



September 30, 2022

To: Mental Health Services Oversight and Accountability Commission  
1812 9th Street  
Sacramento, CA 95811

Cc: Toby Ewing, Ph.D., Executive Director

Dear MHSOAC Commissioners:

Thank you for the opportunity to provide feedback on the *Well and Thriving* report on the Prevention and Early Intervention component of the Mental Health Services Act (MHSA) per the legislative requirement under Senate Bill 1004. Thank you in particular to the Chairs of the PEI Subcommittee, Mayra E. Alvarez and Mara Madrigal-Weiss for shepherding this effort to identify opportunities for promoting preventive and early intervention efforts through and beyond the MHSA. We represent a group of children’s mental health, education, and health advocates in California who are committed to the well-being of children and their families, particularly those from historically marginalized communities. We have synthesized our feedback and **recommendations (bolded)** to the Commission on the first and second draft reports in hopes that the final draft approved by the

Commission reflects what we see as the critical, immediate opportunities for preventing and intervening early in mental health disorders and distress in children and youth. We believe that greater investments in children, youth, and their families are essential to any state strategy in mental health prevention and early intervention given that early investments will reap benefits across the lifespan, before mental health conditions develop or trauma calcifies into severe pervasive distress. Below are some overall observations followed by specific reflections and recommendations on each section of the report.

Overall observations:

Overall, we agree with one of the primary conclusions of the *Well and Thriving* report that moving California's systems of care toward prevention and early intervention requires significant time, leadership, and investment. The report is laudably ambitious in its effort to be comprehensive with respect to existing efforts in mental health prevention and early intervention, including its discussion on social drivers of racial/ethnic disparities in mental health. However, **the report misses an opportunity to identify where the Mental Health Services Oversight and Accountability Commission (MHSOAC) can and should be leading to drive additional state and local investments in time and resources toward true upstream prevention and early intervention where it can be most impactful - in the lives of children, youth, and their families, particularly low-income households and families of color.** As an example, in the report's definitions section on page 3, "recovery" is defined and largely applies to the adult population. **We recommend the addition of resilience and well-being (both of which are used throughout the report but not defined) along with definitions that are inclusive of the experiences of children, including young children who are uniquely dependent on their parents and caretakers to have their social-emotional needs met and establish a trajectory of positive mental health, as well as children and families of color who require adapted interventions that are culturally-responsive and affirming based on shared histories of community and historical trauma.**

Furthermore, the report's recommendations are very lofty and aspirational in nature. In order for the state to achieve its ambitious goals, which we largely concur with, it is essential for this report to include practical next steps and an implementation plan - one that clearly articulates the essential aspirational role of the MHSOAC as a prominent leader in the state's mental health prevention and early intervention ecosystem. The MHSOAC is unique in the state's constellation of social and human service bodies in that it was established by a state ballot initiative and oversees a categorical revenue stream in the form of a millionaire's tax. **The MHSOAC should leverage its unique level of independence to convene and influence other state and local policymakers to lead implementation of this report across the Administration and throughout local governments, and we stand ready to support the MHSOAC in engaging communities, families, and youth in its efforts to align prevention and early intervention across the state.**

Well-established historical national data notes that nearly half of all mental health disorders begin before age 14, and nearly three-fourths before age 25. Current [PEI regulations](#) require counties to spend *at least 51% of their PEI dollars on children and youth 25 and younger*. While this goal is laudable, advocates at the state and local level have consistently observed that the vast majority of PEI funds, particularly Prevention funds, are not targeted to true upstream prevention, such as in [infant and early childhood mental health programs](#), where the benefits can be reaped over a lifetime and across child health domains, including their physical health and education success. **In response, we recommend the**

report's language be more specific on how the OAC plans to incentivize, encourage, and support counties, as well as its peers within the Administration, in investing more in true upstream prevention and children and youth services.

*Finding 1: California does not have a strategic approach in place to address the socio-economic and structural conditions that underpin MH inequities or to advance statewide PEI.*

*Recommendation #1: The State must establish multi-disciplinary leadership, deploy a strategic plan and build capacity for using data and technical assistance to advance a statewide strategic approach to PEI.*

We agree that the state lacks a strategic approach to addressing the root causes of mental health disparities for marginalized communities in California, therefore limiting its ability to truly advance prevention and early intervention. However, there are a multitude of efforts undertaken across sectors and by the Administration that center prevention and early intervention, including CA Department of Social Services draft [Family First Prevention Services Act \(FFPSA\) Five-Year Prevention Services Plan](#), the [Children and Youth Behavioral Health Initiative](#) and the Governor's [Master Plan for Kids' Mental Health](#), Medi-Cal initiatives such as Cal-AIM's [Population Health Management Strategy](#), and the Department of Health Care Services' (DHCS) [Comprehensive Quality Strategy](#) and [Strategy to Support Health and Opportunity for Children and Families](#), the Department of Education's [Community Schools Initiative](#), and finally the [Master Plan for Early Learning and Care](#). The report also references a previously un-advertised [Behavioral Health Prevention Plan](#) from DHCS. Instead of creating yet another plan and stakeholder process, **the MHSOAC should propose and lead one cohesive and comprehensive plan on prevention for all Californians that cuts across funding streams and departments.** We would be glad to work with the Administration and the legislature to ensure that the state's efforts to align prevention and early intervention across agencies is sufficiently resourced.

While we agree that this requires an Executive in the Governor's Cabinet who will "champion" this, the MHSOAC, with its statutory independence and administrative and oversight relationship to counties, could play an essential leadership role to synthesize and align these efforts with a focus on reducing disparities across the state's most marginalized communities. For example, the state's FFPSA Five-Year Plan and the state's Medi-Cal Children's Quality Strategy identify home visiting as a prevention service, and this service is administered by several agencies (e.g. CalWORKS, Medi-Cal, First 5 county agencies, etc.), with little coordination or alignment in terms of intended outcomes or prioritized populations, though the families served are often one and the same. Additionally, the FFPSA Five-Year plan also includes key mental health services such as Motivational Interviewing and Parent Child Interaction Therapy. Both programs are prevalent in California with compelling results. Alignment could strengthen the networks delivering these Evidence Based Practices and increase the number of families served, regardless which door brought them into services. To achieve this, **the MHSOAC should utilize data to invest in the right communities with the right interventions, and then propose and facilitate implementation of these interventions and strategies through leveraging as many resources and initiatives as appropriate.** On Page 21, the report acknowledges that "State requirements are not explicit in the ways counties should define, measure, and report program outcomes" and uplifted requests from county mental health agencies to provide more technical support and guidance to report data effectively. **The MHSOAC, with its relationship to county agencies, could take a leadership role in meeting counties' identified need for greater support on data collection and reporting over the**

continuum of county-administered mental health programs, including but not limited to MHSA-funded efforts, since MHSA funds often supplement and complement a variety of county- and community-led programs targeting low-income communities of color. We again recognize a unified mental health data system would require significant resources as well as expanded oversight jurisdiction for the MHSOAC, and we would look to partner with champions in the Legislature and Administration to support efforts to simplify and make more transparent county mental health data. In the interim, one practical step toward this goal would be for the MHSOAC to publish the new proposed standardized template for county reporting on PEI spending for public comment and feedback with the goal of requiring counties to adopt the final approved template by April 2023.

*Finding 2: Unmet basic human needs and trauma exposure drive MH risks. These factors will continue to disrupt statewide PEI efforts and outcomes unless they are addressed.*

*Recommendation #2: The state's strategic approach to prevention and early intervention must ensure that all people have access to the information and resources necessary to support their own or another person's mental health needs*

Overall, Recommendation 2 seems like an extension of Finding 1 and Recommendation 1 - it is clear that the lack of system coherence and coordination, particularly at the local level, confuses consumers, families, communities, and even service providers, and we are glad to see this reality acknowledged in the report. While we generally agree with Recommendation 2, **we would like to see an explicit role for the MHSOAC in leading local implementation of Recommendation 2, particularly Recommendation 2.2 and 2.3 (promoting inclusive, safe, nurturing environments and reducing trauma through supporting parent and caretakers).** For example, **the MHSOAC could, through its authority granted in SB 1004, adjust the regulations governing PEI spending at the county level to ensure greater and more effective investments in activities highlighted in Recommendation 2,** such as enhanced partnerships between community-based organizations and schools or home visiting for families with infants and toddlers - efforts that have strong evidence for preventing poor outcomes for communities and children of color, and are currently woefully underfunded (as evidenced by the historic multi-billion dollar one-time investments in the CYBHI and Community Schools Initiative).

*Finding #3: Strategies to increase public awareness and knowledge of MH often are small and sporadic while harmful misconceptions surrounding MH challenges persist. Mass media and social media reinforce these misconceptions*

*Recommendation #3: The State's strategic approach to prevention and early intervention must ensure that every Californian has access to effective and appropriate mental health screening and services and supports aligned to their needs*

We fully agree and support Recommendation 3 - the State must ensure that every Californian has access to effective and appropriate mental health screening, services, and supports based on their unique needs. We also recognize this is not a problem that the MHSOAC can directly intervene in or solve, especially without resources and support from the public and the Administration. For example, on page 47, the report acknowledges that localized outreach and engagement strategies are most effective at combating stigma, dispelling myths, and increasing service utilization in marginalized

communities. We agree. However, the report could be strengthened by recommending a single cohesive public awareness strategy or campaign, led by the State, to influence the broader narrative about mental health and influence state leaders' responses to the existing crisis. For example, an MHSOAC-led statewide communications campaign could link the various communications efforts, from ACES Aware in the Office of the Surgeon General to local anti-stigma work in schools in communities of color, to a broader narrative about prevention and early intervention being most impactful before mental health conditions typically emerge. This kind of messaging could significantly add to the political will in California to invest in true upstream prevention and early intervention in historically marginalized communities. Additionally, the report highlights the opportunity for online initiatives to increase awareness and access to digital care like tele-mental health and should **name the initiative that could potentially resource such efforts - the Virtual Behavioral Health Platform being administered by DHCS under the CYBHI**. Finally, the recommendations around increased mental health training and education for staff in non-mental health settings is well-received; however, **we recommend an additional recommendation on how to fund or sustain that level of workforce and community-level capacity-building - perhaps through ongoing local education investments (such as the Local Control Funding Formula) in social-emotional learning or parent engagement, with MHSA dollars as supplements or complements to these investments**. Overall, this section presents a compelling vision for community-level work and could be strengthened by identifying the resources or the leadership necessary to execute new strategies or coordinate existing efforts.

**Overall, the MHSOAC should identify areas where through convening and coordinating across the Administration, it can leverage and align various state efforts to educate the public on mental health issues, including ongoing efforts through the CYBHI, Office of the Surgeon General/ACES Aware, and First 5 California.** While acknowledging that the MHSOAC's statutory oversight and accountability roles are limited in scope, we believe that through partnerships with advocates, communities, families, and youth, the MHSOAC could become a multi-sector mental health convener and build the necessary political will across the state to strengthen and align investments in prevention and early intervention. **More immediately, we recommend the MHSOAC develop and require counties to utilize a template to assess the reach, effectiveness, and cultural-appropriateness of their outreach and engagement strategies funded by PEI in order to ensure that local Prevention dollars are meeting the needs of communities, particularly those for whom mental health stigma intersects with other forms of discrimination such as race, ethnicity, income, immigration status, gender, or sexual orientation.** Lastly, the MHSOAC should leverage the expertise of its Youth Innovation Committee to ensure state and local efforts are informed by young people, including high-school aged youth, particularly as it relates to online communications and campaigns.

*Finding #4: Strategies that increase early identification and effective care for people with mental health challenges can enhance outcomes. Yet few Californians benefit from such strategies. Too often the result is suicide, homelessness, incarceration or other preventable crises.*

*Recommendation #4: The State's strategic approach to prevention and early intervention must ensure that every Californian has access to effective and appropriate mental health screening, services and supports aligned to their needs*

We agree with Finding and Recommendation 4 that there are demonstrable gaps in preventive and early intervention mental health services in California, particularly in light of new data on children in Medi-Cal. Only 14% of the state's low-income teenagers receive a depression screen *and* a follow-up plan, despite the reality that 1 in 3 California teens have signs of serious psychological distress, with teens living below the federal poverty level having disproportionately higher levels of distress than their peers. Even more alarming, while the suicide rate decreased in California during the first year of the pandemic (2020), youth, girls, Black, and Latinx youth all showed increases in suicide during that time. A recent [State Auditor's report](#) noted that nearly three-quarters of 2-year-olds on Medi-Cal did not receive the required number of preventive services, including developmental screenings (a key opportunity to assess a child's social-emotional development and therefore early mental health). This is a dismaying level of neglect for our state's most marginalized children and families, and it is reasonable to guess that children with commercial health plans do not fare exceptionally better, given the reality that children are seen as low-need and low-cost to insure, despite the reality that half of all mental health disorders appear before a child turns 14. **We agree that the state must work to hold both public agencies and public and commercial health plans accountable to providing the services that children and youth need to be healthy and mentally well.**

Anecdotally, advocates and community members report that local MHSA prevention and, in particular, early intervention resources are often used to bridge gaps in medically necessary care, particularly for adults with severe mental illness whose care has often been neglected or poorly-coordinated with necessary social services by commercial or public health plans. Those few PEI resources which are dedicated to early intervention for children and youth, where they could be most impactful, are typically highly specialized clinical services which are difficult for county contractors like small nonprofit community-based organizations to provide at scale. Community stakeholders indicate that PEI dollars are frequently bridging gaps in healthcare rather than supplementing, innovating, or expanding on the investments of healthcare in mental health prevention and early intervention.

**While its accountability and oversight roles are limited, we believe there are opportunities for the MHSOAC to play a role in improving access to mental health care provided by health plans and county agencies in California, and moving the state's healthcare system toward true prevention and child-focused early intervention where it can be most impactful.** Specifically, in the report, the MHSOAC could clarify its role in diversifying the workforce and expanding the available options of culturally-responsive care at the community-level through providing technical assistance, facilitating learning communities, or providing additional state grant funding to counties and community-based agencies who supplement one-time funding, such as CYBHI funds for Behavioral Health Coaches or youth peers, with county PEI dollars. **By re-imagining local PEI spending as complementary to, rather than a substitute for, adequate individual health and mental health care, the MHSOAC, counties, and community-based agencies could focus their efforts on community-level interventions, establishing an evidence base for community-defined evidence-based practices (CDEPs), and enhancing existing social support and services.**

For example, classroom-based models of infant and early childhood mental health consultation, where a clinician provides ongoing support to a child care provider rather than temporary support for a child in distress, show incredible promise for reducing disparities in preschool suspensions and expulsions for Black children, and can support the social-emotional development of all children in the

classroom. Likewise, a campus-wide high school peer support program could intervene in behavior incidents, bringing classrooms or peer cohorts together to heal through circles or other restorative justice practices rather than punitive school discipline measures like suspensions or expulsions. These mental health interventions are not readily available through the traditional healthcare system because there is not an identifiable client or patient, but these are the types of culturally-responsive early intervention support that marginalized children and youth require. **Where PEI investments could be most impactful could be in re-defining the standard of care for marginalized communities, with advocates and state leaders like the MHSOAC supporting or even authoring legislation that would require health plans to adopt these models, and endorsing policy actions that strengthen health plan funding for these prevention programs. Current opportunities and examples of this include publicly supporting and advocating for expansions of Cal-AIM reform efforts such as [Medi-Cal's Population Health Management](#) and the expansion of covered mental health services across public and private health plans of evidence-based practices, such as [dyadic care](#), and culturally-affirming practices like youth peer-to-peer support.**

### Conclusion

In 2021-22, the Mental Health Services Act tax on millionaires generated \$3.5 billion for counties to allocate to local priorities and programming under a fairly broad definition of prevention and early intervention mental health strategies - **this is an unparalleled source of ongoing revenue in mental health prevention and early intervention that could be leveraged, along with other state efforts, to ensure all California's communities, including marginalized children and families can achieve whole-person well-being in such a rich state.** In thinking about how to reimagine the state's prevention and early intervention efforts, particularly through the MHSA, **prevention dollars could be made more impactful by being more aligned with a local public health approach to improve community and population health, particularly through investing in upstream programming in children and their families to reap the benefits across an entire lifespan. Likewise, the MHSA's early intervention dollars should supplement, not supplant adequate and required mental health care from our public and private health plans in California. Likewise, early intervention services should be dedicated to piloting and innovating culturally-responsive and community-defined evidence based practices for children and youth - where early intervention can be most impactful across the lifespan.**

In practice, this would mean our state should prioritize traditional health care resources to right-sizing long-underfunded infant and early childhood mental health programs, sustaining existing and expanding school-based early intervention strategies, and broadly implementing more community-defined evidence-based practices that are culturally-concordant with the needs and experiences of marginalized communities. **Policy levers, led by the MHSOAC as a statewide convener and key agency in mental health policy development and advocates, could then be deployed to broaden the standard of mental health care that our state and county health plans should be obligated to fund sufficiently and in perpetuity. This aspirational vision of the MHSOAC would enhance our state's ability overall to sufficiently resource true upstream prevention and early intervention at the state and ultimately, the local level.,**

We thank you again for the opportunity to provide feedback on the *Well and Thriving* report and would welcome the opportunity to engage with the PEI Subcommittee chairs or staff to discuss any of our recommendations in more detail. We look forward to working together to achieve the ambitious vision laid out in the report for mental health prevention and early intervention in California. If you have any questions or would like to discuss further, please contact Angela M. Vázquez ([avazquez@childrenspartnership.org](mailto:avazquez@childrenspartnership.org)) or Adrienne Shilton ([ashilton@cacfs.org](mailto:ashilton@cacfs.org)).

Sincerely,

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