track and report on the programs and supports offered by counties to assist homeless individuals who have SMI and/or SUD. Causes and contributory factors are complex, and thus our solutions will need to address numerous multidimensional and multi-systemic challenges.

Every year, the states, counties, and many cities perform a "Point-in-Time" count[10] of the homeless individuals in their counties, usually on a specific date in January. Such data are key to state and federal policy and funding decisions. The pandemic disrupted both the methods and the regular schedule for the count in 2021, during which there was no data collected for California's unsheltered population due to Covid-19 protocols. Those preliminary data were taken down subsequently for further review before re-posting. Therefore, the "percent increase" column for this table compares the 2022 totals with the totals for *2020*, for which there was complete data.

[10] Link to data for yearly Point-in-Time Count:
https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2022.pdf

Table 3: State of California Estimates of Homeless Individuals Point in Time[11] Count 2022

Summary of Homeless individuals	SHELTERED	UNSHELTERED	TOTAL 2022	Percent Increase over 2022
Persons in households without children	34,545	110,888	145,433	7.7%
Persons in households with children	21,253	4,285	25,538	-0.9%
Unaccompanied homeless youth	2,828	6,762	9,590	-21.2%
Veterans	3,003	7,392	10,395	-8.8%
Chronically homeless individuals	15,773	45,132	60,905	17.6%
Total (2020) Homeless Persons in CA	56,030	115,491	171,521	6.2%
Total (2020) Homeless Persons, USA	348,630	233,832	582,462	.3%

[11] PIT Count = yearly January Point-in-Time Count of Homeless Individuals, conducted according to the guidance of the U.S. Department of Housing and Urban Development (www.HUD.gov). Sheltered persons include those who were in homeless shelters and various types of transitional or emergency housing.

Questions, continued:

8) **During fiscal year 2022-2023, what new programs were implemented, or existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness?** (Mark all that apply.)
   a. **Temporary Housing**
   b. **Supportive Housing**
   c. **Adult Residential Care Patch/Subsidy**

Child Welfare Services: Foster Children in Certain Types of Congregate Care

In California, about 60,000 children under the age of 18 are in foster care. They were removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determined that these children could not live safely with their caregiver(s). Most children are placed with a family who receive foster children, but a small number of the children need a higher level of care and are placed in a setting with more sophisticated services.

California is striving to move away from facilities formerly known as long-term group homes, and prefers to place all youth in family settings, if possible. Regulations have revised the treatment facilities for children whose needs cannot be met safely in a family setting. The new facility type is called a Short-Term Residential Treatment Program (STRTP). STRTPs are designed to provide short-term placement that includes intensive behavioral health services.

All of California's counties are working toward closing long-term group homes and are establishing licensed STRTPs. This transition will take time and it is important for your board to talk with your county director about what is happening in your county for children in foster care who are not yet able to be placed in a family setting, or who are in a family setting and experience a crisis that requires short-term intensive treatment.

Some counties do not yet have STRTPs and may place children/youth in another county or even out-of-state. Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

Examples of the foster care CDSS data for Q4, 2020, in CA:

- Total foster youth and children: 53,180

- Total placed in an STRTP: 2,444 (or 4.6% of foster youth)
- Total STRTP placed out-of-county: 1174 (or 2.2% of foster youth)
- Total STRTP placed out-of-state: 66 (or 0.12 % of foster youth)

Questions (continued):

9) **Do you think your county is doing enough to serve the foster children and youth in group care?**

The County faces barriers to providing services based on state regulations and challenges related to availability of placements. We need more placement resources locally who are willing and able to maintain children with complex behavioral difficulties.

10) **Has your county received any children needing "group home" level of care from another county?**

No

11) **Has your county placed any children needing "group home" level of care into another county?**

Yes, 6 of the 7 are placed outside of Shasta county.

CBHPC 2023 Data Notebook – Part II:

Stakeholder Engagement in the Public Mental Health System

Context and Background

The topic selected for the 2023 Data Notebook is “stakeholder engagement.” Stakeholder engagement refers to the active involvement of individuals or groups with a vested interest in the mental health system. These stakeholders include consumers of mental health services, their families, mental health professionals, government agencies, community organizations, advocacy groups, and policymakers. Engaging these stakeholders fosters a participatory approach, giving voice to diverse perspectives and enabling collective decision-making. Stakeholder engagement is integral to the implementation of the Mental Health Services Act (MHSA) in California. By involving a wide range of voices, the MHSA can develop and deliver programs and services that are responsive to community needs, ultimately improving mental health outcomes and well-being in California.

Stakeholder engagement offers numerous benefits in the context of mental health. Firstly, it enhances service delivery by allowing the mental health system to address the specific needs and preferences of individuals with mental health conditions. Through collaborative decision-making, services can be designed to be more accessible, culturally sensitive, and person-centered, ultimately leading to improved outcomes for those seeking support.

Secondly, stakeholder engagement empowers the community by providing opportunities for active participation and involvement in the development of mental health policies and programs. By valuing the perspectives of diverse stakeholders, the system becomes more responsive to the concerns, priorities, and aspirations of the community it serves. This active involvement fosters a sense of ownership and empowerment among community members, enabling them to contribute to shaping the mental health services available to them.

Thirdly, it plays a crucial role in ensuring accountability within the mental health system. By involving stakeholders, a system of checks and balances is created, promoting transparency and holding the system accountable for its actions and outcomes. This involvement helps to guarantee that resources are allocated effectively and efficiently, maximizing their impact and addressing any potential issues or discrepancies that may arise.

Overall, stakeholder engagement in mental health has far-reaching benefits. It leads to improved service delivery that is tailored to individual needs, empowers the community

by involving them in decision-making processes, and ensures accountability and transparency within the mental health system. By actively engaging stakeholders, mental health organizations can create a more inclusive and effective system that ultimately improves the well-being of individuals experiencing mental health conditions.

Challenges and Barriers

The effective engagement of stakeholders in the California public mental health system faces several barriers and challenges. One of the primary challenges is ensuring diverse representation among stakeholders. Overcoming language barriers, cultural differences, and limited outreach resources is crucial to capture a wide range of perspectives. Inadequate funding and staffing also pose significant challenges, hindering the capacity to hold regular meetings, conduct outreach efforts, and provide necessary support to stakeholders.

Some other potential barriers include:

- Stigma and discrimination surrounding mental health create additional obstacles to stakeholder engagement. Addressing stigma requires targeted educational campaigns, anti-stigma initiatives, and the creation of safe spaces that foster open dialogue and inclusivity.
- Power imbalances among stakeholders can also impede effective engagement. Achieving equitable representation and providing mechanisms to address power differentials are essential to foster an inclusive and democratic stakeholder engagement process.
- The complexity and fragmentation of the California public mental health system further present challenges. Effective communication strategies, standardized protocols, and clear channels of collaboration are necessary to engage stakeholders from different sectors and align their efforts.
- Limited accessibility poses another barrier to meaningful stakeholder engagement. Proactive measures such as providing accommodations, utilizing virtual platforms for remote participation, and ensuring inclusive physical spaces are essential to address accessibility barriers.
- Stakeholder engagement processes can be time-consuming and may lead to engagement fatigue over time. Balancing the need for sustained engagement with stakeholders' limited time and competing priorities requires clear goals, efficient processes, and recognition of stakeholders' contributions to maintain their interest and involvement.

Overcoming these barriers and challenges necessitates a comprehensive approach. By addressing these challenges, the California public mental health system can cultivate inclusive, responsive, and impactful mental health policies and programs.

Key Stakeholders

In the public mental health system, various stakeholders play vital roles in shaping policies, programs, and services. The California Code of Regulations provides the following definition of “stakeholders” within the public mental health system:

> **Cal. Code Regs. Tit. 9, § 3200.270 - Stakeholders**
> "Stakeholders" means individuals or entities with an interest in mental health services in the State of California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness/ and/or serious emotional disturbance and/or their families.

Additionally, California Welfare and Institutions Code provides a list of stakeholders for the Community Program Planning (CPP) Process:

> **California Code, Welfare and Institutions Code - WIC § 5848 (a)**
> Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans' organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations.

Using these sources, we can identify key stakeholder groups for engagement. Here is a more detailed list of these key stakeholders:

Adults and Seniors with severe mental illness (SMI): This group represents individuals who are directly impacted by mental health conditions. Their perspectives and experiences are essential in understanding the unique challenges they face and in

developing services that meet their specific needs. Engaging adults and seniors with SMI ensures their voices are heard and helps tailor interventions to improve their overall well-being and recovery.

Families of children, adults, and seniors with SMI: Family members are crucial stakeholders as they provide support, care, and advocacy for their loved ones with mental illness. Their insights offer a valuable perspective on the challenges faced by individuals with SMI and the impact on the family unit. Involving families in decision-making processes helps ensure that services are holistic, family-centered, and responsive to the needs of both the individual and their support network.

Providers of Mental Health and/or Related Services: Mental health professionals, including psychiatrists, psychologists, counselors, and social workers, are instrumental in delivering quality care and support. Their expertise and frontline experience provide valuable input on service gaps, best practices, and areas for improvement within the mental health system. Engaging with mental health providers ensures that policies and programs are evidence-based, align with professional standards, and promote quality outcomes.

Law Enforcement Agencies: Law enforcement agencies often come into contact with individuals experiencing mental health crises. Their involvement in stakeholder engagement facilitates collaboration between mental health services and law enforcement, aiming to improve crisis intervention and diversion programs. This partnership can enhance community safety, reduce unnecessary arrests and incarcerations, and facilitate appropriate referrals to mental health services.

Educators and/or Representatives of Education: Educators play a significant role in identifying and supporting students with mental health needs. Their involvement as stakeholders contributes to the development of early intervention strategies, mental health promotion programs, and the implementation of appropriate supports within educational settings. Collaborating with educators helps create a nurturing environment that supports the academic, social, and emotional well-being of students.

Social Services Agencies: Social services agencies, such as those involved in housing, employment, and welfare, intersect with the mental health system. Their participation in stakeholder engagement ensures coordination and integration of services, addressing the complex needs of individuals with mental health conditions holistically. Collaboration with social services agencies supports efforts to provide stable housing, employment opportunities, and social support networks to promote recovery and community integration.

Veterans: Veterans, particularly those who have served in combat or experienced traumatic events, often face mental health challenges such as post-traumatic stress

disorder (PTSD) and depression. Engaging veterans as stakeholders enables the mental health system to address their unique needs and develop specialized programs tailored to their experiences. This collaboration ensures that mental health services for veterans are comprehensive, accessible, and culturally sensitive.

Representatives from Veterans Organizations: Representatives from veterans' organizations, such as advocacy groups or support networks, provide a platform for veterans' voices and perspectives to be heard. Their involvement in stakeholder engagement fosters collaboration and helps shape policies, programs, and services that meet the specific needs of veterans.

Providers of Alcohol and Drug Services: Substance use disorders frequently co-occur with mental health conditions, requiring integrated care approaches. Engaging providers of alcohol and drug services as stakeholders promotes collaboration between mental health and addiction treatment providers. This collaboration ensures a comprehensive approach to addressing the complex needs of individuals with co-occurring disorders, facilitating recovery and reducing barriers to treatment.

Health Care Organizations: Health care organizations, including hospitals, clinics, and primary care providers, are essential stakeholders in the mental health system. Collaboration with these organizations helps integrate mental health care into primary care settings, reduce stigma, and improve access to services. Involving health care organizations enhances the coordination of care and strengthens the overall continuum of mental health support.

Other important Interests: The mental health system involves numerous other stakeholders, such as policymakers, researchers, community leaders, advocacy groups, and philanthropic organizations. Each brings unique perspectives, expertise, and resources to the table. Their involvement in stakeholder engagement ensures that policies and programs are informed by evidence, responsive to community needs, and adequately resourced.

By engaging and involving these diverse stakeholders, the public mental health system can benefit from a comprehensive range of insights, expertise, and perspectives. This collaborative approach leads to more effective, inclusive, and person-centered mental health services that better serve the needs of individuals, families, and communities.

Best Practices for Stakeholder Engagement

There are many resources available regarding promising and best practices for stakeholder engagement. Some commonly identified guiding principles and best practices are:

1. **Inclusive Approach:** Ensure that the stakeholder engagement process is inclusive and representative of diverse perspectives. Include individuals with lived experience, family members, behavioral health service providers, advocacy groups, community organizations, and policymakers. Embrace diversity and strive for equity in representation.
2. **Early and Ongoing Engagement:** Engage stakeholders early in the decision-making process and maintain ongoing communication throughout the planning, implementation, and evaluation stages. Provide opportunities for input, collaboration, and feedback at various stages to ensure meaningful participation.
3. **Purposeful Communication:** Foster open and transparent communication with stakeholders. Provide clear information about goals, processes, and timelines. Use plain language and avoid jargon to ensure that all stakeholders can easily understand and contribute to the conversation. Likewise, practice active listening when stakeholders are speaking. Rather than assuming what they mean, ask follow-up questions to ensure that their input is understood.
4. **Collaboration and Co-creation:** Foster a collaborative environment that encourages stakeholders to actively participate in decision-making. Co-create solutions by involving stakeholders in the design and implementation of programs, policies, and services. Value their expertise and insights.
5. **Training and Education:** Provide stakeholders with relevant training and education to enhance their understanding of behavioral health issues, policies, and practices. Equip them with the knowledge necessary to contribute effectively and make informed decisions.
6. **Flexibility and Adaptability:** Recognize that stakeholders may have different levels of expertise, resources, and availability. Provide flexibility in engagement methods to accommodate diverse needs, such as offering virtual options, providing written materials, and conducting surveys or focus groups.
7. **Data-Informed Decision Making:** Use data and evidence to inform discussions and decision-making processes. Share relevant data with stakeholders to foster informed dialogue and facilitate collaborative problem-solving.
8. **Empowerment and Shared Leadership:** Empower stakeholders to actively contribute and take ownership of the process. Promote shared leadership by involving stakeholders in the development of agendas, facilitating meetings, and encouraging their participation in decision-making.
9. **Recognition and Appreciation:** Recognize and appreciate the contributions of stakeholders. Acknowledge their time, effort, and expertise. Provide opportunities for public recognition, such as featuring success stories or highlighting stakeholder involvement in reports and presentations.

10. **Evaluation and Continuous Improvement:** Regularly evaluate the effectiveness of stakeholder engagement efforts and seek feedback from participants. Use this feedback to refine engagement strategies and improve future processes.

These are just some of the many suggested best practices and guiding principles for quality stakeholder engagement. By incorporating these and other best practices, behavioral health systems can effectively engage stakeholders, leverage their expertise, and create more responsive, person-centered, and equitable services and policies.

MHSA Community Program Planning Process

One of the major ways that the MHSA includes stakeholder engagement is the MHSA Community Program Planning (CPP) Process. This state-mandated participatory process is a collaborative approach used in California to develop and refine mental health programs funded by the MHSA. Counties use the CPP process in the development of Three-Year Program and Expenditure Plans and updates. Counties work alongside stakeholders to analyze current community mental health needs, issues resulting from any lack of community services, and current system capacity, as well as evaluate priorities and strategies to meet the needs of the community.

California Codes and Regulations dictate that the MHSA CPP process should be:

- Based in community collaboration (CCR, 9 CA §3320 and 3200.060).
- Culturally competent (CCR, 9 CA §3320 and 3200.100).
- Client and family driven (CCR, 9 CA §3320, 3200.050 and 3200.120).
- Wellness, recovery and resilience-focused (CA WIC § 5813.5(d)).
- Focused on providing an integrated service experience for clients and their families (CCR, 9 CA §3320 and 3200.190).

MHSA CPP Processes must include the following regarding stakeholder participants:

- **Stakeholders** (as previously defined/discussed based on WIC, § 5848a).
- **Underserved populations.** Representatives from unserved and/or underserved populations and family members of unserved/underserved populations (CCR, 9 CA § 3300).
- **Diversity.** Participants that “reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity” (CCR, 9 CA § 3300).

Additionally, the CPP process should, at a minimum include the following things:

- Staffing for positions and/or units to facilitate the CPP process.

- Training for stakeholders and county staff.
- Outreach to consumers with SMI and their family members to ensure the opportunity to participate.
- A local review process that includes a 30-day public comment period prior to submitting the Three-Year Program and Expenditure Plans or Annual Updates.

The MHSA currently allows counties to use **up to 5% of their total Community Services and Support (CSS) funds** to facilitate a robust planning process. This includes using funding to accommodate stakeholder participation in the CPP process. All counties are required to use the CPP process and document the Three-Year Program and Expenditure Plans and Annual Updates. This includes descriptions of the methods used to collect stakeholder input, documentation that a public hearing was held, summary and analysis and a description of changes made based on community input.

The local MH/BH boards and commissions have the following responsibilities in this process:

- Review and approve the procedures used to ensure stakeholder involvement in all stages of the planning process.
- Review the adopted plan or update and make recommendations.
- Conduct MHSA public hearings at the close of the 30-day public comment periods.

Overall, the MHSA Community Program Planning Process fosters a participatory and community-driven approach to mental health program development. By engaging stakeholders and leveraging their expertise and insights, the CPP Process aims to create programs that are responsive, culturally sensitive, and tailored to the unique needs of the community. This collaborative effort ultimately leads to the implementation of effective and impactful mental health services in California communities.

While the MHSA CPP process is an important (and legally required) example of stakeholder engagement, the principles and practices of stakeholder engagement can be applied to many different programs and processes. This includes but is not limited to mental/behavioral health board/commission meetings, EQRO focus groups, and SAMHSA funded programs.

Resources

The following resources all pertain to stakeholder engagement in mental health, including the CPP process. We encourage counties to utilize these resources to learn more about responsive and effective engagement practices.

- CALBHBC: MHSA CPP One-Pager
- CALBHBC: Community Engagement PowerPoint
- MHSOAC: CPP Processes - Report of Other Public Community Planning Processes
- MHSOAC: Promising CPP Practices
- SAMHSA: Community Engagement – An Essential Component of an Effective and Equitable Substance Use Prevention Program

Part II: Data Notebook Questions

Please respond by means of the Survey Monkey link provided with this Data Notebook.

12. **For each of the following categories, please choose the option from the dropdown menu that best describes how often your county organizes stakeholder engagement meetings or events.**
    - **Quarterly (four times a year)**
    - **Categories:**
        - **MHSA Community Planning Process (CPP)**
        - **MHSA 3-year plan updates**
        - **EQRO focus groups**
        - **Mental/Behavioral Health Board/Commission Meetings**

13. **Estimate the number of people who participated in your stakeholder processes in fiscal year 2022/2023.** *(Numerical response)* **35**

14. **Approximately what percentage of stakeholder engagement events or efforts in your county were in-person only, virtual only, a combination of both in-person and virtual, or written communications** *(please answer with a whole number for each, such that the total of the four amounts to 100)*
    - **In-person only: 90**
    - **Virtual only: 10**

15. **Which of the following languages did your county use to conduct stakeholder meetings or outreach during fiscal year 2022/2023, with or without the use of interpreters?** *(Check all that apply)* **English**

This list of languages reflects the threshold and concentration languages for all counties as of July 2021 from the following DHCS document: Threshold and Concentration Languages (ca.gov)

16. **Which of the following stakeholder groups have you collected and implemented input from within the last year?** *(Check all that apply)*
    - **Adults with severe mental illness (SMI)**
    - **Older adults / Seniors with SMI**
    - **Families of children, adults and seniors with SMI**
    - **Individuals with developmental disabilities and/or their representatives**
    - **Providers of mental health and/or related services**
    - **Representatives of managed care plans**
    - **Law enforcement agencies**
    - Educators and/or representatives of education
    - **Social services agencies**
    - **Veterans**
    - Representative from veterans' organizations
    - **Providers of alcohol and drug services**
    - **Health care organizations**
    - **Hearing impaired individuals**
    - **LGBTQ+ individuals**
    - **Youth**
    - Other important interests (please specify)
    - **Specific racial/Ethnic groups (please specify): Southeast Asian and Latin X**

17. **Please describe how stakeholder input is communicated to the behavioral health director, the mental/behavioral health board/commission, and any other agencies or groups for informing policy.** *(Text response)*

    During the Mental Health Alcohol and Drugs Advisory Board (MHADAB), Meeting Minutes, Board of Supervisor Meetings, publishing agendas and minutes on MHADAB website and Shasta MHSA website

18. **Please describe how your county implements collected stakeholder input to actively inform policy and programs. Include how the county decides what ideas to implement or actions to take.** *(Text response)*

    Information is provided to our Quality Management team, reviewed, changes requested to Mental Health director, reviewed by Mental Health Deputy Directors, Clinical Division Chiefs and if needed

reviewed by Policy Council. However, we will need to meet with our QM team and create plans of action.

19. **Does your county have a Community Program Planning (CPP) plan in place?**
    - **Yes, stakeholder input is gathered. Top concerns are identified. This information is provided to Mental Health leadership to address concerns and implementation.**

      Process Summary: Stakeholders are notified via email and social media. Coordinate with local agencies to increase participation in stakeholder meetings. A stakeholders meeting is held to gather input (inquires can be sent via email as well). Meeting minutes are shared.

20. **Is your county supporting the CPP process in any of the following ways?** *(Please select all that apply)*
    a) Reimbursement of travel costs for stakeholders participating in in-person meetings or events.
    b) Providing refreshments or food for stakeholder participants
    c) Dedicated staff assistance to facilitate stakeholder meetings and events.
    d) Providing information and training for stakeholders on MHSA programs, regulations, and procedures.
    e) Holding meetings in physically/geographically accessible locations around the county.
    f) Utilizing language interpreting services.
    g) Holding meetings at times convenient to community stakeholders' schedules.
    h) Providing technical assistance for stakeholders participating in webinars or teleconferences.
    i) Other (please specify)
    j) None of the above

21. **Does your county provide training for staff on cultural awareness, community outreach, and stakeholder engagement? If yes, how? If no, why not?**
    - **Yes (Our department provides interpreter training and cultural competency training)**

22. **Which of the following barriers does your county face regarding achieving meaningful and impactful engagement of stakeholders (specifically, mental health consumers and family members)?** *(Check all that apply)*
    a. General difficulty with reaching stakeholders.
    b. Difficulty conducting community outreach to racial/ethnic communities or other specific communities of interest.

c. **Difficulty reaching stakeholders with disabilities.**
d. **Lack of funding or resources for stakeholder engagement efforts.**
e. **Shortage of properly trained staff to support and facilitate stakeholder engagement.**
f. **Difficulty adapting to virtual meetings/communications.**
g. **Difficulty providing accommodations to stakeholders.**
h. **Difficulty incorporating stakeholder input in the early stages of programming.**
i. Lack of "buy-in" from decision makers when it comes to implementing stakeholder input.
j. Other (please specify)

23. Are your behavioral health board/commission members involved in your county's stakeholder engagement and/or CPP processes? If yes, describe how.

a. **Yes (decisions go before the local mental health board for approval)**

Note: *California WIC 5892 allocates Mental Health Services Funds for county mental health programs to pay for the expenses of mental health board members to perform their duties, and to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process. This includes 5% of total CSS funds to support a robust CPP process with community stakeholders.*

24. Has the COVID-19 pandemic increased or decreased the level of stakeholder engagement and input in your county?

a. Increased
b. **Decreased**
c. No change

25. Is there a fear or perception in your county that spending time, money, or other resources on stakeholder engagement conflicts with the need to provide direct services? *No*

26. What is one change or improvement regarding stakeholder engagement that your county would like to make within the next fiscal year? *(*Create clear communication and timelines to complete established goals.)

27. Do you have any other thoughts or comments regarding stakeholder engagement in your county or statewide? We are working to clarify the various opportunities for stakeholder input. We hope to better assist community members in attending the opportunities that most interest them and are most suited for the input they choose to provide.

Post-Survey Questionnaire

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Behavioral Health Planning Council. Questions below ask about operations of mental health boards, and behavioral health boards or commissions, etc.

28. What process was used to complete this Data Notebook? (Please select all that apply)

a. MH board reviewed WIC 5604.2 regarding the reporting roles of mental health boards and commissions.
b. MH board completed majority of the Data Notebook.
c. Data Notebook placed on agenda and discussed at board meeting.
d. MH board work group or temporary ad hoc committee worked on it.
e. MH board partnered with county staff or director.
f. MH board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.
g. Other (please specify)

29. Does your board have designated staff to support your activities?

a. Yes, Community Development Coordinator

30. Please provide contact information for this staff member or board liaison.

Name – Jacquelynn Rose
County – Shasta
Email Address – jmrose@co.shsata.ca.us
Phone Number – (530) 229-8266

31. Please provide contact information for your board's presiding officer (chair, etc.)

Name – Ron Henniger
County – Shasta
Email Address – [redacted]
Phone Number – [redacted]

32. Do you have any feedback or recommendations to improve the Data Notebook for next year?