



WELLNESS • RECOVERY • RESILIENCE



Commission Packet

**Commission Meeting
November 21, 2019**

**The Mission Inn
3649 Mission Inn Avenue
Riverside, CA 92501**

**Call-in Number: 1-866-817-6550
Participant Passcode: 3190377**

Khatera Tamplen
Chair
Lynne Ashbeck
Vice Chair

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

November 21, 2019
9:00 AM – 4:00 PM

The Mission Inn
3649 Mission Inn Avenue
Riverside, CA 92501

Call-in Number: 866-817-6550; Code: 3190377

Public Notice

The public is requested to fill out a “Public Comment Card” to address the Commission on any agenda item before the Commission takes an action on an item. Comments from the public will be heard during discussion of specific agenda items and during the General Public Comment period. Generally, an individual speaker will be allowed three minutes, unless the Chair of the Commission decides a different time allotment is needed. Only public comments made in person at the meeting will be reflected in the meeting minutes; however, the MHSOAC will also accept public comments via email, and US Mail. The agenda is posted for public review on the MHSOAC website <http://www.mhsoac.ca.gov> 10 days prior to the meeting. Materials related to an agenda item will be available for review at <http://www.mhsoac.ca.gov>. All meeting times are approximate and subject to change. Agenda items are subject to action by the MHSOAC and may be taken out of order to accommodate speakers and to maintain a quorum.

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Khatera Tamplen
Chair

AGENDA
November 21, 2019

Lynne Ashbeck
Vice Chair

Approximate Times

9:00 AM Convene and Welcome

Chair Khatera Tamplen will convene the Mental Health Services Oversight and Accountability Commission meeting and will introduce the Transition Age Youth representative, Jorge Campos. Roll call will be taken.

9:10 AM Announcements

9:20 AM Consumer/Family Voice

Mary Hogden will open the Commission meeting with a story of recovery and resilience.

9:40 AM Action

1: Approve September 26, 2019 MHSOAC Meeting Minutes.

The Commission will consider approval of the minutes from the September 26, 2019 meeting.

- Public Comment
- Vote

9:45 AM Action

2: Suicide Prevention Strategic Plan

Presenter:

- Ashley Mills, Senior Researcher, MHSOAC

The Commission will consider adopting “Striving for Zero: California’s Strategic Plan for Suicide Prevention, 2020 – 2025.”

- Public Comment
- Vote

11:00 AM Action

3: Mental Health Student Services Act Request for Proposals Outline

Presenter:

- Tom Orrock, Chief of Commission Grants, MHSOAC

The Commission will consider approval of an outline for the Mental Health Student Services Act Request for Proposals.

- Public Comment
- Vote

12:00 PM **General Public Comment**
Members of the public may briefly address the Commission on matters not on the agenda.

12:15 PM **Lunch Break**

1:15 PM 4: Stakeholder Request for Proposals Outline

Presenter:

- Tom Orrock, Chief of Commission Grants, MHSOAC

The Commission will consider approval of the outline for the six Request for Proposals for the stakeholder contracts.

- Public Comment
- Vote

2:15 PM **Information**

5: UCLA Community Wellness Measures and Outcomes Progress Report

Presenters:

- Dr. Sheryl Kataoka, MD, MSHS, Professor-in-Residence, UCLA Center for Health Services and Society
- Dr. Bonnie T. Zima, MD, MPH, Professor-in-Residence, Associate Director, UCLA Center for Health Services and Society

The Commission will hear a progress report presentation on the UCLA Community Wellness Measures and Outcomes Project.

- Public Comment

3:00 PM **Action**

6: MHSOAC Conflict of Interest Code

Presenter:

- Filomena Yeroshek, Chief Counsel, MHSOAC

The Commission will consider adoption of the proposed amendments to the Commission's Conflict of Interest Code presented at the August 22, 2019 meeting.

- Public Comment
- Vote

3:20 PM **Information**

7: Executive Director Report Out

Presenter:

- Toby Ewing, Ph.D., Executive Director, MHSOAC

Executive Director Ewing will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

- Public Comment

3:45 PM General Public Comment

Members of the public may briefly address the Commission on matters not on the agenda.

4:00 PM Adjourn

AGENDA ITEM 1

Action

November 21, 2019 Commission Meeting

Approve September 26, 2019 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the September 26, 2019 Commission meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None.

Enclosures (1): (1) September 26, 2019 Meeting Minutes.

Handouts: None.

Proposed Motion: The Commission approves the September 26, 2019 meeting minutes.

State of California

**MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION**

Khatera Tamplen
Chair
Lynne Ashbeck
Vice Chair
Toby Ewing, Ph.D.
Executive Director

Minutes of Meeting
September 26, 2019

MHSOAC
Darrell Steinberg Conference Room
1325 J Street, Suite 1700
Sacramento, CA 95814

866-817-6550; Code 3190377

Members Participating:

Khatera Tamplen, Chair
Lynne Ashbeck, Vice Chair
Mayra Alvarez
Reneeta Anthony
Ken Berrick

John Boyd, Psy.D.
Itai Danovitch, M.D.
David Gordon
Mara Madrigal-Weiss
Gladys Mitchell

Members Absent:

Senator Jim Beall
Sheriff Bill Brown
Keyondria Bunch, Ph.D.

Assemblymember Wendy Carrillo
Tina Wooton

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program,
Legislation, and Technology

Brian Sala, Ph.D., Deputy Director,
Evaluation and Program Operations

CONVENE AND WELCOME

Chair Khatera Tamplen called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:06 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Chair Tamplen reviewed the meeting protocols.

Youth Participation

Chair Tamplen stated the Commission made a commitment to include a young person around the table at every Commission meeting to learn the Commission process and to give their perspective on issues. Kylene Hashimoto introduced herself.

Announcements

Chair Tamplen made the following announcements:

- The October MHSOAC meeting has been canceled.
- The next MHSOAC meeting is scheduled for November 21st.
- The first listening session for the Mental Health Student Services Act (MHSSA) will be held tomorrow, September 27th, at 10:00 a.m., at the Commission office.
- The next Prevention and Early Intervention Subcommittee Meeting will be held on October 11th in Salinas.

New Personnel

Chair Tamplen invited Dr. Brian Sala, Deputy Director of Evaluation and Program Operations, to introduce a new staff member. Deputy Director Sala introduced Jim Meyer, the new Chief of Innovation Incubation.

Chair Tamplen invited Tom Orrock, Chief of Commission Grants, to introduce a new staff member. Mr. Orrock introduced Cheryl Ward, a new Health Program Specialist.

Moment of Silence and Remembrance of Rusty Selix

Chair Tamplen asked for a moment of silence in honor of Rusty Selix, who recently passed away. Commissioners shared their memories and gratitude for Mr. Selix's work and accomplishments in the mental health field.

Moment of Silence and Remembrance of Commissioner Emeritus Larry Poaster

Chair Tamplen asked for a moment of silence in honor of Commissioner Emeritus Larry Poaster, who recently passed away. Commissioners shared their memories and gratitude for Commissioner Emeritus Poaster's work and accomplishments in the mental health field.

Consumer/Family Voice

The Commission made a commitment to begin Commission meetings with an individual with lived experience sharing their story. Chair Tamplen invited Irene Wei to share her story of recovery and resilience.

Irene Wei shared the story of living with the diagnosis of Bipolar Disorder, being placed on a 5150, hospitalized four times, placed on many different medications with awful side effects. She stated one aspect of her life that the illness and side effects of the medications hit particularly hard were her hobbies, such as playing music, drawing, and participating in sports. This made her feel like a failure and that she was useless and a burden to everyone.

Ms. Wei stated seeking help was not easy. Although her mother did everything in her power help her receive the care she needed, Ms. Wei was in self-denial and made no effort to build a support system she could rely on. Ms. Wei thanked her mother for recognizing the warning signs early on, visiting her every moment she could during her hospitalizations, and giving her the hope and strength to continue, even while being devastated and terrified for her daughter.

Ms. Wei's circumstances caused her to miss a year of high school. Being behind a year, she no longer had classes in common with her friends, who did not understand her situation. She stated she was labeled as a "drama queen" or "that crazy girl." She stated people did not try to comprehend or ask her what she was going through.

Ms. Wei stated she saw a therapist weekly and slowly made steps toward recovery, reclaiming more and more of her identity. By attending peer support groups, she came to terms with her illness and accepted it. She began taking notes and observing symptoms, along with her early warning signs and triggers. She stated with each episode she got better and better at coping with it. By the end of her senior year, she was managing her disorder well enough to pass the high school proficiency examination and pass on time with her peers.

Ms. Wei stated she began participating in advocacy programs, is a board member for the Mental Health Association for Chinese Communities, and began an art-themed YouTube channel, which now has approximately 10,000 subscribers.

Ms. Wei stated, if she could write a letter to herself during those bleak nights full of doubts and uncertainty, she would write that she would be okay; that the recovery process is slow and lengthy, but there is always a light at the end of the tunnel; and that she should be proud of how far she has come and hopeful for how far she will go.

Comments and Discussion

Chair Tamplen thanked Ms. Wei for sharing her recovery process and for being brave enough to share her story with the Commission and at the Youth Innovation Planning Project Committee meeting.

Commissioner Mitchell stated she is inspired by hearing speakers with lived experience. She stated she is so proud that Ms. Wei was able to work through her challenges, complete her degree, and recapture her identity. She stated Ms. Wei is truly a champion. She thanked Ms. Wei for sharing her story.

Commissioner Anthony voiced her appreciation for Ms. Wei's coming forward and sharing intimate details of her life. She stated this demonstrates being a warrior for others. She thanked Ms. Wei for her braveness.

Commissioner Mitchell asked what Ms. Wei is doing with her projects and how she got 10,000 followers.

Ms. Wei stated she began posting time-lapse videos of her art creation process. This expanded into making tutorials and doing challenges. She stated she is proud to be a part of the great art community on YouTube.

Kylene Hashimoto stated she is so proud of Ms. Mei's accomplishments.

Commissioner Gordon stated he was impressed with how articulate Ms. Wei was in describing her experience and journey. He stated he wished all high school students in California could hear Ms. Wei's story. It would be an inspiration. He asked to talk further about this before the end of today's meeting.

Ms. Wei stated her story will be posted online through the Mental Health Association for Chinese Communities website soon.

ACTION

1: Approve August 22, 2019, MHSOAC Meeting Minutes

Action: Commissioner Danovitch made a motion, seconded by Commissioner Alvarez, that:

The Commission approves the August 22, 2019, Meeting Minutes.

Motion carried 9 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Berrick, Boyd, Danovitch, Gordon, Madrigal-Weiss, and Mitchell, and Chair Tamplen.

The following Commissioner abstained: Vice Chair Ashbeck.

INFORMATION

2: Department of Health Care Services

Presenter:

- Kelly Pfeifer, M.D., Deputy Director, Mental Health and Substance Use Disorder Services

Chair Tamplen stated the Commission will receive an overview of the projects underway with the Mental Health and Substance Use Disorder Services Division at the Department of Health Care Services (DHCS). She introduced Dr. Kelly Pfeifer.

Kelly Pfeifer, M.D., Deputy Director, Mental Health and Substance Use Disorder Services, DHCS, provided an overview of her vision that individuals deserve person-centered care, that individuals deserve a path that goes from prevention to treatment to recovery, and that individuals deserve that path to come together as much as possible in an integrated way. She stated what she sees in DHCS staff is a vision of finding ways to do it better.

Dr. Pfeifer stated the DHCS has been on an integration path for years, the first step of which was bringing mental health and alcohol and drug treatment services into the DHCS. She stated, although this was a great lift, there are now two siloes of all things behavioral health and all things Medi-Cal. On the frontlines, where it matters, things are not integrated because payments, administration, oversight, and regulation are all separate.

Dr. Pfeifer stated, although the journey is slow, any improvement is encouraging. She stated there is now an effort to integrate across the Medi-Cal and non-Medi-Cal services. She stated, in her role leading behavioral health for the DHCS, she will be

working closely with the Medi-Cal team so that, over time, the DHCS will deliver on the promise that every person who is suffering from a mental illness or substance use disorder deserves integrated care and that the DHCS will support that integration at every level.

Commissioner Questions

Commissioner Danovitch asked about the obstacles that the DHCS is most focused on to get to integrated, high-value, person-centered care and the resources required to address that.

Dr. Pfeifer stated most of the obstacles fall into the categories of payment, workforce, and data. DHCS has put a concerted amount of effort toward them. She discussed those items separately:

- Payment – the DHCS is looking at how Medi-Cal is paid to ultimately drive innovation and delivery system transformation. There is a need to learn from innovations that work locally and spread them statewide. That is where technical assistance comes in.
- Workforce – peers are a critical component of the workforce. The best person to connect with someone about the real things going on in their life is a peer. There were technical challenges with the bill that the DHCS worked with the author to amend; some amendments were taken while others were not. The concern is that the current iteration of the bill is a more expensive way to allow peer support specialists to be part of the workforce.
- Data – there are many different data systems at the DHCS and not all of them talk to each other. The DHCS is currently implementing a Behavioral Health Modernization Program to look at the different data systems, where they overlap, and how things can be done better. It is important that the DHCS is transparent about what is happening with Mental Health Services Act (MHSA) funds and ensure that the public understands how those funds are being used.

Commissioner Berrick asked if the idea of whole person care extends to the children's services system and integrating child welfare, juvenile justice, and education.

Dr. Pfeifer stated the Governor and Secretary have the unprecedented vision to bring in a mental health leader to identify key priorities in the state, how to address homelessness, how to address the justice involved and the tragedies that happen when addiction is criminalized, and how to address discrimination against people of color, how to remedy bad policy decisions, and how to move forward.

Dr. Pfeifer stated the DHCS has an emerging vision to look at how to do better with these populations, such as reforming how specialty mental health services are delivered to foster children and working closely with the California Department of Social Services so that children in the system can get wraparound care in a family setting without being in a group home or institution, working with the jails and prisons to better treat substance disorder, and ensuring that individuals leaving the jail or prison system have a Medi-Cal card to access benefits.

Commissioner Anthony stated one of the difficulties within the systems is the lack of coordination between the Medi-Cal treatment side and behavioral health. New laws have affected Medi-Cal to automatically discontinue a person from Medi-Cal after twelve months. The individual is informed that they have been discontinued via a letter sent to their last mailing address. The letter states they are no longer eligible unless they contact the office, but most counties have telephone systems that are not user-friendly and create additional difficulties if an individual suffers from anxiety or other issues.

Commissioner Anthony stated, although it was a good idea to redetermine eligibility annually, what has resulted is an action to cut individuals off by not helping them to continue to receive treatment.

Dr. Pfeifer stated the DHCS Managed Care Plan Division has been working on how to better reach individuals prior to disenrolling such as texting and emailing to help individuals stay enrolled without losing their benefits. There is also the issue of county-to-county transfers that has been a struggle especially with substance use disorders. The DHCS has been working on solving these issues.

Kylene Hashimoto asked who is doing the analysis and evaluation of the data and if there is someone with lived experience involved.

Dr. Pfeifer stated the DHCS does a lot of data collection but does not always collect the data that matters most. She stated, while measuring processes, penetration rates, and compliance is important, it does not tell the whole story. She stated there are many data systems within the DHCS and there is not a way to involve youth in the internal workings of the Department. She stated she is interested in exploring the stakeholder processes further to get input about the types of stories that should be told about the success of the MHSA and the kind of work that is being done.

Vice Chair Ashbeck asked for more detail on how to align, scale, and replicate things that work locally statewide and how the Commission can assist in those efforts.

Dr. Pfeifer suggested creating a network of coalitions and learning collaboratives. She stated there is untapped potential in figuring out how to link innovations that individual counties are doing to spread the work statewide. She stated she is excited to work with the Commission to figure it out.

Commissioner Alvarez stated the need to bring different interests together in order to solve problems. She asked how Dr. Pfeifer sees herself working with the Department of Social Services, the Department of Education and the critical partnership that must be established in order to better address the mental health and wellbeing of everyone, particularly children and youth.

Dr. Pfeifer stated the need to hear ideas from individuals who are on the ground in the community to help solve these complex issues. She stated the DHCS had a public stakeholder meeting yesterday with a group of community members who do coalition work, which will inform how funding will be distributed. A key piece of that is building relationships with other key departments; more work needs to be done there.

Commissioner Alvarez asked how technology will play a role in the work and priorities of the DHCS moving forward.

Dr. Pfeifer stated there are many opportunities to deliver services in more culturally relevant ways and ways that are more palatable to youth. Telehealth in psychiatry is starting to bloom in substance use disorder but more work needs to be done. The DHCS has been working hard to spread telehealth and identifying needs early to help individuals get the help they need.

Commissioner Boyd asked if the DHCS is looking at other states and around the world as it considers how to learn from best practices.

Dr. Pfeifer stated a mental health delegation will be traveling to Trieste, Italy, to learn more about integrating the community with the physical and behavioral health systems. She stated other states have done different versions of trying to integrate financing for physical and behavioral health, such as Washington, Arizona, and New York. She stated it is important to learn the hard lessons along with the success stories.

Dr. Pfeifer stated the need to be thoughtful about taking the lessons learned and applying them to California. It may seem like a slow process to create those balances, but it needs to be done right to ensure that services continue, and individuals will not be put at risk during the transition.

Commissioner Madrigal-Weiss stated it is not only about bringing everyone to the table but helping with capacity and infrastructure. She gave the example of the California Department of Education, which has one person working on mental health, even though California is one of the largest states.

Commissioner Gordon stated schools are a great point of access not only for students five years and older, but for families who live in underserved communities. He asked how to potentially expand the use of schools as points of access and points of services for the whole family, particularly focusing on children zero to five, who may not be able to access services.

Dr. Pfeifer stated, since she is new to her position, she is still learning about the pathways.

Commissioner Danovitch asked about burnout, culture, and the legacy of how things have been done. He asked how Dr. Pfeifer plans to energize the staff in her division and at the county level, and to empower the workforce to be able to respond to the types of challenges that are being discussed.

Dr. Pfeifer stated family medicine has a crisis of burnout; there is always more work to do than there are resources. There has been good research of what it takes to be a happy employee. The three questions that tend to matter are: do people care about you personally, do you do work that matters, and can you see progress? These things are the best anecdote to burnout – making sure there is a culture where people are cared about personally, where everyone's contribution counts, why the work makes an impact on the people cared about, and what matters is measured so progress can be seen.

Dr. Pfeifer stated a big piece to energizing at the county level is partnerships. There has been a substantial amount of pressure between the DHCS and the counties because the Department's job is to hold counties accountable. Morale is improving due to the vision of new leadership who are coming together to achieve common goals.

Kylene Hashimoto stated the Youth Innovation Planning Project Committee has looked over the data and identified major challenges around youth mental health and is in the process of innovating solutions and sparking a conversation within counties of how to move forward to address those issues. One of the things the Committee has determined is that mental health within the education system is huge. It is the path the Committee wants to take to find those innovative ways to implement it into the system. She asked Dr. Pfeifer to join in that conversation with the Committee to consider how to move forward with this new movement.

Dr. Pfeifer stated she would love to attend the Youth Innovation Planning Project Committee at least once to listen and learn. She stated she will not be any good at her job without listening to the voices of youth.

Kylene Hashimoto asked if there is a plan of action to have a person dedicated to youth mental health.

Dr. Pfeifer stated the need for her to better understand what is underway for the different populations of youth, such as foster care and communities of color. She stated she must learn more before she can generate a plan.

Commissioner Berrick stated workforce is being looked at the wrong way. He stated the biggest reason workforce is being lost is because individuals feel that they are not as successful in their work as they need to be.

Dr. Pfeifer agreed and stated the need to ask if the right things are being measured. Creating a better children's mental health system is a big piece of her job.

Commissioner Alvarez stated the Commission wants to be in partnership with Dr. Pfeifer. She stated it would be helpful to get clarity on how often the Commission can come to Dr. Pfeifer for her input or to provide information to help Dr. Pfeifer in her job.

Dr. Pfeifer stated Commissioners can email her or send her information anytime. She stated she regularly meets with Executive Director Ewing to ensure she is made aware of issues that matter to the Commission.

Commissioner Mitchell stated the importance of incorporating into the culture that the work done in the mental health field has an impact on someone who cannot speak for themselves. She stated the documentation required in order to be reimbursed is an unfair burden. This needs to change.

Dr. Pfeifer agreed that a better system will not be created without fixing the documentation issue.

Vice Chair Ashbeck stated the documentation issue is not only about the volume but that each county has a different set of requirements. She stated it would even simplify the process to standardize the documentation requirements across all counties.

Chair Tamplen thanked Dr. Pfeifer for mentioning measuring what matters. She stated the consumer community in Alameda County calls it "measure what you treasure," including feeling hopeful for the future and that progress is being made, feeling empowered and included in the decision-making process, feeling connected and in a

relationship with the individuals worked with, feeling support for social connections and integration in the community, feeling that the environment is welcoming, and feeling satisfied with the services provided.

Dr. Pfeifer stated the easiest thing to measure that takes the least amount of work and is also important are process measures. The things that are most difficult and nearly impossible to measure sometimes are things that matter most.

Chair Tamplen stated many counties are involving consumer and family liaisons in their leadership positions. She asked if that is true at the state level and if there is a position dedicated to a consumer and family liaison.

Dr. Pfeifer stated she is so new in her position that she does not yet know. She stated she will go back to the team to better understand if there are consumers in leadership roles. She agreed with the importance of getting the consumer voice at the table. She stated the California Behavioral Health Planning Council (CBHPC) includes council members with lived experience and family members. She stated the Department counts on them to provide the voice of the individuals who are benefiting from the services.

Chair Tamplen stated the need to do more and to create employment positions at that level.

Public Comment

Poshi Walker, LGBTQ Program Director, Mental Health America of Northern California (NorCal MHA), Co-Director, #Out4MentalHealth, stated concern about the way that data is collected and reported. Currently, demographic data is reported in a siloed way. The speaker gave the example that the number of African Americans served in a county may be known, but not how many of those were youth, adults, or older adults. The speaker stated this is especially true for sexual orientation and gender identity data. The speaker stated, although Assembly Bill (AB) 959 requires counties to collect this data, there is still incredible pushback to get the information collected and reported in a consistent manner so the data is useable and can promote change.

Poshi Walker stated there are physical and mental health disparities for members of the LGBTQ community, especially queer and transgender people of color (QTPOC). NorCal MHA recently did a statewide survey and will soon be publishing the findings. It was learned that the QTPOC community has greater disparities than White LGBTQ individuals and that transgender and binary individuals have huge disparities. One of the most alarming statistics seen is that 78 percent of LGBTQ youth ages 12 to 17 stated they had considered suicide in their lifetime and youth ages 18 to 24 were almost as high. These disparities will not be rectified until the data is collected and resources can be put towards solving the problems.

ACTION

Consent Calendar

Chair Tamplen stated the Commission voted, in May of this year, to authorize a Consent Calendar process for considering certain Innovation project proposals. She stated the new process is for staff to recommend plans for which the staff analysis has

identified no significant concern, including from public comment, to be included in the Consent Calendar.

Chair Tamplen stated the Sutter-Yuba County Innovation project is the first plan brought before the Commission under this new process. She stated she has reviewed the staff analysis and concurs with it being put on the Consent Calendar.

Chair Tamplen stated the items on the Consent Calendar will be voted on without presentation or discussion, unless a Commissioner requests an item to be removed from the Consent Calendar. She asked if a Commissioner wished to remove an item from the Consent Calendar.

No removal action was requested by the Commission.

3: Sutter-Yuba County Innovation Plan

Chair Tamplen stated the Commission will consider approval of \$5,939,288 in Innovation funding to support the Sutter-Yuba Innovative and Consistent Application of Resources and Engagement (iCARE) Innovation Plan.

Public Comment

Shawna Maxwell, Sutter-Yuba County Behavioral Health, spoke in support of the proposed Sutter-Yuba County Innovation Project.

Action: Vice Chair Ashbeck made a motion, seconded by Commissioner Madrigal-Weiss, that:

The Commission approves the following items on the Consent Calendar:

- *Sutter-Yuba County Innovation plan: Approve \$5,939,288 in Innovation funding to support the five-year project, "Sutter-Yuba Innovative and Consistent Application of Resources and Engagement (iCare) Innovation Plan."*

Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Berrick, Boyd, Danovitch, Gordon, Madrigal-Weiss, and Mitchell, Vice Chair Ashbeck, and Chair Tamplen.

ACTION

4: Glenn County System-wide Mental Health Assessment and Response Treatment Team (SMART)

Presenters:

- Detective Greg Felton, Glenn County Sheriff's Office
- Lisa Cull, LMFT, Clinician, Glenn County Health and Human Services
- Amy Lindsey, LMFT, Deputy Director, Glenn County Behavioral Health
- Nancy Callahan, Ph.D., Consultant, I.D.E.A. Consulting

Chair Tamplen stated the Commission will hear about the results of the Glenn County System-wide Mental Health Assessment and Response Treatment Team (SMART) Innovation Project that was approved by the Commission in 2014. SMART is a collaborative multi-agency team that responds quickly and efficiently to critical school incidents such as school threats, suicidal behavior, violence, and bullying. The Commission will consider opportunities to explore collaborative partnerships to expand this model. Chair Tamplen asked the representatives from Glenn County to present this agenda item.

Presentation

The presenters provided an overview, with a slide presentation, of the collaborative multi-agency SMART team, Comprehensive School Threat Assessment Guidelines manual, School Threat Assessment Decision Tree, the six principles of threat assessment, transient and substantiated threat examples and referral process to the SMART team, trends over the last five years, and ongoing services.

The presenters played a video that they show as part of the training for teachers, which shows the seriousness of teachers and school staff involved in students' lives and the responsibility they carry to speak up if they have concerns about a student.

The Glenn County Innovation plan came to an end last year but will be sustained through Medi-Cal and school district funding.

Commissioner Questions

Commissioner Gordon asked how the team monitors social media, at what point the team goes to a home of a youth, and what that looks like.

Lisa Cull, LMFT, Clinician, Glenn County Health and Human Services, stated the counties educate the community, school sites, and students to report anything seen on social media to the crisis line or the sheriff's office.

Detective Greg Felton, Glenn County Sheriff's Office, added that he does covert social media monitoring of students in the community.

Commissioner Berrick asked if the evaluation research compared information with other comparable communities in size and scope to see if there is a documentable prevention.

Amy Lindsey, LMFT, Deputy Director, Glenn County Behavioral Health, stated they hear that other communities want to do this program, but they do not have the necessary funding. She stated the need to learn how to move this program forward.

Commissioner Berrick asked, since not all communities have this program, how the SMART Team will measure whether or not there has been a reduction, either by comparing data to other comparable communities that do not have this intervention or by comparing the SMART Team's numbers of violent incidents pre- and post-project.

Nancy Callahan, Ph.D., Consultant, I.D.E.A. Consulting, stated the SMART Team has been working to determine the outcomes to measure. The SMART Team does not have access to the data from other communities but could begin to look across communities as the SMART program is rolled out to other communities.

Commissioner Anthony asked how the SMART Team continues to interact with children if the family chooses to move them out of the regular school system into home school and how the SMART Team ensures continuity for that family.

Ms. Cull stated many students who end up being expelled opt for independent study or partial school day. Students can be accessed during the partial school days and services are provided at the home. The SMART Team includes many ways to keep in contact with the family.

Detective Felton stated the SMART Team sometimes attends Individualized Education Program (IEP) meetings to question if the best place for the student is at school, or they meet the families at home to question if home schooling is best for a student. It depends on each student's needs.

Commissioner Boyd asked if technology companies have been considered to help strengthen collaboration or to be used as a resource.

Detective Felton stated he has not been contacted for collaboration from social media companies.

Commissioner Madrigal-Weiss stated the need to not stop here but to push the conversation towards prevention. She stated research shows that when children and youth feel connected to their schools and have positive relationships at the school with staff and other students, they are less likely to engage in violence, participate in bullying or vandalism, or feel isolated. It is important to consider what can be done in the school environment to create a positive and nurturing school culture.

Ms. Lindsey stated the prevention piece will happen after teams are placed in the counties to collaborate with schools.

Dr. Callahan stated, during the five years this program was in place, the SMART Team has learned what they need to do to teach the schools to be active. The prevention part is the SMART Team learning how to better coordinate with the schools while, at the same time, empowering the schools to take responsibility for their students.

Detective Felton stated one of his goals is to encourage every youth he comes in contact with to be a part of the community.

Ms. Cull stated the best piece of advice to administrators is to build a relationship with students. The best way to combat a student's acting out is to nurture them. They will listen to advice when they are being supported.

Kylene Hashimoto stated school staff are trained in threat assessment. Students are closest to other students. She asked if students are made aware of what to look for and who to report possible issues to.

Ms. Cull stated the SMART Team educates students throughout the school year on warning signs and makes survival cards with the number to the crisis line available to every student.

Commissioner Mitchell asked about barriers to the SMART program.

Ms. Cull stated presentations are made annually at each school site with all school staff personnel. Every school site has used the SMART program at least once. Many times, schools call for consultation on referrals or guidance.

Commissioner Mitchell asked if the school principals are included in the training.

Ms. Lindsey stated the schools in Glenn County are small. Presentations are done at the back-to-school event, which includes the superintendents, principals, and teachers. She stated the SMART Team also goes out to each school site to meet with the principals and vice principals.

Ms. Cull stated every time there is a referral for a threat assessment, the first question the SMART Team asks is if the school has notified the school administrator, thereby instructing the schools that the referral should always come from the administrator because they need to know if there is a serious safety issue on their campus.

Commissioner Gordon stated one thing that concerns him about the replication of programs like this is some individuals think it is a plug-and-play system. The schools are trying to move toward a system that is based on prevention, but no one would know that unless they became an integral part of the school program. He stated the continuity and consistency of the personnel is crucial and needs to be agreed to up front.

Ms. Lindsey stated, when speaking to the counties and schools, the right person for the job must be located. She gave the example that she and Ms. Cull can ask a student a question twenty times to no avail, but, when Detective Felton asks that same question once, the student is often willing to answer. It is important to find the right person to do the job.

Commissioner Danovitch stated he is concerned they are missing the forest for the trees, because the plan sounds terrific, but the question is how should this plan be scaled to different counties, and how would that be done. There is a research and evaluation component, and how do the measures they set out to evaluate perform?

Dr. Callahan stated the relationship between law enforcement and mental health is important. It is not about a random call; it is about interaction – that they communicate twenty times a day and meet weekly.

Commissioner Danovitch asked how the impact of this program is evaluated, and if they could summarize what the evaluation plan was at the time this proposal was made.

Ms. Lindsay stated that will be covered in the rest of the presentation.

Presentation, continued

Ms. Cull continued the slide presentation and discussed the data collected during the five years of the SMART project and key findings.

Public Comment

Smitha Gundavajhala, Program Coordinator, Youth Leadership Institute, commended Glenn County for tackling the difficult issue of school shootings. The speaker stated the need for systemic investment to effect change. The speaker encouraged the Commission to collaborate more with the California Department of Education and to have real conversations with the Governor on what the budget looks like, because nothing can be done without funding.

Tiffany Carter, Statewide Advocacy Liaison, ACCESS California, NorCal MHA, echoed the comments of the previous speaker. The speaker stated their father shared with them that one of the things that was consistently conveyed during his 27 years as a sheriff and detective was that the way that criminal activity is learned is not just by observation and data but also by direct dialogue with individuals who have committed crimes. There is a need to stay in tune with new techniques and the thought processes of individuals who have committed crimes.

Tiffany Carter stated this is also true in the mental health field. While an array of services and service providers are necessary, talking to individuals with lived experience is imperative. The speaker asked how the SMART Team is staying abreast of new techniques and new experiences that individuals are having. The speaker asked if youth are involved in this process to share what is going on with peers and the community and if there are appropriate crisis intervention options for youth.

Andrea Crook, Advocacy Director, ACCESS California, NorCal MHA, referred to the presentation slides on key findings, and noted that Slide 39 states the "FBI could only verify that 25 percent of shooters had ever been diagnosed with a mental illness (only three diagnosed with psychotic disorder)" and yet the list of concerning behaviors on Slide 40 lists mental health as the number one concerning behavior with the individuals who were identified in the survey. The speaker stated individuals with mental illness are much more likely to be the victims of a crime than perpetrators and mental illness is very different from the violent felonies that are taking place. The speaker asked for further clarification because mental health is listed on Slide 40 and is contrary to the evidence.

Commissioner Discussion

Chair Tamplen stated Commissioner Bunch, who was unable to be in attendance due to illness, is listening on the phone and asked about next steps. Chair Tamplen asked staff if the SMART project is possible to scale. She asked staff to come back with a proposal around initiatives to address these issues.

Executive Director Ewing stated this is an issue statewide and this is an area where an individual county's innovation could begin to shape a statewide strategy. He stated staff will explore ways that the Commission may facilitate that with county behavioral health and Agency partners, the Department of Social Services, the Department of Education, other state-level partners, and youth.

Commissioner Mitchell stated the SMART program seems doable for every school district in every county. A student who is experiencing a number of issues can be

referred for a number of reasons. They can come from CPS, probation, other sources but the outcome is the same with an emphasis on the concerning behaviors to look for.

Commissioner Gordon underscored Commission Madrigal-Weiss's caution that obviously the threat assessment detection is part of a much larger need to intervene and create a culture of prevention and support for all children from the beginning. He stated the school districts in Sacramento County are working toward the goal of a clinician available in or accessible to every school in the county to become a part of the SMART Team with schools and hopefully with law enforcement, as well, to create a culture of wellness and prevention from which these kinds of activities can spring forth. He stated the main goal is not to have children in those kinds of circumstances in the first place.

GENERAL PUBLIC COMMENT

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), spoke about the Request for Proposals (RFP) for stakeholder advocacy that will come out soon. The speaker stated, although they are grateful for the opportunities for public comment, all of this has taken place since the last MHSOAC meeting.

Stacie Hiramoto stated the Commission put out a public comment survey, but the survey was released on August 27th and was due on September 9th, which was less than two weeks and included the Labor Day holiday. The speaker stated the questions on the survey were puzzling to REMHDCO. Although there is one question on needs, it seems like a survey of organizations. The Cultural and Linguistic Competence Committee (CLCC) would have been a perfect place to discuss this, but it was not brought up.

Stacie Hiramoto stated there was a Commission meeting in Los Angeles with less than two weeks given to gather input, but REMHDCO was told there was not going to be a call-in number. This means that individuals who were unable to go to Los Angeles within the two weeks' time were unable to comment.

Stacie Hiramoto asked for additional ways for individuals to interact with staff in development of the stakeholder advocacy RFP. The speaker asked for more than two weeks' notice for meetings or surveys in the future.

Stacie Hiramoto noted that the Office of Health Equity and other organizations do not seem to know about the survey or the RFP.

Poshi Walker agreed that the survey was incredibly daunting, difficult to fill out, and seemed to be more about asking how good their agency was rather than asking about the needs of the population to enable the RFP to be designed to meet those needs. The speaker agreed that there was very little notice.

Poshi Walker stated the LGBTQ Listening Session is scheduled for Rosh Hashanah, one of the holiest days of the Jewish year, and it is in Los Angeles, where there is a high concentration of Jews. The speaker noted that even non-practicing Jews often honor Rosh Hashanah and will be unable to attend the Listening Session.

Poshi Walker stated concern that the October MHSOAC meeting has been cancelled. The speaker stated the Commission voted to put Innovation projects on a Consent Calendar to allow more time for oversight and other work of the MHSOAC, but the Commission is canceling the opportunity to hold one of its scheduled monthly meetings. Much of the work for #Out4MentalHealth is done at the local level with five active task forces, one in each mental health region. A meeting has been scheduled in October so members of the task force could attend the MHSOAC meeting the next day. The speaker was disappointed that the October MHSOAC meeting has now been canceled.

Poshi Walker encouraged the Commission to have the October meeting to get some of the great work done that the Commission has not had time to do, and to hear from local LGBTQ leaders about what is happening on the local level. The speaker invited everyone to participate in the October #Out4MentalHealth meeting with the task force leaders.

Smitha Gundavajhala stated there is a need for youth voice to weigh in on work that is being done and a need to explore new and emerging areas that the Commission may not have the capacity to address alone.

Smitha Gundavajhala stated mental health is not an isolated issue. It is highly disciplinary in that the ways in which mental health intersects with policy issues are unique. The speaker encouraged the Commission to do a workforce, education, and training (WET) program for high school and college-age students with task forces that would allow the students to explore some of these emerging intersections, such as education and mental health, juvenile justice and mental health, substance use and mental health, and climate change and mental health.

LUNCH BREAK

ACTION

5: Election of the MHSOAC Chair and Vice Chair for 2020

Facilitator:

- Filomena Yeroshek, MHSOAC Chief Counsel

Chair Tamplen stated nominations for chair and vice chair for 2020 will be entertained and the Commission will vote on the nominations and elect the chair and vice chair. She asked Ms. Yeroshek to facilitate this agenda item.

Ms. Yeroshek briefly outlined the election process and asked for nominations for chair of the MHSOAC for 2020.

Chair Tamplen nominated Vice Chair Ashbeck to be the Chair of the Commission for 2020. Commissioner Mitchell seconded.

Public Comment

Stacie Hiramoto spoke in support of the nomination to elect Vice Chair Ashbeck as chair of the Commission for 2020.

Action: Chair Tamplen made a motion, seconded by Commissioner Mitchell, that:

The Commission elects Vice Chair Lynne Ashbeck as chair of the Mental Health Services Oversight and Accountability Commission for 2020.

Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Berrick, Boyd, Danovitch, Gordon, Madrigal-Weiss, and Mitchell, Vice Chair Ashbeck, and Chair Tamplen.

Ms. Yeroshek asked for nominations for vice chair of the MHSOAC for 2020.

Commissioner Alvarez nominated Commissioner Madrigal-Weiss to be the Vice-chair of the Commission for 2020. Chair Tamplen seconded.

Public Comment

Smitha Gundavajhala spoke in support of the nomination to elect Commissioner Madrigal-Weiss as Vice-chair of the Commission for 2020.

Action: Commissioner Alvarez made a motion, seconded by Chair Tamplen, that:

The Commission elects Commissioner Mara Madrigal-Weiss as Vice-chair of the Mental Health Services Oversight and Accountability Commission for 2020.

Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Berrick, Boyd, Danovitch, Gordon, Madrigal-Weiss, and Mitchell, Vice Chair Ashbeck, and Chair Tamplen.

ACTION

6: MHSOAC Draft Strategic Plan

Presenters:

- Susan Brutschy, President, Applied Survey Research
- Lisa Colvig-Niclai, Vice President of Evaluation, Applied Survey Research

Chair Tamplen stated the Commission began its strategic planning process in the fall of 2018 with the help of Applied Survey Research (ASR). With ASR's facilitation, the Commission held four public meetings, including several breakout sessions with the public, and two half-day meetings with Commission staff to receive feedback and input into the process. Additionally, ASR conducted personal interviews and focused conversations and received over 400 online survey responses from consumers, providers, family members, and other stakeholders.

Chair Tamplen stated the Commission will be presented with the draft MHSOAC Strategic Plan. She asked the representatives from ASR to present this agenda item.

Susan Brutschy, President, ASR, provided an overview, with three slide presentations: Commission Update; the draft Results-Based Strategic Plan 2019-2023; and the implementation Plan.

Commissioner Questions and Discussion

Commissioner Danovitch stated he needed to leave before the presentation is finished, but wanted to express gratitude for ASR's stewardship, and that he is enthusiastic and excited to hear the rest of the presentation, so he will catch up on what he misses. He stated he thinks this is outstanding work.

Vice Chair Ashbeck referred to Slide 7 of the second PowerPoint presentation and suggested, given the conversation this morning with Dr. Pfeifer, adding another green box for "Other Public Sector Agencies." She stated the first box, "Public Mental Health System" is for the counties. The new box would include public schools, law enforcement, and juvenile justice. She stated it will take the intersection of those entities to effect change.

Vice Chair Ashbeck suggested that the first green box be titled "Public Sector" with county mental health being one item in the box or adding a different box that speaks to the alignment with other public sectors doing the work.

Executive Director Ewing stated the "Public Mental Health System" box highlights that the vision of the MHSA is not just about the public mental health system and the evidence for that is the prevention language. Prevention includes avoiding involvement with the public mental health system. It's about recovery and reducing disparities.

Commissioner Gordon suggested changing the green box on Slide 7, "the public mental health system is more effective," to "public mental health provided across all systems is more effective" to better align with the Mission on Slide 4.

Commissioner Anthony suggested adding "to work in partnership with others."

Executive Director Ewing agreed that it should read "the public sector is more effective at addressing mental health."

Ms. Brutschy stated another way to handle it is to ensure there are measurements that go along with that cross-systems piece.

Commissioner Alvarez referred to the third set of green boxes on Slide 7, "the public supports mental health," and the box about public will. She stated she agrees about the public will but suggested including that the consumer voice is better heard or is greater agency as a second bullet.

Chair Tamplen agreed and suggested "consumers will not experience stigma, discrimination, or prejudice."

Lisa Colvig-Niclai, Vice President of Evaluation, ASR, stated it is one of the results on Slide 8.

Executive Director Ewing agreed with adding the bullet "consumer voice is heard and respected." He stated key metrics will be developed in the implementation phase for each of these bullets.

Commissioner Boyd stated the whole language associated with addiction is completely absent in this. That needs to be looked at.

Executive Director Ewing asked for guidance on that. He stated the language of the MHSA is about mental health. The field is moving towards behavioral health and brain health. There are tensions over those words, what they mean, to whom, and under what conditions, so the ASR stuck with the mental health language of the MHSA. It is not clear that the policy has kept pace with the culture of the field and significant conversation came up about using MHSA dollars for addiction issues.

Commissioner Boyd stated, if the MHSA was before voters today, it clearly would have addressed that. He stated language is being used throughout this document and planning process that does not necessarily reflect the frame of the MHSA in many ways nor the responsibilities of this Commission, which was spelled out, adopted, and authorized by legislation. He suggested hearing key stakeholder engagement and input on this issue.

Executive Director Ewing stated it is an option for the Commission to adopt the behavioral health language rather than mental health.

Chair Tamplen agreed and stated it is an excellent point.

Commissioner Berrick stated he did not feel there was a specific intent for the MHSA to exclude addiction. He agreed with moving toward behavioral health language. He stated children with addicted parents have behavioral health issues in many cases. He stated mental and behavioral health are so closely related that breaking them apart is not helpful.

Commissioner Gordon stated the need to make clear to the public and lay person that the inclusion and collaboration of systems is at the heart of the matter. There are only two places to compel individuals to be: in jail, if they are convicted of something, or in school, if they are between the ages of 5 and 18. He stated those places have a huge role in everything. Teachers who see 170 students per day are the front line of this work. The messaging around that is crucial in order to be transformational.

Commissioner Anthony stated the conversation is digressing. It is important to state "mental health." Part of legislation and why the tax is in effect is to improve mental health. If it includes students and other wellbeing issues such as addiction and success in school, that is a piece, but it is not appropriate to take out the term "mental health" because that is the whole intent of the legislation.

Commissioner Alvarez stated, in keeping up with the field and impacted individuals and the fact that addiction is a mental health issue and is related to coping mechanisms for many mental health issues, she asked to put it on the legislation list to update the language of the law.

Commissioner Boyd acknowledged that no terminology is perfect. Behavioral health is commonly understood as including both mental health and addiction. The challenge with that term is that "behavioral" implies that an individual should be able to control it. He suggested "mental health and addiction care" as a possibility for the green box on Slide 7.

Commissioner Berrick suggested a conversation about how to hold the value underneath the terms used and how to ensure that the language expresses it.

Vice Chair Ashbeck suggested, in addition to core principles at the beginning of the plan, including something about shared language and the terms that will be used and that Commissioners agree what those are. This will help readers not to jump to the conclusion that something has been left out.

Kylene Hashimoto stated members of the public are more familiar with the term “mental health” rather than “behavioral health.” She gave the example of going to a behavioral health center and thinking she had to go there because of her behavior, such as dealing with anger issues. She suggested “mental health and substance abuse.”

Vice Chair Ashbeck referred to Slide 4, the Commission’s Vision, Mission, and Principles, and stated the Mission box does not speak about anything relative to behavioral health, mental health, or substance abuse. Although it is a nice sentence, the mission as stated could also be for health care, dental care, law enforcement, or education. She asked that the Mission box be refined.

Commissioner Anthony stated she liked the statement in purple on Slide 4, “the Commission’s purpose is to transform the delivery of mental health services in California.”

Ms. Brutschy gave a shout-out to the MHSOAC Transparency Suite. She stated it is an incredibly powerful tool. The ASR team is thinking about how to connect oversight and accountability with the Transparency Suite. It not only has information on each county and their programs but also includes a glossary of terms and how they are measured. It would be a nice addition to the scorecard.

Presentation, continued

Ms. Colvig-Niclai continued the slide presentation and discussed the implementation, sustainability, and outcomes measurements, including the framework and results scorecard, of the Draft Results-Based Strategic Plan 2019-2023. She demonstrated the results scorecard.

Commissioner Questions and Discussion

Commissioner Boyd stated the need to ensure that the issue of getting the data has been addressed. He asked for definitions for several words, such the word “effectively” in the measurement of the “percent of counties effectively utilizing MHSA funds.” He stated the need to determine where that data was found and how it would be defined as part of next steps.

Ms. Brutschy stated, if the theory of change is the plan, the results framework is the accountability for the plan. Part of this is already laid out in the Transparency Suite and part of it is the structure of how much the Commission has done, how well it was done, and if it made any difference.

Commissioner Anthony asked if the results scorecard tool is new or if it is already available to the Commission.

Executive Director Ewing stated it is both. There is a tool that can be used to do this that has been set up as a proxy. It has not been finalized yet. The next step for the

Commission is to discuss the appropriate key metrics to include in the tool. He stated this tool will also show the impact of the things the Commission spends its time on.

Commissioner Boyd stated less may be more as opposed to a large list. He suggested coding it to highlight areas that are clearly within the Commission's purview to make it more meaningful. That is part of accountability.

Commissioner Boyd asked if terms used in the tool have been community-defined. He stated the need for the measures of collaboration to be those that are defined by the community.

Commissioner Boyd suggested, outside of the number of website hits, including a measurement for virtual connection and social media.

Presentation, continued

Ms. Colvig-Niclai continued the slide presentation and discussed communicating progress and seeking feedback for the Draft Results-Based Strategic Plan 2019-2023. She stated the three PowerPoint presentations presented today are available for Commissioners' use. She encouraged creating three two-page information sheets condensing the PowerPoint presentations as a way to disseminate the information broadly.

Public Comment

Poshi Walker stated, when engaging diverse populations, the members of the Commission's committees are subject matter experts representing diverse populations. They were intended to be advisory committees to Commissioners, and yet there does not seem to be a connection between the activities of the committees and the Commission. The speaker suggested making a place on the agenda for the CLCC and/or the CFLC to educate the Commission about a portion of the population.

Poshi Walker stated stakeholder contractors are also subject matter experts. The speaker stated their team would love to come and educate the Commission on different aspects of what the populations need.

Poshi Walker spoke against using the term "behavioral health." It feels like they are being told to behave better. The speaker stated concern that mental health will be subsumed. The speaker also stated that addiction is not just about substances. One of the worst addictions is gambling, which is one of the most difficult addictions to cure.

Stacie Hiramoto echoed Poshi Walker's comments about the connection of the CLCC and the CFLC to this Commission. There are many individuals on the committees who have never been to a Commission meeting.

Stacie Hiramoto complimented the ASR for listening to stakeholders during the strategic planning process. The speaker sent a letter to Commissioners regarding procedural concerns from a number of agencies. The speaker stated the concerns will be better addressed during the operations portion of the strategic planning process at a future meeting.

Smitha Gundavajhala stated the need to strengthen the stakeholder process. The speaker echoed Poshi Walker's comments about taking time during meetings to be educated by committee members. Even if the time allotted was five minutes, it would strengthen the linkage of stakeholder voices to Commission decisions.

Smitha Gundavajhala stated concern about the data collected to inform the strategic planning process. The average number of respondents was seven individuals per county. This is a non-representative number. When thinking about solutions that work for the population, the voices of seven individuals per county may not necessarily present the most accurate input for decision making and funding.

Smitha Gundavajhala stated concern that the portion of consumers was only nine percent in the data collected to inform the strategic planning process. The speaker stated the need to do better on consumer voice, given the spirit of the MHSA is to uplift the stakeholder voice. The speaker suggested having an intentional space within each county for community members to talk about this. Creating community mental health coalitions in every county will provide a ready space for community members to hear about what is happening in the Commission, to weigh in, to be involved in mental health conversations, and to provide a place for the Commission to seek input on issues.

Andrea Crook agreed with the concern around the low representation of the client voice. The speaker thanked Stacie Hiramoto for their feedback around the core mission and vision, going back to the basics and general standards of the MHSA, and ensuring that that is not lost as an overarching goal.

Andrea Crook stated, in preparation for the October 8th interview with Thomas Insel, M.D., the newly appointed "mental health czar" for the state of California, ACCESS California hosted a listening session webinar this week to get feedback from stakeholders throughout the state. The speaker stated one of the questions asked of stakeholders was about the issues they think Dr. Insel should focus on. The responses were a transparent stakeholder process, housing, recovery-oriented systems of care, whole-health outcomes, and other concerns. Overwhelmingly, individuals responded that their number one issue they felt Dr. Insel should take on was a transparent stakeholder process.

Andrea Crook stated there are rumblings about a ballot measure to take the MHSA back to the voters to change the language. Another question that was asked of stakeholders was if they wanted to see that happen. Overwhelmingly, individuals said they would like to update the language and they would like to see the discretionary five percent that goes to the community planning process become mandatory.

Tiffany Carter asked about the response process to recommendations that are made, such as Poshi Walker's comments about committees to advise the Commission. The speaker asked about the processes those recommendations take in order to be acknowledged and implemented and for stakeholders to know that the recommendations made by stakeholder contractors were taken into consideration.

Chair Tamplen stated the request about the committees should be first made to the committees themselves so the chairs of the committees can bring it to the attention of the full Commission.

INFORMATION

7: Executive Director Report Out

Presenter:

- Toby Ewing, Ph.D., Executive Director, MHSOAC

Executive Director Ewing presented his report as follows:

Personnel

There is a bill on the Governor's desk that would give the Commission the flexibility to hire additional staff. Two new staff members were introduced earlier in this meeting. The plan is to bring in student interns and additional staff.

The new communications person will be introduced at the next Commission meeting. One of their first duties will be to complete a biennial report.

Additional Office Space

Additional office space is currently being used across the hall. Contracts need to be signed and improvements need to be made before staff can officially move in.

Policy Project Updates

Assembly Bill 1315 Early Psychosis Initiative

Staff is talking with partners, UC Davis in particular, about possibly doing a day-long convening early next year as an efficient way to educate the field about what is happening on the federal, county, and Commission levels and to provide guidance on how the \$15 million funding will be allocated.

Criminal Justice and Mental Health

Three Innovation projects are being supported and counties are being engaged with additional Innovation Incubator funds. Staff has been in discussion with the Department of Finance, the Department of State Hospitals, and the Council on Criminal Justice and Behavioral Health to find connections.

Fiscal Reporting Tool

The transparency tool has not been updated because the state changed the way it does accounting so the latest fiscal year does not match the prior fiscal years. Efforts are being made to tie together information from the old reporting strategy and the new reporting strategy.

As part of that effort, Dawnte Early, Ph.D., Chief, MHSOAC Research and Evaluation, has been negotiating with Agency about joining a master data sharing agreement that covers all of the departments under Health and Human Services Agency, the Department of Education, and the Employment Development Department.

Mental Health Student Services Act (MHSSA)

The first MHSSA Listening Session is scheduled for September 27th. Three additional Listening Sessions are proposed with at least one of those in partnership with the Department of Education to ensure input from local education partners, as the legislation requires a strong county behavioral health and education partnership.

MHSOAC Documentary

The documentary is scheduled to launch before the holidays. The launch was originally planned for October but there was a delay. Tom Chiodo, Executive Producer, Special Projects, Washington Educational Telecommunications Association (WETA), who presented to the Commission last January, shared with staff that consumers have been brought into the process as a direct result of Steve Leoni's public comment about the importance of the inclusion of the consumer voice. Mr. Chiodo expressed his appreciation to staff about the value that this has added to the documentary.

Schools and Mental Health

Staff is putting out a report, building a learning collaborative, doing data linking, designing strategies to release MHSA funding, continuing the youth innovation work, and engaging in conversations about foundation interest to organize a Schools and Mental Health Conference.

The Commission was approached by Goldie Hawn to partner with the work she has been doing on the neurology of learning. Her nonprofit foundation has done research and developed a strategy to engage young children around mindfulness and healthy brain development. She is interested in finding ways that the Commission might connect. Her goal is to help make the connection between healthy development in children, educational outcomes, and wellbeing for young people.

State Suicide Prevention Plan

Staff is working on a communication strategy on the State Suicide Prevention Report. It is currently being edited, the graphics are being worked on, and staff is in communication with the Governor's office about implementing it soon after the Governor's January budget. These are currently just conversations, but staff is optimistic that it will be released in the next few months.

Workplace Mental Health

The project is moving forward. Staff participated in a three-day set of events in Napa and had the chance to sit down with approximately 40 individuals who are among the largest purchasers of health care to talk about parity and the challenges of securing appropriate mental health care through the commercial sector for companies that are struggling the same way that the public sector is struggling and, in many cases, are far behind the public sector in terms of the adequacy of their networks and the quality of the care. They are interested in how to fix that.

Regarding the strategic planning discussion, it is necessary to recognize that 60 percent or more of Californians receive their mental health benefits through their employer. In order to take pressure off the public system, it is important to think

about how to strengthen access to care regardless of who the payer is. It should not be financing that drives decisions around the quality of care; it should be need.

Speaking Engagements

Chair Tamplen spoke at a Southern California Association about public/private partnership to strengthen Full Service Partnerships. There was media follow-up on that. Staff is increasingly hearing from foundations wanting to learn how to support the work of the Commission and how the Commission can support the work that they are doing, particularly helping to move foundation-funded innovations to scale.

GENERAL PUBLIC COMMENT

Stacie Hiramoto stated she was disappointed to hear that the October MHSOAC meeting was canceled. There are many things that, even without a quorum, Commissioners who were able to make it could discuss. Stakeholders have a lot of input around the rules of procedure. The time could also be used to hear reports about what stakeholder contractors are doing, or Commissioners could hear an update on the California Reducing Disparities Project, which is on the verge of coming to an end unless it is extended. Commissioners could hear more about the Innovation Incubator project. Commissioners could be updated on the stakeholder advocacy grants, which seem to have limited public comment and the outline is to be released in November. The October meeting could be used as a listening session for public comment on all the stakeholder advocacy grants. The speaker asked the Commission to consider meeting in October.

ADJOURN

Vice Chair Ashbeck stated Valley Children's Hospital and Universal Health Services announced a partnership last week that they are going to build a new 128-bed in-patient behavioral health hospital in Madera. She stated, while in-patient beds are not the solution, they are part of the puzzle. She noted that there will be at least 24 dedicated beds for children. Currently, there are only 16 beds in Fresno County and 33 in Kern County, which are the only beds between Los Angeles and Sacramento for children 5-17. She stated this is a big victory for the Central Valley and good for California.

There being no further business, the meeting was adjourned at 4:02 p.m.

AGENDA ITEM 2

Action

November 21, 2019 Commission Meeting

Strategic Statewide Suicide Prevention Plan

Summary: The Mental Health Services Oversight and Accountability Commission will consider adopting “Striving for Zero: California’s Strategic Plan for Suicide Prevention, 2020 – 2025.”

Background: Assembly Bill 114 (Chapter 38, Statutes of 2017) directed the Commission to develop a statewide strategic suicide prevention plan. In early 2018, the Commission formed a Suicide Prevention Subcommittee, which included Commissioners Tina Wooton (Chair), Khatera Tamplen, and Mara Madrigal-Weiss. The subcommittee consulted with local, state, and national experts, visited sites, and reviewed current policy and practice. The subcommittee held a series of meetings, public hearings, and community forums around the state over a period of 10 months to hear from community members, people with lived experience, and other subject matter experts, as well as from state and county leaders, service providers, and other Californians.

The draft plan was released for public comment on July 3, 2019. The subcommittee met on July 16th in Los Angeles, on August 15th in Eureka, and on August 28th in Sacramento to hear feedback and consider input on the draft plan. The subcommittee directed staff to make revisions as directed by the Project Chair, and the subcommittee voted unanimously to submit the revised draft plan to the Commission to consider for adoption.

Presenter:

- Ashley Mills, MS, Senior Researcher and Project Staff Lead

Enclosures(3): (1) PowerPoint presentation; (2) “Striving for Zero: California’s Strategic Plan for Suicide Prevention, 2020 – 2025;” (3*) Written public comment (*if any is received).

Handout: None.

Proposed Motion: The MHSOAC adopts “Striving for Zero: California’s Strategic Plan for Suicide Prevention, 2020 – 2025.”



Striving for Zero:

California's Strategic Plan for Suicide Prevention, 2020 – 2025

November 21, 2019
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WELLNESS • RECOVERY • RESILIENCE

Project Overview

- Assembly Bill 114
- Suicide Prevention Subcommittee
- Overview of project activities
 - Subcommittee Meetings
 - Community Forums
 - Site Visits
 - Public Hearings
 - Local and National Initiatives



Report Overview

- Strategic Aims and Goals
- Background
- State Workplan



Strategic Aim 1: Establish suicide prevention infrastructure

- Goal 1: Enhance visible leadership and networked partnerships
- Goal 2: Increase development and coordination of suicide prevention resources
- Goal 3: Advance data monitoring and evaluation

Strategic Aim 2: Minimize risk for suicidal behavior by promoting safe environments, resiliency, and connectedness

- Goal 4: Create safe environments by reducing access to lethal means
- Goal 5: Empower people, families and communities to reach out for help when behavioral health needs emerge
- Goal 6: Increase connectedness between people, family members, and community
- Goal 7: Increase the use of best practices for reporting of suicide and promote healthy use of social media and technology

Strategic Aim 3: Increase early identification of suicide risk and connection to services based on risk

- Goal 8: Increase detection and screening to connect people to services
- Goal 9: Deliver a continuum of crisis services within and across counties

Strategic Aim 4: Improve suicide-related services and supports

- Goal 10: Deliver best practices in care targeting suicide risk
- Goal 11: Ensure continuity of care and follow-up after suicide-related services
- Goal 12: Expand support services following a suicide loss



Strategic Aim 1

- Goal 1: Enhance visible leadership and networked partnerships
- Goal 2: Increase development and coordination of suicide prevention resources
- Goal 3: Advance data monitoring and evaluation



Strategic Aim 2

- Goal 4: Create safe environments by reducing access to lethal means
- Goal 5: Empower people, families and communities to reach out for help when behavioral health needs emerge
- Goal 6: Increase connectedness between people, family members, and community
- Goal 7: Increase the use of best practices for reporting of suicide and promote healthy use of social media and technology



Strategic Aim 3

- Goal 8: Increase detection and screening to connect people to services
- Goal 9: Deliver a continuum of crisis services within and across counties



Strategic Aim 4

- Goal 10: Deliver best practices in care targeting suicide risk
- Goal 11: Ensure continuity of care and follow-up after suicide-related services
- Goal 12: Expand support services following a suicide loss



Background

- Plan Development
- Suicidal Behavior and Suicidal Behavior in California
- Risk and Protective Factors
- Best Practices
 - Universal Prevention
 - Selective Prevention
 - Indicated Prevention



State Workplan

- State Objectives and Implementation Schedule to achieve the 12 goals outlined under the four strategic aims
- Comprehensive Suicide Prevention Using:
 - Leadership
 - Data
 - Training
 - Policy



Next Steps

- If the proposed motion is adopted today, Staff will:
 - Work with State leaders, including the Governor's Office, Administration, and the Legislature to begin to implement next steps as outlined
 - Implement a communications strategy to guide suicide prevention efforts and investments
 - Provide technical assistance to support local planning and development



Proposed Motion

The MHSOAC adopts Striving for Zero: California's Strategic Plan for Suicide Prevention, 2020-2025





Striving
for
Zero

**CALIFORNIA'S STRATEGIC PLAN
FOR SUICIDE PREVENTION 2020 – 2025**

Support for people at risk for suicide or those supporting people at risk is available by calling the **National Suicide Prevention Lifeline** 1-800-273-TALK (8255)

Apoyo y ayuda para personas a riesgo de suicidarse o para las personas que los apoyan está disponible llamando al **National Suicide Prevention Lifeline** 888-682-9454

About the Commission

The Mental Health Services Oversight and Accountability Commission, an independent state agency, was created in 2004 by voter-approved Proposition 63, the Mental Health Services Act. Californians created the Commission to provide oversight, accountability, and leadership to guide the transformation of California's mental health system. The 16-member Commission is composed of one Senator, one Assembly member, the State Attorney General, the State Superintendent of Public Instruction, and 12 public members appointed by the Governor. By law, the Governor's appointees are people who represent different sectors of society, including individuals with mental health needs, family members of people with mental health needs, law enforcement, education, labor, business, and the mental health profession.

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Dedication

This plan is dedicated to people lost to suicide and people experiencing suicidal behavior, and their loved ones. The Commission would like to express its thanks to the many survivors, community members, family members, administrators, providers, researchers, and policymakers who contributed to the development of this plan. We greatly appreciate the time, commitment, and energy devoted to exploring the challenges and solutions surrounding efforts to prevent suicide.

We would like to extend a special thank you to the survivors of suicide attempt and loss who bravely and honestly shared their stories, experiences, and unique insights into opportunities to improve suicide prevention strategies. Many people are affected by suicide, including Commissioners and staff directly involved in the development of this plan. The Commission affirms the urgency of putting in place sound strategies to prevent further loss of life.

Lives can be saved. There is hope.

Get Help Now

If you or someone else needs support, a trained crisis counselor can be reached by calling the National Suicide Prevention Lifeline at **800-273-TALK (8255)** or by texting TALK to **741741**.

- Personas que hablan español, llamen a the Lifeline al **888-682-9454**.
- For teens, call the TEEN LINE at **310-855-4673** or text TEEN to **839863**.
- For veterans, call the Lifeline at **800-273-TALK (8255)** and **press 1**.
- For LGBTQ youth, call The Trevor Project at **866-488-7386** or text START to **678678**.
- For transpeople, call the Trans Lifeline at **877-565-8860**.
- For people who are deaf or hard of hearing, call the Lifeline at **800-799-4889**.
- For law enforcement personnel, call the COPLINE at **800-267-5463**.
- For other first responders, call the Fire/EMS Helpline at **888-731-FIRE (3473)**

All of the resources above provide confidential help and are available 24 hours a day, seven days a week. Suicide risk assessment is a collaborative and transparent process between the person at risk and the person conducting the assessment. Working together, support services and referral options are identified based on risk and need.

If Someone is Showing Warning Signs or Communicating a Desire to Die, Take the Following Steps:

- 1. ASK** “Are you thinking about suicide or feeling that life may not be worth living?” and assess the person’s safety by asking if the person has a specific plan and any intent to act on that plan. Ask if the person has already begun acting on these thoughts or made a suicide attempt. Risk of death by suicide increases significantly as people put more pieces of a plan in place.
- 2. EXPRESS compassion.** The desire to die by suicide can be a frightening and isolating experience. Express compassionate care to emphasize that help is available, including confidential resources.
- 3. REACH OUT** for support by calling the crisis lines (see above) to be connected to resources. All crisis lines are available for people in crisis AND individuals supporting people in crisis.
- 4. FOLLOW-UP** by calling, texting, or visiting to ask how the person is doing and if additional support is needed.

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Suicide is a significant public health challenge. According to the latest data, 4,323 Californians lost their lives to suicide in 2017. California's state suicide rate remains relatively stable, and rates are increasing in some communities.

Striving toward no lives lost to suicide will require a dedicated and sustained effort to integrate practices known to prevent suicide into our education, justice, healthcare, and other systems and our communities.

All Californians need to be vigilant – aware and responsive to the warning signs of suicide in their loved ones and even in themselves.

There is hope. The evidence for effective suicide prevention practices is growing every day. This comprehensive strategy incorporates the latest information and evidence to guide state and local actions for the benefit of all Californians and to save lives.

Executive Summary

More than 47,000 Americans lose their lives to suicide each year. While global suicide rates are decreasing, the national suicide rate has been on a steady rise since 1999. Some key facts about suicide in the United States and California:

- Suicide is the tenth leading cause of death in the U.S., and the second leading cause for people ages 10 to 34.
- Each year an estimated 25 suicide attempts occur for every death by suicide; among youth, up to 200 attempts occur for every suicide death.
- In 2017, the national suicide rate was 14 per 100,000 people. While California's rate – 10.7 per 100,000 residents – is lower relative to other states, certain counties and demographic groups have much higher rates.
- While women and youth of color attempt suicide at greater rates than other groups, middle-aged and older white men die by suicide at greater rates. In the U.S., nearly 7 out of 10 suicides are by white men.
- The most common method for suicide attempt is drug overdose, while firearms are the most common means for suicide death.

Suicide is a complex public health challenge involving many biological, psychological, social, and cultural determinants. The major risk factors for suicide are a prior suicide attempt; substance use disorder; mood disorders, such as depression; medical illness; and access to the methods to attempt suicide. The common factors that reduce risk for suicide are access to effective medical and mental health care; connectedness to others; problem-solving skills; and caring contacts, such as postcards or letters, from service providers and caregivers.

Challenges to Effective Suicide Prevention

Prevention efforts are challenged by misconceptions about suicidal behavior, despite advancements in the study of suicide and its prevention. These pervasive myths may prevent people at risk from seeking help and discourage people from asking loved ones about thoughts of suicide. The internal suffering that accompanies the desire to die may remain hidden unless a person is directly asked about the person's thoughts and needs. Misconceptions also undermine the effectiveness of strategies to reduce access to potentially lethal methods of injury. Such interventions are common in other prevention fields, yet they remain underutilized in suicide prevention. Physical barriers on bridges, locking doors on railways, and locking windows at lethal heights prevent accidental *and* intentional falling. Likewise, safely storing guns in the home prevents accidental *and* intentional injury and death among children and adults.

Effective prevention efforts must recognize that risk factors can be dynamic, changing over a person's lifetime. Researchers are exploring the variability in risk and protective factors among vulnerable groups, and much remains unknown. Suicide prevention also requires engagement of private and public partners

across multidisciplinary fields, which requires a commitment to wide-scale collaborations that integrate planning and coordinate actions. Efforts are further complicated by inconsistent definitions of suicidal behavior, which affect data monitoring. Lastly, assessing for risk is not a uniform practice in California. This leads to inconsistency in suicide risk detection, which also is constrained by significant ethical, training, and legal considerations.

Suicidal Behavior in California, 2017

4,323: The number of Californians who died by suicide

18,153: The number of Californians who received service in an emergency department for intentional self-harm

108,075: The number of suicide attempts in California, based on the estimate of 25 suicide attempts for every one suicide death

Over 1.1 Million: The number of adult Californians who reported serious thoughts of suicide

Application of the Public Health Model to Prevent Suicide

Despite the challenges, research demonstrates that effective interventions can save lives, and that public health strategies can prevent loss of life on a broad scale. The Public Health Model involves four repeating steps: 1) defining the problem; 2) identifying the factors that increase or lower risk; 3) developing and evaluating prevention interventions; and 4) implementing interventions and disseminating results to increase the use of effective interventions.¹ (See Figure 1.) The Public Health Model is a key feature of the statewide strategic suicide prevention plan detailed in this document.

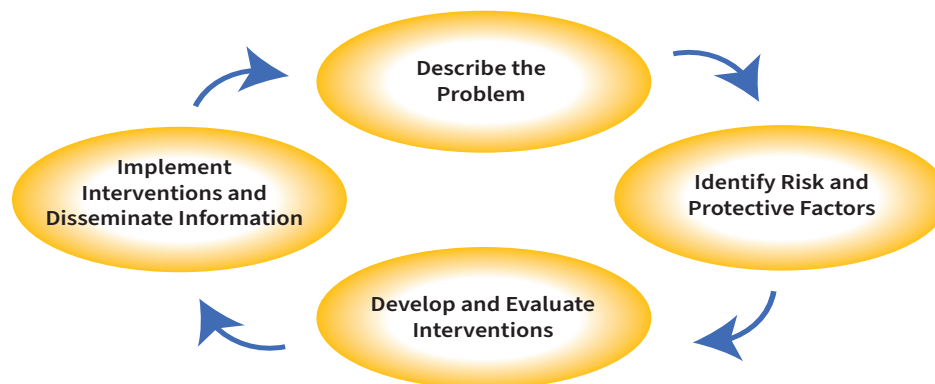


Figure 1. Public Health Model adapted from the World Health Organization's Preventing Suicide: A Global Imperative

Opportunities to Save Lives

California's Mental Health Services Oversight and Accountability Commission was directed by the Legislature to develop a new suicide prevention plan for the state. The Commission began its effort in early 2018 by reviewing California's previous strategic plan. Developed in 2008, the plan made numerous noteworthy recommendations, many of which were not fully implemented. Under the leadership of a subcommittee chaired by Commissioner Tina Wooton, the Commission engaged national and local experts; reviewed research; conducted site visits; and convened public hearings and forums across the state, where community members, policy leaders, and those with lived experience provided guidance and insight.

The Commission's goal was to produce an achievable policy agenda and a foundation for suicide prevention based on best practices. Its overarching objective is to equip and empower California communities with the information they need to minimize risk, improve access to care, and prevent suicidal behaviors. While the state can support local communities and assume a leadership role, the success of any strategic plan depends on the integrated efforts of private and public partners. This synergy is already taking place on many fronts. Private and public health care systems are integrating behavioral health systems and providers. Public health leaders are investigating risk factors for suicide and novel interventions for its prevention, within communities and service delivery systems. Schools are working with local leaders to increase access to mental health services and provide social emotional learning that will help students over their lifetimes. Businesses are recognizing the importance of workplace wellbeing and expanding pathways to support through modern employee assistance programs.

Comprehensive Approach Targeting a Continuum of Risk

California's Suicide Prevention Plan is Framed by Four Strategic Aims.



STRATEGIC AIM 1: Establish a Suicide Prevention Infrastructure

Similar to other public health challenges, preventing suicide statewide demands a strong infrastructure of information, expertise, evaluation, and communication. This infrastructure must support the systematic delivery of best practices, so success is not dependent on the valiant efforts of a single person, agency, or setting. Everyone can potentially play a role in suicide prevention. Information must be disseminated through trusted channels. Leaders must sustain suicide prevention as a public health priority and define the roles that partners play in planning, delivering, and monitoring efforts. Resources must be integrated and coordinated. Data must be standardized and routinely collected and monitored.



STRATEGIC AIM 2: Minimize Risk for Suicidal Behavior by Promoting Safe Environments, Resiliency, and Connectedness

Risk for suicide in all communities can be reduced by reducing environmental threats to safety, while building individual, family, and community resiliency. People at risk for suicide often experience extreme ambivalence about the desire to die or live, and experience a high degree of suffering. Eliminating or reducing access to a lethal method, such as a gun, creates time and opportunity for intervention during what are often transient crises. People can be taught skills to manage stressors, and to understand when they need to reach out for additional support. Increasing social connectedness can reduce stigma and isolation. Media, including the entertainment industry, can prevent suicide through responsible reporting of suicide death, by destigmatizing mental health needs, and by highlighting mental health resources.



STRATEGIC AIM 3: Increase Early Identification of Suicide Risk and Connection to Services Based on Risk

Risk may elevate for some despite efforts to create safe environments and build resiliency. Anyone can recognize the warning signs of suicide and can learn to communicate effectively with people at risk to determine the type of support needed. Screening tools can identify people at risk for suicide in many settings, while brief interventions – like those used for problem alcohol use – empower people at risk to recognize their personal warning signs, identify coping strategies and a supportive social network, reduce access to lethal means, and seek professional help to manage suicide crises. Crisis services and support also can assist with assessing for suicide risk and connection to services, and must be widely available, accessible, and varied to benefit the diverse range of people in need of help.



STRATEGIC AIM 4: Improve Suicide-Related Services and Supports

Timely services and supports must be available to people experiencing suicidal behavior, especially attempted suicides, and people experiencing the suicide death of a loved one. Behavioral health providers must be equipped to help those at risk and trained to deliver care that reflects best practices. For example, low-cost, high-impact post-hospitalization postcards and referral services are effective strategies for preventing future suicidal behavior and must be a standard component of aftercare following hospital or emergency department discharge. Swift response to support families, loved ones, and, in some cases, entire communities, must follow every suicide.

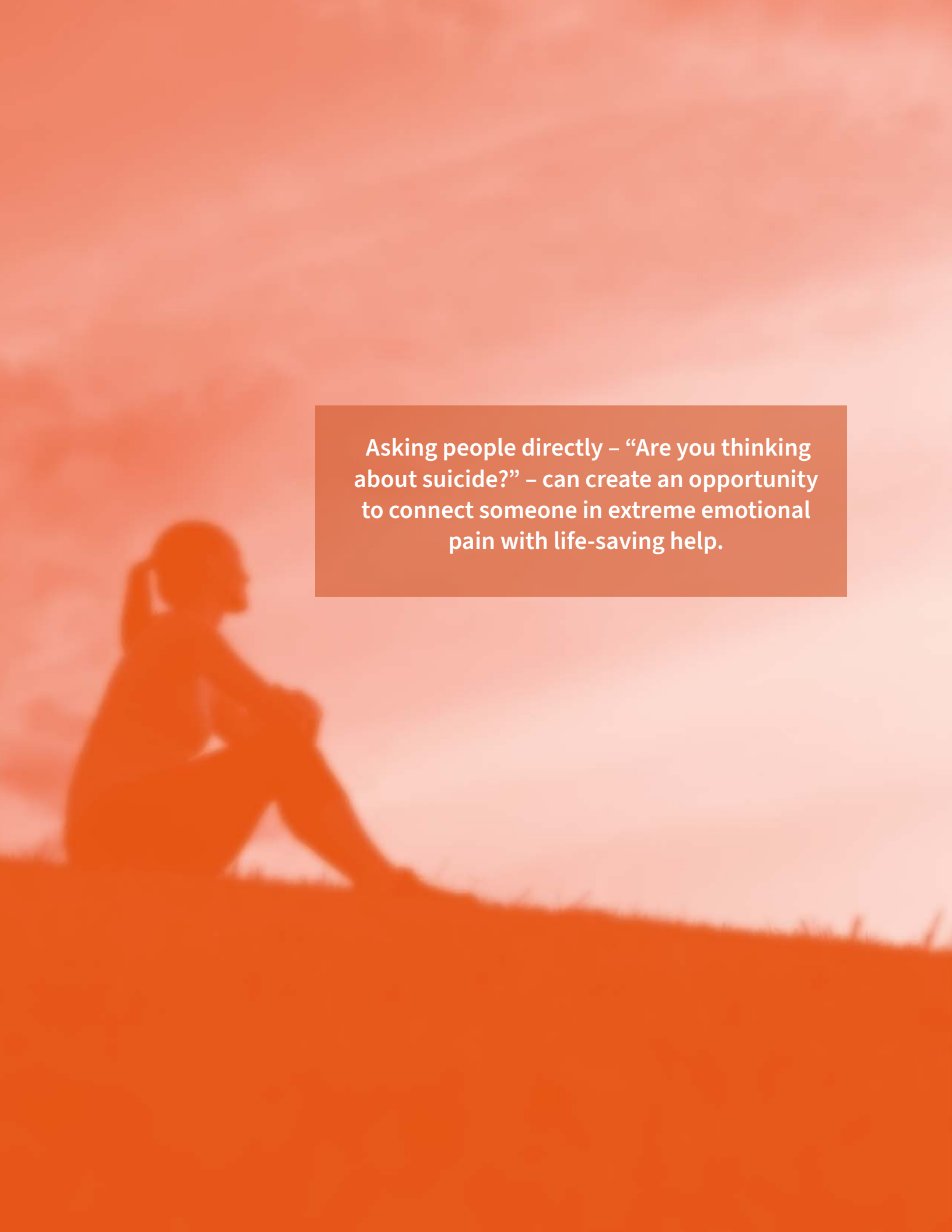
Next Steps

Lives can be saved from suicide if resources are dedicated to fortifying key components of a suicide prevention infrastructure. A five-year state workplan is detailed at the end of this plan. The state should take the following first steps now:

- Create the **Office of Suicide Prevention**, supported by the California Suicide Prevention Council. The Office should be charged with implementing the plan and evaluating progress. The Office should be within the California Department of Public Health.
- Expand the **California Violent Death Reporting System** within the Department of Public Health by allocating local assistance funding to supplement federal funding. This funding should support technical assistance to increase the standardized data entered into the system and increase the timely dissemination of information at the local and state levels to guide prevention efforts.
- Require **standardized suicide prevention training** for providers in all hospital settings and expand current requirements to **screen for suicide risk** in health care and behavioral health care settings. Training must include standardized suicide risk assessment and management of best practices. The state could accelerate the use of suicide risk assessment and management by advancing healthcare technology that supports triage-based assessments and timely connection to services.
- Require all hospitals to develop and implement **written uniform policies for discharge** after a person has received suicide-related services. Policies must include protocols for developing discharge plans, which must include a collaborative process to create a safety plan and to identify appropriate aftercare services; a plan for transitioning a person to another care setting or provider, home, school, and work; and a process for following-up with the person via written correspondence, email, text message, or other communication as directed by the person.

Striving for Zero

The elimination of suicide in California will require leadership, commitment, and honest conversations about suicide risk, resiliency, and barriers that disrupt suicide prevention efforts. This plan outlines public health aims aligned with nationally directed strategies and calls for crucial advancements in innovation and health care access using practices capable of helping millions of people. California has the ingenuity, capacity, and leadership to take a decisive stand against suicide. One life lost to suicide is one too many, so let's begin now.

A silhouette of a person sitting on a grassy hill, looking out over a sunset sky. The person is positioned on the left side of the frame, with their back to the camera and head turned slightly to the right. The sky is a mix of orange and yellow, suggesting a sunset or sunrise. The overall mood is contemplative and serene.

Asking people directly – “Are you thinking about suicide?” – can create an opportunity to connect someone in extreme emotional pain with life-saving help.

Stigma and Myths

Stigma is a Major Obstacle to Preventing Suicide.

Stigma refers to negative attitudes and beliefs about people with behavioral health needs. Such needs include problem substance use and problem eating, serious psychological distress, and mental health needs, and their severity can range from distress to diagnosable illnesses and disorders. Stigma not only discourages people from seeking help, but also can prevent people, families, and communities from becoming connected with meaningful support. Stigma also affects the reporting and recording of suicides and the circumstances leading up to a suicide, such as a previous attempt or death in the family. Consequently, prevention efforts are stymied by the underreporting of suicidal behavior. To demonstrate

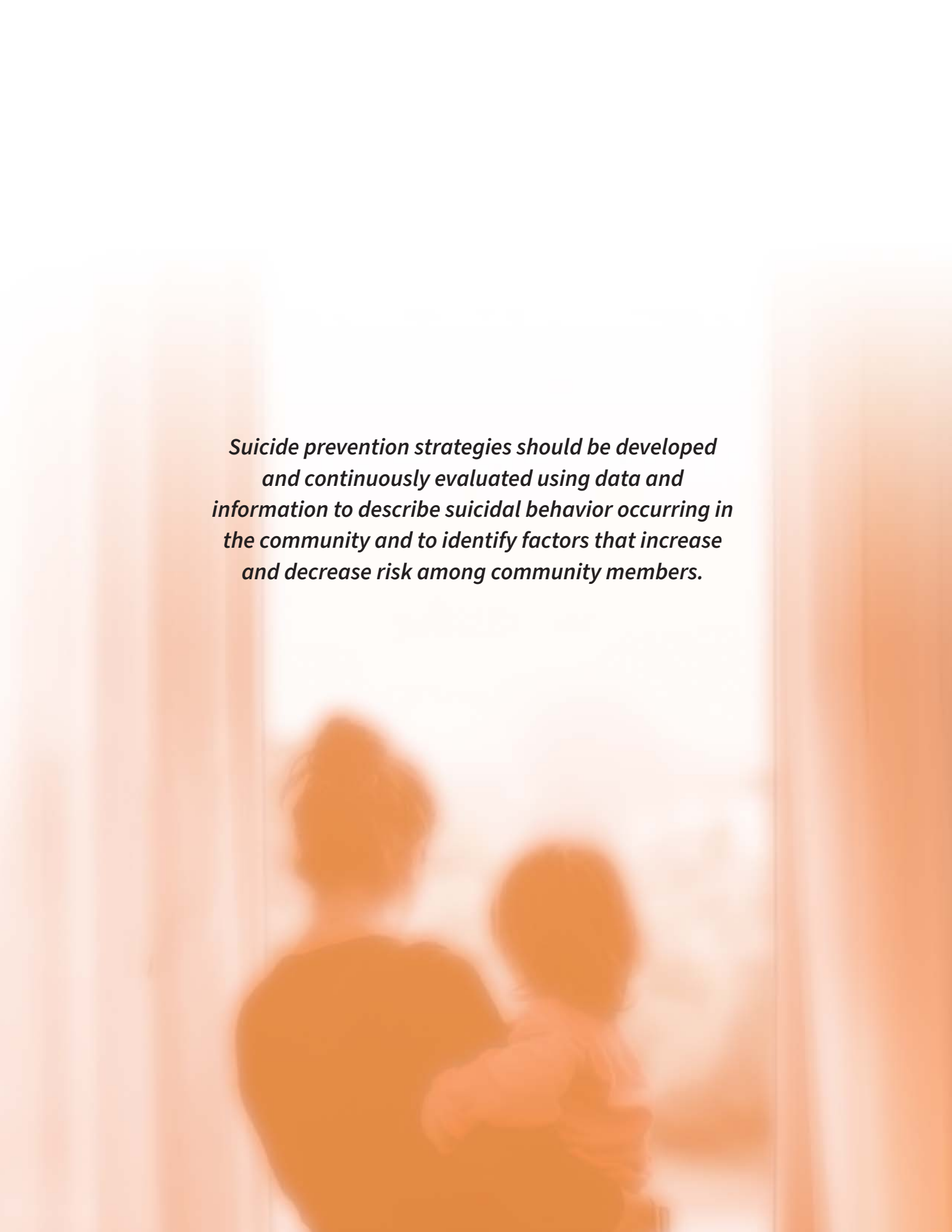
one tactic that can combat stigma, the Commission uses non-stigmatizing language throughout this plan. Stigmatizing language includes the phrases *committed suicide*, *completed* or *successfully completed suicide*, *suicidal person*, *unsuccessful* or *failed suicide attempt*, and *mentally ill*.

STIGMATIZING:	NON-STIGMATIZING:
Committed Suicide	Died by Suicide
Suicidal Person	Person at Risk of Suicide
Mentally Ill Person	Person Living with Mental Health Needs

Myths and Misconceptions About the Prevention of Suicide also Hinder Prevention Efforts.²

Below are common examples of these myths and the facts associated with each.

MYTH	FACT
Most suicides are impulsive and happen without warning.	Over 70 percent of people who die by suicide communicated to someone their plans for the attempt prior to death. ³ Planning, including obtaining the means by which to attempt suicide and identifying a location, often happens well before the attempt – sometimes years in advance. ⁴ Most suicides are preceded by warning signs, such as communicating the desire to die, of having no reason to live, or the feeling of being a burden.
People who want to die are determined and there is no changing their minds.	Over 90 percent of people who were interrupted in a suicide attempt will not go on to die by suicide at another location or by other methods. ⁶ Research suggests that those at risk for suicide often show extreme ambivalence about the desire to die or live, and express a high degree of suffering. The accounts of attempt survivors suggest that many people are relieved to have lived through an attempt and regain their desire to live. ⁷ This fact highlights the opportunity to intervene and separate the person at risk from lethal means for a suicide attempt.
Communicating about suicide will plant the seed for thoughts of suicide, increasing risk.	Communicating openly about suicide and asking about risk has been shown to be lifesaving. It encourages people to seek help, promotes a sense of belonging, and connects people to care.



Suicide prevention strategies should be developed and continuously evaluated using data and information to describe suicidal behavior occurring in the community and to identify factors that increase and decrease risk among community members.

Introduction

Suicide is a serious public health challenge, accounting for nearly 800,000 deaths each year worldwide.⁸ In the United States, suicide remains among the top 10 causes of death, claiming twice as many lives each year as homicide. Suicide rates have remained relatively intractable nationally over the past 50 years, and rose 33 percent between 1999 and 2017 – from 10.5 to 14 per 100,000 Americans.⁹ It is estimated that for every suicide, there are approximately 25 suicide attempts.¹⁰ For youth aged 15 to 24, as many as 200 attempts may occur for every death.¹¹

Thoughts of suicide are more common. In 2017, for example, an estimated 9.8 million adults nationally reported experiencing thoughts of suicide. Far fewer – 2.8 million adults – made suicide plans, while 1.3 million adults attempted suicide.¹²

Beyond its profound impact on the person, family, community, and society, suicide poses an estimated economic cost of \$93.5 billion in lost productivity and medical expenses in the U.S.¹³ In California, suicide resulted in an average of \$1,085,227 per death in lost productivity and medical expenses in 2010.¹⁴ This does not include the cost of other suicidal behavior, such as suicide attempts that did not result in death.

Nationally and in California, suicide has emerged as a public health emergency in need of innovation across multiple levels of prevention, in part because of historically intractable rates.¹⁵ A public health approach offers considerable promise to meet the challenge.¹⁶ This approach seeks to increase the health of the community in order to reduce the risk experienced by each person and, likewise, to increase the health of each person to reduce risk in the community.¹⁷ Under this model, individual health is shaped by the physical, psychological, cultural, and social environments in which people live, work, and go to school.¹⁸

Application of the Public Health Model to Prevent Suicide

The Public Health Model involves four repeating steps: 1) defining the problem; 2) identifying the factors that increase or lower risk; 3) developing and evaluating prevention interventions; and 4) implementing interventions and disseminating results to increase the use of effective interventions. (See Figure 1.) The Public Health Model is a key feature of the statewide strategic suicide prevention plan detailed in this document.

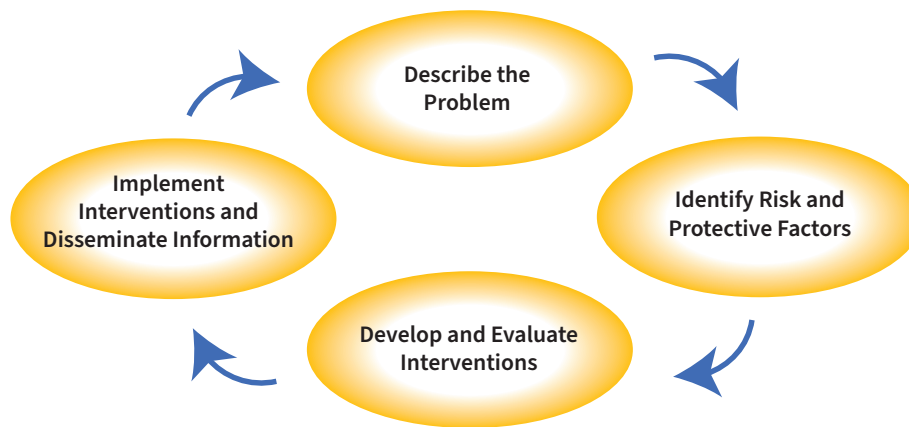


Figure 1. Public Health Model adapted from the World Health Organization's Preventing Suicide: A Global Imperative

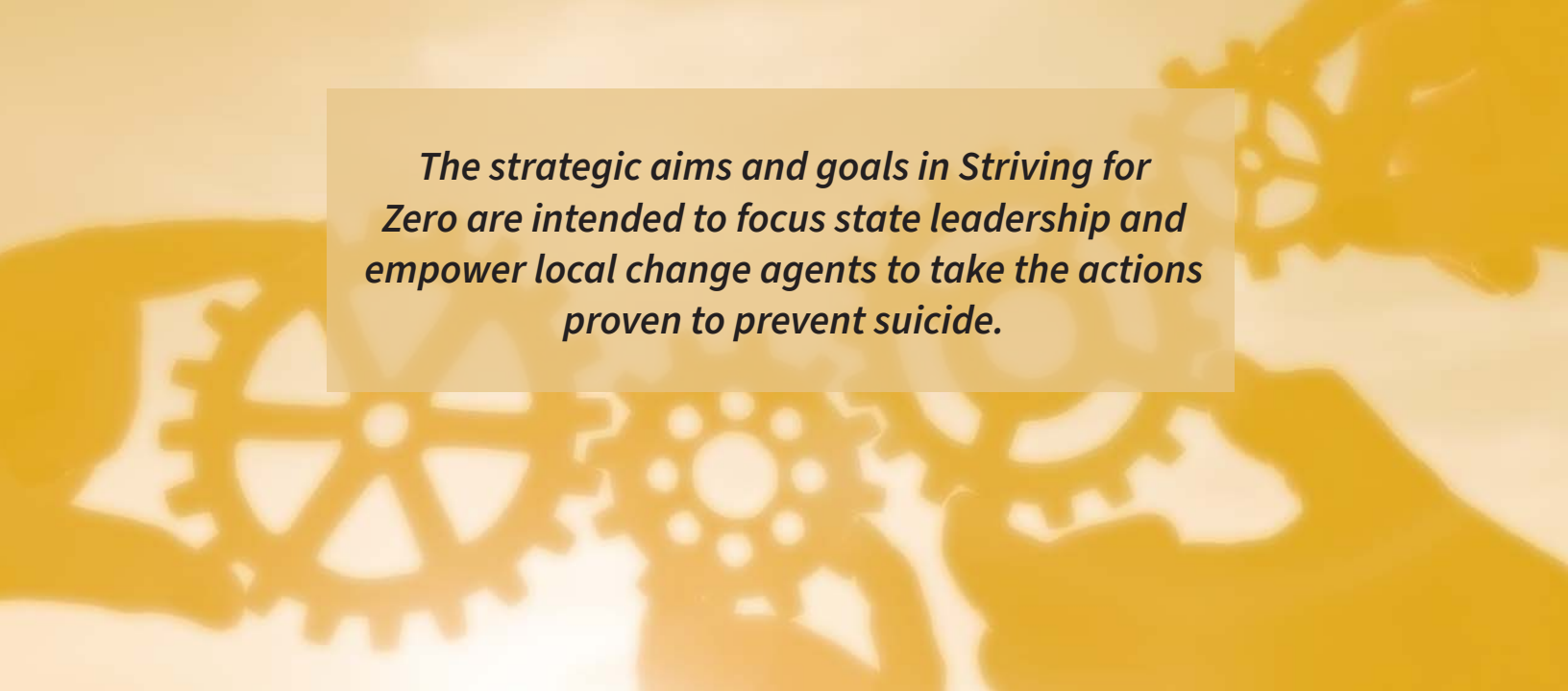
California’s Strategic Plan for Suicide Prevention

The first half of California’s Strategic Plan for Suicide Prevention outlines the strategic aims, goals, and actions needed to prioritize suicide prevention efforts across the state over the next five years, with the ultimate goal of no lives lost to suicide. These pages detail the tactics, or “how to” steps, that can help California communities effectively prevent suicide using contemporary best practices. The second half of the plan describes terms, theory, challenges, and evidence related to the coordinated delivery of suicide prevention efforts. Finally, the document concludes with a five-year workplan to implement state objectives that support local and regional efforts.

This document builds upon multiple ongoing state and local suicide prevention efforts. As part of those efforts, many resources have been developed to support implementation of best practices in suicide prevention. Over 100 suicide prevention reports, webinars, ads, posters, and public campaign resources can be found at Each Mind Matters Resource Center at <http://emmresourcecenter.org>.

For More Information or Resources, Visit These Sites:

- **Suicide Prevention Resource Center** | <http://www.sprc.org/>
- **Each Mind Matters** | <http://emmresourcecenter.org>
- **Know the Signs** | <https://www.suicideispreventable.org/>
- **National Suicide Prevention Lifeline** | www.suicidepreventionlifeline.org
- **National Action Alliance for Suicide Prevention** | <https://theactionalliance.org/>
- **American Association of Suicidology** | <https://suicidology.org/>
- **American Foundation for Suicide Prevention** | <https://afsp.org/>



The strategic aims and goals in Striving for Zero are intended to focus state leadership and empower local change agents to take the actions proven to prevent suicide.

Strategic Aims and Goals

California's Strategic Plan for Suicide Prevention establishes a foundation of suicide prevention directed by best practices for the benefit of state and local partners. Increasing the use of best practices in suicide prevention statewide is an achievable goal. But responsibility for success must be shared among private and public partners, and efforts must be driven by private and public data and resources, including human and fiscal assets. State funding should support key areas outlined in the report's action steps, which include establishing state leadership, delivering technical assistance, developing guidance, and fortifying and expanding data collection and reporting systems. To ensure sustainability, however, other public and private assets must be leveraged and continuously pursued.

The following pages present a roadmap to align local and regional efforts with state priorities in delivering best practices in suicide prevention. Local communities can start now to identify local health and behavioral health leaders, build coalitions, and identify data and information to understand and communicate the problem of suicidal behavior in their communities. Communities can then take the subsequent steps in the Public Health Model by identifying risk and protective factors; developing interventions and conducting evaluation; and disseminating effective practices.

Key Action Partners

To effectively reduce suicide, a broad range of partners must commit to integrate suicide prevention into their organizations' leadership, values, and work. Many are already fully engaged and are making a difference; many others will need to take on new responsibilities to help reduce the loss, pain, and suffering associated with suicide. Key action partners should be included in the planning and, when appropriate, implementation of suicide prevention objectives.

Below is a list of key action partners essential to *Striving for Zero*.

- People with lived experience with suicidal behavior (survivors of loss and attempt)
- Advocates, researchers, and providers working with vulnerable groups (youth, older adults, veterans, LGBTQ, firearm/violence prevention)
- Business sector (gun vendors, funeral directors, entertainment leaders, media representatives, other businesses identified via data collection)
- Coroners/Medical Examiners
- Criminal and juvenile justice (professionals, researchers, leaders)
- Education (school, college, and university administrators, teachers, counselors, staff)
- Faith-based communities (members and leaders)
- Families (parents, caregivers, others viewed as family)
- First responders
- Health, public health, and behavioral health care (researchers, leaders, providers, administrators)
- Tribal communities (leaders, traditional healers, advocates)

Plan Components

This plan serves as strategic guidance to equip local communities with information on best practices and areas of focus with the greatest potential for preventing suicide. The plan is organized using the following components:

- **Strategic aims** are broad areas of focus to reduce suicidal behavior.
- **Goals** accompany each strategic aim to help governments, community organizations, providers, and other partners to focus suicide prevention efforts using best practice approaches or interventions. These efforts are detailed in the Best Practice in Suicide Prevention section of this plan.
- **Desired outcomes and short-term targets** are identified under each goal. Measuring incremental steps and progress toward reaching each goal, while monitoring suicide data, will be critical.¹⁹ Desired outcomes, such as reduction in suicide or suicidal behavior, may or may not directly result from specific strategies and may take more than five years to achieve. Short-term targets are measurable direct results from the implementation of state and local objectives, and are anticipated to be achievable in less than five years – or the term of this plan.
- **Objectives** at the state, regional, and local levels are included under each goal and are listed to support planning. A five-year workplan for each state objective can be found beginning on page 77.

Plan Quick View

California's Strategic Plan for Suicide Prevention is framed by four strategic aims and 12 goals. Each goal statement embeds suicide prevention strategies and approaches with the greatest potential to prevent suicide in communities across the state. See the Best Practices in Suicide Prevention on page 65 section of this plan for more detail about the evidence of effectiveness.



STRATEGIC AIM 1: ESTABLISH A SUICIDE PREVENTION INFRASTRUCTURE

- Goal 1: Enhance visible leadership and networked partnerships
- Goal 2: Increase development and coordination of suicide prevention resources
- Goal 3: Advance data monitoring and evaluation



STRATEGIC AIM 2: MINIMIZE RISK FOR SUICIDAL BEHAVIOR BY PROMOTING SAFE ENVIRONMENTS, RESILIENCY, AND CONNECTEDNESS

- Goal 4: Create safe environments by reducing access to lethal means
- Goal 5: Empower people, families, and communities to reach out for help when behavioral health needs emerge
- Goal 6: Increase connectedness between people, family members, and community
- Goal 7: Increase the use of best practices for reporting of suicide and promote healthy use of social media and technology



STRATEGIC AIM 3: INCREASE EARLY IDENTIFICATION OF SUICIDE RISK AND CONNECTION TO SERVICES BASED ON RISK

- Goal 8: Increase detection and screening to connect people to services
- Goal 9: Deliver a continuum of crisis services within and across counties



STRATEGIC AIM 4: IMPROVE SUICIDE-RELATED SERVICES AND SUPPORTS

- Goal 10: Deliver best practices in care targeting suicide risk
- Goal 11: Ensure continuity of care and follow-up after suicide-related services
- Goal 12: Expand support services following a suicide loss





STRATEGIC AIM 1: ESTABLISH A SUICIDE PREVENTION INFRASTRUCTURE



1
STRATEGIC
AIM

GOAL 1: ENHANCE VISIBLE LEADERSHIP AND NETWORKED PARTNERSHIPS

Desired Outcome  Increased awareness and sustainability of suicide as a preventable public health priority.

Short-term Target  By 2025, state leadership is advancing suicide prevention as a public health priority, and all counties have leaders and coalitions engaged in suicide prevention efforts.

State Objectives

Objective 1a Establish centralized, visible state-level leadership by creating the Office of Suicide Prevention within the California Department of Public Health to provide strategic guidance, deliver technical assistance, develop and coordinate trainings, monitor data, conduct state-level evaluation, and disseminate information to advance statewide progress.

Objective 1b Engage private and public partners by creating the California Suicide Prevention Council to advance suicide prevention efforts with strategic planning and dissemination of best practices in their respective sectors.

Local and Regional Objectives

Objective 1c Establish leadership to provide clear direction for suicide prevention efforts and prioritize goals with maximal impact. Suicide prevention leadership may come from a coalition, a task force, or from health or behavioral health agencies or organizations.

Objective 1d Identify leaders who can champion suicide prevention as a public health priority. Leaders drive progress, develop and sustain relationships with partners, and help focus attention on suicide prevention as a core mission when faced with competing priorities.

Objective 1e Hold regularly scheduled meetings to convene stakeholders, prioritize suicide prevention activities based on data and community input, leverage resources to build capacity across systems and communities/regionally, and expand services based on effectiveness.


Objective 1f Formalize a coalition of private and public partners to advance suicide prevention efforts by being an “action arm” to local and regional leaders.²⁰ Private and public leaders should be brought together to leverage their influence to champion efforts prioritized in their own sectors.²¹ Within coalitions, sector-specific or strategy-specific subgroups should be created to focus expertise and keep members energized and engaged.²² Consistent logistical support, strategic guidance, technical assistance and other infrastructure should be provided to the coalition by local leadership.²³




1

STRATEGIC
AIM

GOAL 2: INCREASE DEVELOPMENT AND COORDINATION OF SUICIDE PREVENTION RESOURCES

Desired Outcome  Increase in coordination and integration of suicide prevention resources through planning and collaboration across diverse partners and systems.

Short-term Target  By 2025, all counties are working to prioritize suicide prevention and are implementing suicide prevention initiatives, which could include activities such as establishing a dedicated website listing local suicide prevention resources, forming coalitions, and creating strategic plans.

State Objectives

Objective 2a Accelerate the development and management of suicide prevention resources in communities across California, and support capacity building to use best practices in suicide prevention by disseminating guidance and resources.

Objective 2b Identify opportunities to integrate suicide prevention strategies across systems and programs. The state should promote communication and information sharing among private and public partners and provide guidance on incorporating suicide prevention messaging into diverse settings, strategies, and public health campaigns.

Objective 2c Align efforts and investments to address multiple forms of violence that may share risk and protective factors with suicide, including strategies for reducing trauma in early childhood.

Local and Regional Objectives

Objective 2d Develop a local suicide prevention plan and implementation strategy to prevent suicidal behavior across the lifespan and to address the goals outlined in the state's strategy, in addition to addressing local needs. Funding allocated to local behavioral health departments under the Mental Health Services Act can be used for suicide prevention planning, as well as developing and implementing strategies.

Objective 2e Map local and regional assets across sectors to coordinate resources and align funding priorities. Develop data that demonstrates how investments in specific suicide prevention strategies could lead to improved outcomes and cost savings in other areas, such as emergency services and healthcare. Assets may include programs or features of the community, such as safe and welcoming community spaces, parks, or centers. Assets can be mobilized through planning processes that identify underutilized community strengths, such as Asset-Based Community Development strategies.²⁴

Objective 2f Document the roles and responsibilities of each partner, and any data or funding streams associated with partners and their affiliation. Each partner has a role to play, and all partners bring potential for innovating common practices.


Objective 2g Integrate suicide prevention strategies into existing services being delivered through local settings, systems, and programs. Community health workers and in-home service providers, for example, should be trained to recognize warning signs of suicide and able to connect people at risk to care or crisis services.


Objective 2h Leverage partnerships through a coalition (see Goal 1) to identify shared prevention goals across diverse settings and communities, such as education, child welfare, social services, health care, and justice settings. These partners may share goals with suicide prevention for reducing risk and increasing protective factors, such as creating safe and active communities to reduce social isolation. All can be leveraged to reduce suicidal behavior and meet other goals for health and wellness promotion.



1
STRATEGIC
AIM

GOAL 3: ADVANCE DATA MONITORING AND EVALUATION

Desired Outcome  Increase in the use of standardized data to guide suicide prevention state and local policy and planning, resource management, and investment.

Short-term Target  By 2025, 80 percent of all suicide deaths are electronically entered into the California Violent Death Reporting System and communities are using publicly available, timely aggregated data to strengthen suicide prevention strategies.

State Objectives

Objective 3a Establish centralized electronic reporting systems to capture data related to suicide deaths and suicidal behavior. The systems should include data by demographics—such as race/ethnicity, age, sex, gender identity, and sexual orientation—as well as vulnerable group membership, such as military service and women in the perinatal and postpartum period. Uniform coding procedures should be used.

Objective 3b Develop a data monitoring and evaluation agenda on suicide deaths and suicidal behavior, including data elements documenting interrupted or aborted suicide attempts and crisis service interventions (“save data”) that resulted in the de-escalation of desire and intent to die by suicide. The agenda should include guidance to support state and local data and information sharing, including methods for sharing confidential information among diverse partners while adhering to state and federal privacy and security laws.

Objective 3c Standardize policies and procedures for investigating and reporting suicide as a cause of death. These should include uniform definitions of suicide, as well as protocols for working with suicide loss survivors and informing health officials in the context of a suicide cluster. Such protocols should include clear requirements for how cause of death is determined, how investigations are conducted, and how information is reported, and by whom, within a certain time following death. The procedures also should include training on methods for minimizing misclassification and accelerating timely reporting.

Local and Regional Objectives

Objective 3d Use local data and information to define the problem of suicidal behavior, identify factors that increase or lessen risk for suicide, develop interventions, conduct evaluations, and disseminate effective preventive practices.

Objective 3e Use suicide death and attempt data to evaluate the proportion of suicidal behavior that results in death. The results should be used to identify high-risk groups, target them with selective prevention strategies, and focus resources on specific lethal means restriction strategies.

Objective 3f Consider the use of death review teams for clinical and forensic review of suicide deaths. Team members should include representatives of coroners and medical examiners, law enforcement, subject matter experts, and others with legal access to confidential information. Data compiled by the team should be used to support prevention goals using the Public Health Model.

Objective 3g Partner with coroners, medical examiners, and local health department representatives to identify and eliminate barriers to the electronic reporting of suicide death data into the California Violent Death Reporting System. The effort should enable access to data to strengthen suicide prevention, while establishing policies and procedures to protect privacy.

Objective 3h Use anonymous community surveys to fill data gaps. For example, people with non-fatal, self-directed violence may not seek medical attention following the injury, thereby reducing the number of such reports.²⁵ Communicate that help is available by listing or displaying suicide prevention resources directly on the survey.

Objective 3i Build relationships with local colleges and universities and identify capacity for research to support local and state suicide prevention goals.




STRATEGIC AIM 2: MINIMIZE RISK FOR SUICIDAL BEHAVIOR BY PROMOTING SAFE ENVIRONMENTS, RESILIENCY, AND CONNECTEDNESS




2

STRATEGIC
AIM

GOAL 4: CREATE SAFE ENVIRONMENTS BY REDUCING ACCESS TO LETHAL MEANS

Desired Outcome  Decrease in suicides and initial and subsequent intentional self-harm hospital visits.

Short-term Target  By 2025, all counties are using data and information to develop and implement targeted lethal means restriction strategies to prevent suicidal behavior and are measuring effectiveness.

State Objectives

Objective 4a Create a research and policy agenda to advance the goal of creating safe environments by reducing access to lethal means.

Objective 4b Monitor state-level trends in lethal means used for suicidal behavior and develop a statewide strategy for technical assistance to expand efforts to reduce access to the lethal means identified.

Objective 4c Disseminate information regarding federal funding available to support suicide barriers in the design or redesign of bridges and other sites where deaths by suicide may occur.

Local and Regional Objectives

Objective 4d Use the Public Health Model to evaluate risk and identify the methods of suicidal behavior used by community members and by specific demographic (such as race/ethnicity, age, sexual orientation, and gender identity) and cultural groups to guide development of focused prevention efforts. Once identified, develop tailored means restriction strategies and evaluate impact.

Objective 4e Promote safe medication disposal methods in the community or through pharmacies and other health care providers, including activities such as “take back” campaigns led by local public health departments that help people dispose of unused or expired medications. Partner with local pharmacies to increase the availability of methods to dispose of unused medication and highlight suicide and overdose prevention resources for people filling prescriptions.

Objective 4f Disseminate information to local gun shop and range owners to increase awareness of suicide prevention efforts, suicide warning signs, and available resources. Partner with local firearm safety trainers to incorporate suicide prevention awareness into trainings. Invite local gun shop and range owners to join local coalitions. Partner with law enforcement to guide dissemination of lawful options for temporarily transferring firearms for storage in times of suicide crisis or when Gun Violence Restraining Orders apply.²⁶ Resources to support this strategy can be found here: <https://emmresourcecenter.org/resources/suicide-prevention-gun-shop-activity>.

Objective 4g Disseminate information through local health departments to community partners about available overdose prevention resources, methods, and medications to counteract overdose, such as naloxone for opioid overdose.

Objective 4h Form regional and local workgroups composed of community members, first responders, transportation representatives, coroners and medical examiners, and crisis service providers to identify specific sites in the community frequently used for suicide, or those that provide the opportunity for suicide.

- These sites can be in the built environment or natural sites. Common types of sites include buildings, bridges, and train railways. Characteristics communities should consider in identifying sites are places that provide the opportunity for a person at risk to fall from a height and sites from which falling would place a person in front of a moving vehicle, such as a train. More than one suicide at a site should raise safety concerns.
- Once sites are identified, develop and implement plans to construct barriers to deter or prevent falling. Consider the benefits and risks of installing signs that list crisis services resources, such as suicide prevention hotline information, and provide positive, life-affirming messages. One risk, for example, could be drawing attention of people at risk to a particular site.


Objective 4i Create agreements among local bridge and rail authorities, first responders, and crisis services providers to collect data documenting events in which people were prevented from falling, any services they received and the outcomes. Include reporting requirements, such as biannual or quarterly reports.




2

STRATEGIC
AIM

GOAL 5: EMPOWER PEOPLE, FAMILIES, AND COMMUNITIES TO REACH OUT FOR HELP WHEN BEHAVIORAL HEALTH NEEDS EMERGE

Desired Outcome  Increase behavioral health service utilization and reduce unmet behavioral health need as assessed by the California Health Interview Survey.

Short-term Target  By 2025, all counties have peer support providers trained in suicide prevention integrated into local outreach and engagement services and programs.

State Objectives

Objective 5a Create a research and policy agenda to advance the goal of empowering people, families, and communities to reach out for help when behavioral health needs emerge.

Objective 5b Integrate social-emotional learning programs into private and public education curricula to strengthen communication and problem-solving skills, emotional regulation, and conflict resolution skills among children and youth.

Local and Regional Objectives

Objective 5c Identify community needs and expand community-based services for managing stressors and building resiliency, which may include coping skills, critical thinking, stress management, conflict resolution, and problem-solving skills. Expand community-based services to include activities that increase life skills, including mindfulness practices, critical thinking, stress management, conflict resolution, problem-solving, and coping skills; tailor activities based on age group and setting, and according to how different groups experience and mitigate stress. Cultural models of suicide can clarify how culture affects the experiences of stressors, the cultural meaning of stressors, and how different cultures express suicidal behavior.²⁷

Objective 5d Expand outreach and engagement strategies to promote behavioral health and community services and resources. To do this, identify barriers that community members face in seeking services for behavioral health needs, and develop strategies to make services more accessible, convenient, and culturally respectful to increase the likelihood people will pursue and stay connected to such services.

Objective 5e Partner with community organizations and businesses to expand awareness of suicide warning signs and prevention resources. Coordinate suicide prevention awareness campaigns with other social marketing campaigns designed to reduce mental health stigma and discrimination and reduce relevant public safety threats, such as misuse of medication or unsafe gun storage practices.

Objective 5f Expand services to increase mental health literacy across the lifespan, encourage people to seek help for health and behavioral health needs, and promote messages of hope that lives can be saved from suicide.


Objective 5g Develop a network of peer support providers to help people navigate health and behavioral health care systems. Peer support providers are people with lived experience with suicidal behavior or behavioral health needs. Assess the importance of ensuring cultural congruency between people with lived experience and a target audience, such as youth helping youth or veterans helping veterans. Ensure youth peers have clear and easy pathways to caring adults who can help them navigate their options. Create a transparent feedback loop to encourage peer support providers to identify ways health and behavioral health systems can be more responsive to people at risk for suicide.




2

STRATEGIC
AIM

GOAL 6: INCREASE CONNECTEDNESS BETWEEN PEOPLE, FAMILY MEMBERS, AND COMMUNITY

Desired Outcome  Increase in reported school connectedness among public school students in grades 7, 9, and 11 as assessed by the California Healthy Kids Survey.

Short-term Target  By 2025, all counties have suicide prevention strategies that include community-based services intended to reduce social isolation and strengthen relationships between people and their families, friends, and caregivers and are measuring effectiveness of services.

State Objectives

Objective 6a Create a research and policy agenda to advance the goal of increasing connectedness between people, family members, and community.

Objective 6b Identify and promote opportunities to foster positive and supportive relationships.

Local and Regional Objectives

Objective 6c Increase services intended to build positive attachments between children, youth, their families, other adults, and social supports in their community to increase a sense of belonging, strengthen a sense of identity and personal worth, and provide access to larger sources of support. Social support can be found in schools, faith-based communities, cultural centers, and other community-based organizations.

- Tailor strategies to be responsive to needs based on age and culture. For example, create social support groups, led by veterans or active-duty members of the military, which allow military service members to safely share their experiences; disseminate talk-based warmline phone numbers targeting older adults to reduce feelings of isolation and loneliness; and use communication methods relevant to an older population, such as advertising in health care settings or through traditional media.

Objective 6e Promote a culture free of stigma and discrimination by allowing for an open dialogue about mental health and mental health resources, and by delivering supportive messages of hope and recovery for people with behavioral health needs. Establish policies and methods for enforcement to create cultures that support healthy lifestyles and environments that are affirmative and that prevent violence, including bullying and discrimination.

Objective 6f Identify opportunities to integrate suicide prevention strategies into services intended to reduce other forms of violence, such as child and elder maltreatment. These forms of violence may share risk and protective factors with suicidal behavior. For example, reducing interpersonal stress and teaching conflict resolution skills among at-risk families has the potential to increase a sense of connectedness and protect against suicide.


Objective 6g Partner with community-based organizations to build and promote opportunities for volunteerism to increase connectedness and a sense of purpose.




2

STRATEGIC
AIM

GOAL 7: INCREASE USE OF BEST PRACTICES FOR REPORTING OF SUICIDE AND PROMOTE HEALTHY USE OF SOCIAL MEDIA AND TECHNOLOGY

Desired Outcome  Reduce events referred to as “suicide clusters,” when multiple suicides occur within a particular time period or location, especially among youth.

Short-term Target  By 2025, all counties are conducting activities to increase awareness of best practices for reporting suicide to local media partners. Activities could include offering informational sessions, posting information online, and holding informational sessions.

State Objectives

Objective 7a Create a research and policy agenda to advance the goal of increasing use of best practices in reporting of suicide and to promote healthy use of social media and technology.

Objective 7b Increase awareness of best practices for reporting on suicides by collaborating with journalism associations and organizations to disseminate information and resources to journalism and media partners.

Objective 7c Integrate into college and university journalism curricula best practices for communicating about suicide through various forms of media and entertainment.

Objective 7d Identify and disseminate best practices for using and consuming social media and technology to improve wellbeing, destigmatize mental health needs, and increase help-seeking for behavioral health services.

Local and Regional Objectives

Objective 7e Identify media and entertainment industry partners and deliver training on best practice guidelines for reporting about suicide. Identify local public information officers and spokespeople, including first responders and law enforcement officials, and deliver training in best practices for messaging following a suicide.

Objective 7f Disseminate information found online at <http://reportingonsuicide.org/> and <http://suicidepreventionmessaging.org/> to members of the media – reporters, editors, and producers – regarding how risk is conferred and to improve understanding of guidelines supporting suicide prevention on a broad scale. Resources to support this strategy can be found here: <https://emmresourcecenter.org/resources/making-headlines-guide-engaging-media-suicide-prevention-california>.

Objective 7g Partner with members of media to disseminate information about resources, encourage people to seek help for behavioral health needs, and reduce stigma and discrimination that may prevent people from accessing services and supports. Entertainment media include film, television, podcasts, music, and theater.

Objective 7h Disseminate information about how suicide risk can effectively be expressed by people on various social media sites and highlight social media resources for identifying and reporting concerns about content. Most social media sites now have a method for reporting content that raises alarms.

Objective 7i Integrate into public campaigns and health and mental health curriculum in schools best practices for developing healthy social media habits and using social media in a way that promotes connectedness to reduce isolation.

Objective 7j Minimize the circulation of misinformation by creating communication strategies for use in the event of a suicide – including pre-existing agreements with media partners. Include a formal strategy for managing information on the most used social media sites and monitor social media posts by others related to the suicide death.



STRATEGIC AIM 3: ENHANCE EARLY IDENTIFICATION OF SUICIDE RISK AND INCREASE ACCESS TO SERVICES BASED ON RISK




3

STRATEGIC
AIM

GOAL 8: INCREASE DETECTION AND SCREENING TO CONNECT PEOPLE TO SERVICES BASED ON SUICIDE RISK

Desired Outcome  Decrease in suicidal behavior and increase in connection to services based on risk.

Short-term Target  By 2025, all people screened for suicide in health care settings are connected to services necessary to reduce risk and increase factors that protect against suicide, and receive brief interventions (if applicable).

State Objectives

Objective 8a Create a research and policy agenda to advance the goal of increasing detection and screening to connect people to services based on suicide risk.

Objective 8b Adopt the Zero Suicide Initiative within health and behavioral health care systems

Objective 8c Expand resources to support health care providers increase access and linkage to behavioral health services and culturally appropriate support services for people identified as needing such services. This strategy includes providers in correctional settings.

Objective 8d Increase standardized training offered to health and behavioral health care providers in suicide risk assessment and management best practices. Enhance uniform suicide risk assessment and management in health and behavioral health care settings to align with Joint Commission guidelines and the Zero Suicide Initiative. Such settings include state and local correctional facilities.

Objective 8e Invest in technology in health and behavioral health care systems to improve uniform suicide risk assessment and management. Goals include identifying people at risk and triaging those at risk into appropriate services and culturally appropriate support.

Local and Regional Objectives

Objective 8f Deliver suicide prevention training to people who are in positions to identify warning signs of suicide and refer those at risk to behavioral health services and culturally appropriate supports. Support youth gatekeepers by identifying trusted adults who can help them with next steps once a young person is identified as at risk. Provide people the opportunity to reinforce knowledge and skills acquired during training through periodic booster sessions. Build capacity and sustainability for suicide prevention training across systems using train-the-trainer models or evidence-based online trainings.

- Consider the intensity of training needed and offer a variety of sessions to expand capacity and meet varied demand. For example, in a school setting, teachers, administrators, and other school personnel might receive brief trainings on suicide prevention awareness. Selected teachers, especially those who lead youth groups, and counselors might receive intensive trainings focused on how to deliver brief interventions.

Objective 8g Screen people seen in health and behavioral health care settings for suicide risk and deliver best practices in suicide risk assessment and management to those who screen positive for risk. Such settings include state and local correctional facilities.

- Suicide screenings can follow positive results on other screening tools. For example, screening specific to suicide risk should follow positive screens for depression, anxiety, trauma, physical pain, and problem alcohol, drug use, and eating. Comprehensive suicide risk assessments follow screening.
- The Joint Commission recommended the use of screening and assessment tools that include the following: Ask Suicide Screening Toolkit (ASQ) by the National Institute of Mental Health; the Columbia—Suicide Severity Rating Scale (C-SSRS) Triage Version; Patient Health Questionnaire 9 (PHQ-9) Depression Scale; Suicide Behavioral Questionnaire Revised; Scale for Suicidal Ideation-Worst; and the Beck Scale for Suicide Ideation.²⁸

Objective 8h Integrate best practices in suicide risk assessment and management in health and behavioral health care settings and workflows. Create uniform policies and procedures to make screening, assessments, and decision-making routine. Clarify billing methods for services.

Objective 8i Deliver training to key action partners for conducting suicide screening in community-based settings when a person is identified as exhibiting warnings signs or communicating a desire to die. The Columbia-Suicide Severity Rating Scale has been adapted to meet the needs of diverse settings and populations and can be accessed for free here: <http://cssrs.columbia.edu/>.


Objective 8j Train first responders and other personnel patrolling or monitoring community sites used for suicidal behavior, such as bridges and railways. The training should include how to identify warning signs, use de-escalation techniques, and disseminate information on local suicide prevention resources, including crisis hotline numbers. Consider pairing first responders with trained behavioral health or crisis service providers to deliver interventions, if needed.



3

STRATEGIC
AIM

GOAL 9: PROMOTE A CONTINUUM OF CRISIS SERVICES WITHIN AND ACROSS COUNTIES

Desired Outcome  Increase in linkage to community-based services for people experiencing suicidal behavior and their families and caregivers.

Short-term Target  By 2025, 80 percent of all crisis services providers are trained in suicide prevention and are referring people in distress to community-based services based on risk assessments.

State Objectives

Objective 9a Develop and implement a strategy to coordinate the delivery of crisis services, including an assessment of current crisis services infrastructure and private and public funding for services.

Objective 9b Create a research and policy agenda to advance the goal of promoting a continuum of crisis services within and across counties.

Objective 9c Create uniform standards for suicide and crisis hotlines in the state, including standards for training and core competencies for call responders; protocols for performance and quality assurance monitoring; and procedures for making referrals to services, including emergency services.

Local and Regional Objectives

Objective 9d Evaluate the continuum of crisis services available through private and public resources and identify gaps in the continuum, such as warm lines to reduce loneliness and isolation and access lines to connect people to local resources. Identify potential funding sources within each region of the state.

Objective 9e Promote the use of crisis services as alternatives to hospitalization and as a resource to support people in distress, by advertising crisis hotline and warmlines numbers and other methods. Deliver suicide prevention training to all providers of such services.

Objective 9f Disseminate information on available crisis service resources to health and behavioral health care partners. Encourage these partners to include crisis services in safety plans developed through an alliance between partners and people at risk.

Objective 9g Create memorandums of understanding between systems of care and community-based crisis services to provide follow-up for people transitioning out of care systems, including protocols for protecting the confidentiality of people at risk. Health and behavioral health care systems should have protocols in place for obtaining consent for follow-up care from people at risk. To coordinate efforts, document clear methods of communication between crisis service providers and other systems, such as community corrections, child welfare, and veterans' services.





STRATEGIC AIM 4: IMPROVE SUICIDE-RELATED SERVICES AND SUPPORTS



4
STRATEGIC
AIM

GOAL 10: DELIVER BEST PRACTICES IN CARE TARGETING SUICIDE RISK

Desired Outcome  Decrease in suicidal behavior as measured by intentional self-harm data reported by hospitals.

Short-term Target  By 2025, 50 percent of licensed behavioral health care providers have received standardized training in best practices in suicide risk assessment and management and in interventions specific to preventing suicide.

State Objectives

Objective 10a Create a research and policy agenda to advance the goal of delivering best practices in care targeting suicide risk.

Objective 10b Create a process to certify providers trained in delivering best practices in suicide risk assessment and management and in interventions specific to preventing suicide. Certification could include minimum education, training, and continuing education requirements, and should include a review and approval process. This strategy includes providers in correctional settings.

Objective 10c Create a strategy to increase health and behavioral health care workforce capacity to deliver suicide-related services.

Local and Regional Objectives

Objective 10d Expand the use of telehealth and telemedicine providers with training in best practices for suicide-related treatment - especially in rural communities - to enhance timely access to care targeting suicide risk.

Objective 10e Promote safety planning by prompting health and behavioral health care providers to record safety plans in electronic medical record systems and by making plans accessible to people via commonly used portals.²⁹

Objective 10f Create a local online, public directory that lists providers delivering suicide-related treatment and includes information about insurance eligibility and criteria for new clients.

Objective 10g Partner with health and behavioral health care systems and providers to improve delivery of services and supports to caregivers and family members of people transitioning from care settings following services for suicidal behavior. The efforts should prioritize safety and address service gaps. People at risk should be key decision-makers in defining support networks and the role each member of the network plays in creating safety and recovery.


Objective 10h Disseminate information to caregivers and family members on how to support a person at risk by serving as a resource identified by the person in safety planning; how to reduce environmental safety risks by promoting means safety, especially at home; and how to help manage harmful behaviors stemming from underlying health and behavioral health needs, such as escalating alcohol or drug use.




4

STRATEGIC
AIM

GOAL 11: ENSURE CONTINUITY OF CARE AND FOLLOW-UP AFTER SUICIDE-RELATED SERVICES

Desired Outcome  Reduce subsequent suicidal behavior among people discharged from emergency departments and hospital settings after suicide-related services.

Short-term Target  By 2025, all people prior to being discharged from emergency departments and hospital settings after receiving suicide-related services create a plan for follow-up care and contact over a 12-month period or more, as needed.

State Objectives

Objective 11a Create a research and policy agenda to advance the goal of ensuring continuity of care and follow-up after suicide-related services.

Objective 11b Establish a program to deliver training on lethal means restriction counseling to health care providers, and distribute gun and medication lock boxes and locks to hospitals, with prioritized distribution to families and caregivers of people being discharged following a suicide attempt.

Objective 11c Ensure delivery of best practices for continuity of care following discharge after suicide-related services in emergency departments and hospital settings, including the routine, standardized use of follow-up cards, texts, and emails.

Local and Regional Objectives

Objective 11d Increase the use of electronic health records to document a person's safe transition to another provider, and ensure life-saving information is transmitted, while protecting the person's privacy.

Objective 11e Facilitate safe and timely care transitions by providing linkages to culturally and linguistically appropriate outpatient behavioral health providers, crisis services, safety planning or crisis response planning, and by reducing access to lethal means.

Objective 11f Disseminate to emergency department administrators the *Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments* found at http://www.sprc.org/sites/default/files/EDGuide_full.pdf, along with the *Quick Guide for Clinicians* found at http://www.sprc.org/sites/default/files/EDGuide_quickversion.pdf, to increase awareness of safe discharge practices for people seen for suicide-related services.

Objective 11g Train health care providers to deliver lethal means counseling to family members and caregivers supporting people who are discharged from a health care setting after suicidal behavior.

Objective 11h Disseminate information on lethal means counseling to health care providers across hospital settings. Prioritize providers who predominantly serve at risk-groups or work in high-risk settings, such as emergency departments. Promote free online training, such as Counseling on Access to Lethal Means available at <https://training.sprc.org/>, and the use of online toolkits, such as <https://health.ucdavis.edu/what-you-can-do/>.

Objective 11i Create uniform policies and procedures for safely transitioning people or students back into the workforce and home or school following a suicide attempt, suicide, or hospitalization for a behavioral health crisis.

Objective 11j Create uniform policies and procedures to connect people released from correctional settings who have been identified as at risk for suicide, or who were receiving suicide-related services in custody, to appropriate services in the community. Include a standardized process for transferring confidential data and information.

Objective 11k Create uniform policies and protocols to support health and behavioral health care providers in the creation or revision of safety plans for persons at risk. Examples include uniform procedures for establishing a connection between the person and a new provider; policies ensuring timely delivery of information to the new provider; and policies addressing the importance of follow-up within 24 to 48 hours of the transition. Create memorandums of understanding among local crisis service providers to establish relationships with people prior to discharge and ensure follow-up after discharge.


Objective 11l Create uniform protocols for counseling people discharged from emergency departments and hospitals after receiving suicide-related services on restricting access to lethal means. Families and caregivers should be included in such counseling.




4

STRATEGIC
AIM

GOAL 12: EXPAND SUPPORT SERVICES FOLLOWING A SUICIDE LOSS

Desired Outcome  Reduce the amount of time between a suicide loss and access to bereavement services specifically designed to meet the needs of suicide loss survivors.

Short-term Target  By 2025, all counties have written policies and procedures for coordinated, timely, and respectful responses by service providers following a suicide loss, including formal agreements with local coroners and medical examiners to support the initiation of services.

State Objectives

Objective 12a Create a research and policy agenda to advance the goal of expanding support services following a suicide loss.

Objective 12b Assess and expand effective resources available to suicide loss survivors and develop capacity statewide to deliver appropriate and respectful services following a suicide loss. The resources should include information and training for bereavement service providers on topics specific to suicide and to grief that is unique to suicide loss.

Objective 12c Ensure written postvention – a planned response for the delivery of services after a suicide - policies and procedures are developed, adopted, and disseminated to staff in all settings where people are receiving behavioral health services and supports.

Local and Regional Objectives

Objective 12d Develop an integrated postvention services plan to guide delivery of best practices following a suicide loss. The plan should tailor strategies to settings and cultures, including schools, workplaces, faith communities, hospitals and health care settings, tribal communities, and correctional facilities. The plan should identify a lead agency or organization responsible for ensuring adequate capacity, training, and effectiveness in the delivery of activities that support survivors, service providers, and community members after a suicide loss. Enter into agreements that contain clearly defined roles and procedures to increase the effectiveness of coordinated responses, such as procedures for sharing private information and data based on the role of each provider. Resources to guide creation of a community postvention response can be found here: <https://www.cibhs.org/pod/after-rural-suicide>.

Objective 12e Develop an online bereavement toolkit consisting of community- specific resources. Partner with hospitals, first responders, funeral directors, faith-based communities, and coroners and medical examiners to distribute the toolkit in print or via web links. Resources to support funeral directors' participation in this strategy can be found here: <https://www.sprc.org/resourcesprograms/help-hand-supporting-survivors-suicide-loss-guide-funeral-directors>.

Objective 12f Provide training to first responders, crisis service providers, and access line responders on best practices in supporting suicide loss survivors, from understanding their unique needs to helping them access resources.

Objective 12g Create local suicide bereavement support programs or expand capacity and sustainability of existing programs using *Pathways to Purpose and Hope*, found at <https://emmresourcecenter.org/resources/pathways-purpose-and-hope-guide-creating-sustainable-suicide-bereavement-support-program>.

Objective 12h Expand support services designed and facilitated by survivors of suicide loss. Train survivors of suicide loss to speak safely and effectively about their loss and create a local speakers bureau to give a forum for survivors to deliver suicide prevention messaging to the public. Provide training for suicide loss survivor service facilitators and create opportunities for service facilitators to support each other, including group debrief sessions.

Objective 12i Enter into memorandums of understanding with coroners and medical examiners to establish coordinated, timely, and respectful responses following a suicide loss, and establish policies and protocols to govern activities in the event of a suicide. Components should include how information is shared, and with whom, and how the privacy of families is respected, including a process for determining how and when to reach out to family members with resources and support. This strategy includes people who die by suicide in correctional or hospital settings.



Striving for Zero incorporates the latest science regarding suicide and its prevention and the experiences and insights of California's communities.

Plan Development

With Assembly Bill 114 (Chapter 38, Statutes of 2017), the California Legislature directed the Mental Health Services Oversight and Accountability Commission to develop a statewide strategic suicide prevention plan. The Commission began the work in early 2018 by forming a Suicide Prevention Subcommittee, which included Commissioners Tina Wooton (Chair), Khatera Tamplen, and Mara Madrigal-Weiss.

Community Engagement and Site Visits

The Commission organized a series of meetings and events to help members better understand challenges in suicide prevention and identify opportunities for improvement. The gatherings were designed to engage Californians in a discussion about suicide and its prevention and to ensure that statewide planning reflected the state's unique cultural, ethnic, linguistic, and economic diversity. Open to the public, the meetings sought to incorporate a broad range of perspectives to support the development of shared knowledge to advance strategic planning. Please visit www.mhsoac.ca.gov for a full list of community engagement activities and summaries from events.

The Subcommittee held meetings in Fresno, Sacramento, San Diego, and Shasta counties to hear presentations on local suicide prevention initiatives and explore with community members the challenges and opportunities surrounding suicide prevention. Several priority areas emerged from these meetings: the urgency of early identification of suicide risk; the need for better methods to reduce isolation; the lack of access to appropriate services; and the importance of leveraging partnerships to build capacity. At two public hearings, the Commission explored these and other issues with suicide loss and attempt survivors, providers, researchers, and other subject matter experts, and heard recommendations for closing gaps in data collection, service delivery, and training and education.

The Commission also convened workshops and forums designed to gather perspectives from communities affected by suicide in ways that are not well documented by data, groups such as youth, first responders, and people from diverse cultural backgrounds. A common finding from these events was that suicide prevention efforts are most effective when they are culture-specific and include planning and delivery by people from the at-risk group. In addition, project staff participated in the City of Los Angeles Mayor's Challenge to Prevent Suicide,³⁰ and heard input from members of the California Department of Education's Student Mental Health Policy Workgroup, Indian Health Services, California Rural Indian Health Board, and many other organizations.

The Commission also visited several sites to explore opportunities for suicide prevention. These included the Rancheria Health Center and Counseling and Recovery Engagement Center in Shasta County, UCSF Benioff Children's Hospital in Alameda County, and the Golden Gate Bridge.

Research and Subject Matter Expert Consultation

As part of its research for this report, project staff met with local and national leaders in suicide prevention. Staff worked with representatives of departments under the California Health and Human Services Agency as well as other government and private partners. These included behavioral health, public health, law enforcement, and education officials as well as representatives of foundations, nonprofit organizations, the healthcare industry, and other businesses. Staff also engaged with national leaders from the American Foundation for Suicide Prevention, National Zero Suicide Initiative, National Action Alliance for Suicide Prevention, Suicide Prevention Resource Center, Centers for Disease Control and Prevention, U. S. Substance Abuse and Mental Health Services Administration, and Suicide Awareness Voices of Education. Staff participated in a national convening of behavioral health and suicide prevention experts and attended a training on the Zero Suicide Initiative.

Finally, the Commission conducted a critical review of the latest research on suicide prevention best practices and consulted national and global frameworks for preventing suicide, including:

- The 2012 National Strategy for Suicide Prevention, developed by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention
- Public Health Action for the Prevention of Suicide: A Framework (2012) and Preventing Suicide: A Global Initiative (2014) by the World Health Organization
- Preventing Suicide: A Technical Package of Policy, Programs, and Practices by the Centers for Disease Control and Prevention

The Commission contracted with content experts at Stanford University to provide technical guidance on research and best practices in suicidology and public health strategy. Suicidologist Dr. Rebecca Bernert led the team of technical advisors, which included Drs. Keith Humphreys and Shashank V. Joshi.

Previous Suicide Prevention Plan

Development of this suicide prevention blueprint included a review of the state's previous plan. In September 2006, Governor Arnold Schwarzenegger directed the former Department of Mental Health to develop a statewide strategic suicide prevention plan. It was approved by the Governor's Office on June 30, 2008, but many of the recommendations were not fully implemented. The new plan retains much of what was proposed, with updated best practices in means restriction, health care, and data monitoring and evaluation. Key advancements directed by the previous plan – some of which were partially implemented – are briefly highlighted below.

Leadership

The 2008 plan called for a dedicated state office to provide coordination and collaboration across the state. The Office of Suicide Prevention was established by the Department of Mental Health, but was transferred and reorganized into the Suicide Prevention Program after the department was closed in 2012.³¹ The program is currently housed within the Department of Health Care Services.³² Core functions of the office, such as convening regional meetings, disseminating resources to county suicide prevention liaisons, and coordinating suicide prevention activities to advance the goals under the plan, have since ended.

Guidance for Policy and Practice

Local suicide prevention activities have expanded since 2008, largely through funding with Mental Health Services Act (MHSA) dollars. A portion of the funding is directed toward the prevention of the consequences of unmet mental health needs, including suicide. County behavioral health departments use this funding to reduce risk factors for mental health needs through “prevention programs” and “early intervention programs,” and by initiating suicide prevention efforts that prevent suicide as a consequence of mental health needs.³³ Local behavioral health departments spent over \$13 million during fiscal year 2016-2017 on suicide prevention activities, including suicide prevention hotlines, gatekeeper training, depression screening for older adults, and services supporting suicide loss survivors.³⁴

Several counties have suicide prevention plans and local task forces or collaboratives with multi-disciplinary partners that are working together to prevent suicide. Counties with local plans include Contra Costa, Fresno, Kings, San Diego, San Mateo, Santa Clara, Solano, Tulare, and Tuolumne. Counties that have local collaboratives include Contra Costa, Fresno, Kings, Los Angeles, Napa, Nevada, San Diego, San Mateo, Shasta, Solano, Tulare, Tuolumne, and Ventura. Other counties, such as Marin, Santa Cruz, and Stanislaus, are in the planning phase. For example, Stanislaus County was approved to use MHSA Innovation funding to use collective impact principles to develop a local suicide prevention plan but does not have a plan in place at this time.³⁵

California public schools with students in grades seven through 12 are required to develop a "Pupil Suicide Prevention Policy." The policy must be created in consultation with school and community stakeholders, school-employed mental health professionals, and suicide prevention experts, and must include procedures related to suicide prevention, intervention, and postvention. All policies were to be in place by the 2017-2018 school year. A review conducted in 2018 by the Trevor Project found that 86 percent of schools that are required to have plans have them in place, leaving approximately 69 schools without plans.³⁶

Local and state correctional officials have made significant changes to suicide prevention efforts in custodial settings. Each local correctional facility is required to have a comprehensive suicide prevention program to identify, monitor, and deliver services to people at risk of suicide.³⁷ The program must include suicide prevention training, screening at intake, processes for facilitating coordination between staff and health care providers, housing considerations to reduce access to lethal means, supervision, reporting requirements, and an administrative review process for suicide and suicidal behavior.³⁸ Changes to regulations effective July 1, 2020 require two to four hours of suicide prevention training for all correctional and probation officers.³⁹

In 2017, the California State Auditor issued a report calling for more transparency of suicide and suicide attempt in state correctional facilities.⁴⁰ The following year, legislation was passed to require the California Department of Corrections and Rehabilitation to submit to the Legislature an annual report on the department's efforts to prevent suicide and suicide attempt among inmates.⁴¹ The department must include progress toward the goals of conducting risk assessments, delivering suicide prevention training to staff, and reducing risk factors associated with suicide, among other objectives.⁴² There is no statewide effort in place to evaluate these changes.

Training and Workforce Enhancements

Another goal of the 2008 plan was to develop and implement training and workforce enhancements to prevent suicide. Legislation passed in 2017 required licensed psychologists to receive no less than six hours of training in suicide risk assessment and intervention by 2020.⁴³ Additional legislation was passed in 2018 to extend this requirement to mental health professionals licensed by the Board of Behavioral Sciences.⁴⁴ In addition to increased training for clinicians, the Legislature allocated \$1.7 million for one-time general funding for online suicide prevention training for all public middle and high school students and staff in California.⁴⁵ Despite these critical advancements, there still remains a need for standardized training guided by best practices. Finally, legislation passed in 2018 requires licensed health care practitioners who provide prenatal or postpartum care to screen clients for mental health needs and requires health plans to create maternal mental health programs.⁴⁶ There is no requirement, however, to assess for or manage suicide risk if mental health needs are identified.

Technical Assistance

The 2008 plan outlined the need for technical assistance, such as establishing regional learning collaboratives, training guidance, an online clearinghouse, and ongoing support for local suicide prevention efforts. The Commission approved one-time MHSA funding of \$40 million over four years for statewide infrastructure, such as a clearinghouse of best practices to assist in training and technical assistance efforts, as well as a suicide hotline system, which would benefit all counties.⁴⁷ That investment resulted in several initiatives administered by the California Mental Health Services Authority – some of which are still operational.⁴⁸ These initiatives created regional networks focused on collaboration and development of best practices and delivered suicide prevention training. They also produced social media marketing campaigns, and partnered with crisis centers to expand cultural and linguistic competent outreach, technology capacity to chat and text functions, and improved crisis line data collection.⁴⁹ Among the work made possible by this investment are the Know the Signs Campaign, the Directing Change program and film contest, and the California Suicide Prevention Network.

The Know the Signs Campaign is a social marketing initiative to educate Californians on how to recognize the warning signs of suicide, how to talk to someone in crisis, and how to access services.⁵⁰ The campaign also works with members of the media to promote consistency with national recommendations for reporting suicides in the news. Directing Change is a program and film contest in California designed to engage students in creating films to promote positive conversations about mental health and suicide prevention.⁵¹ Lastly, the California Suicide Prevention Network was established to centralize statewide suicide prevention activities, reduce stigma associated with suicide, and increase access to care for people at risk of suicide.⁵² The network also produced common metrics for evaluating suicide prevention hotlines: the demographic data of callers, the reason for the call, call volume, and the suicide risk of caller.⁵³

Suicide Hotline Assessment

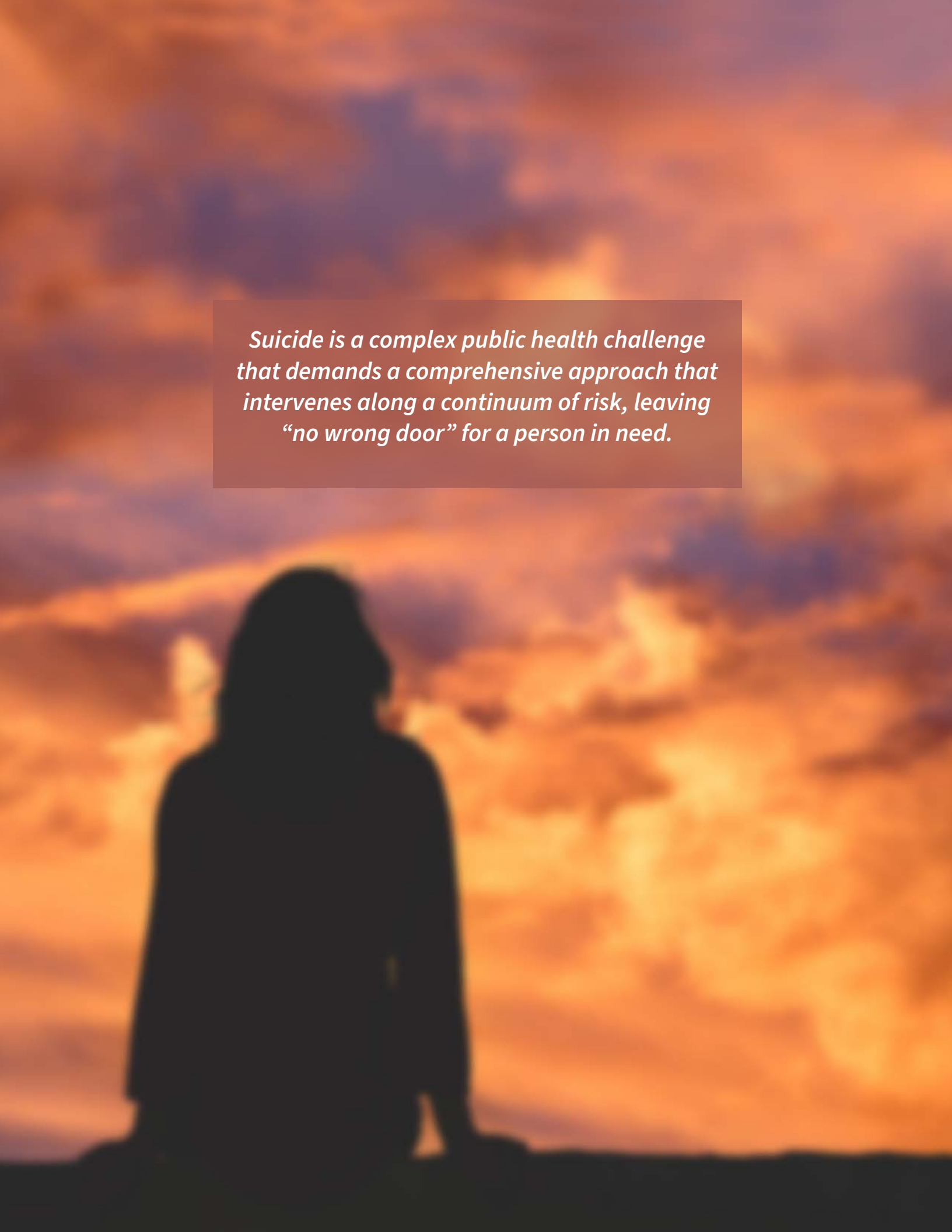
One next step identified in the 2008 plan was to assess the status of coverage and accreditation for suicide prevention hotlines.⁵⁴ The Department of Health Care Services was directed in 2016 to conduct a comprehensive assessment of suicide hotlines and to recommend funding strategies to ensure hotlines have adequate resources to meet demand.⁵⁵ The department produced a report that documented the structure, capacity, and funding of suicide hotlines accredited by the American Association of Suicidology across the state.⁵⁶ The report highlighted the demand for a statewide suicide hotline system but also stated that a lack of data prevented the department from determining the funding needed to meet demand.⁵⁷ As of 2019, \$4.3 million per year of MHSA funding, along with local and private funds, support California's 11 National Suicide Prevention Lifeline Centers.⁵⁸

Public Review

The draft statewide strategic suicide prevention plan was first released for public comment on July 3, 2019. The Subcommittee received written and verbal comments before the plan was submitted to the Commission for consideration.

Plan Note

This plan does not include physician-assisted dying, which is sometimes referred to as assisted suicide. In California, the End of Life Option Act allows qualified adults with a terminal illness to request aid-in-dying drugs from their physician.⁵⁹



Suicide is a complex public health challenge that demands a comprehensive approach that intervenes along a continuum of risk, leaving “no wrong door” for a person in need.

Suicidal Behavior: Definitions, Theory, and Key Concepts for Prevention

Suicidal behaviors exist on a broad continuum of risk, and include desire to die; suicidal ideation; suicide attempt planning; suicide attempts; and death by suicide. The Centers for Disease Control and Prevention uses the term **self-directed violence** to describe a range of violent behaviors that can be fatal or non-fatal, suicidal or non-suicidal; suicide itself is defined as “death caused by self-directed injurious behavior with any intent to die as a result of the behavior.”⁶⁰ For the purposes of this document, non-fatal, suicidal self-directed violence is referred to as “suicidal behavior.”

Definitions of Self-Directed Violence

Self-directed violence is behavior that is self-directed and deliberately results in injury or the potential for injury to oneself.⁶¹ Behavior can be non-suicidal or suicidal.

Non-suicidal self-directed violence is behavior that is self-directed and deliberately results in injury or the potential for injury to oneself, with no evidence - implicit or explicit - of suicidal intent.

Suicidal self-directed violence is behavior that is self-directed and deliberately results in injury or the potential for injury to oneself, with evidence - implicit or explicit - of suicidal intent. Suicidal self-directed violence includes:

- **Suicidal attempt**, a non-fatal, self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
- **Interrupted or aborted suicide attempt**, an effort to injure oneself that is stopped by the person attempting self-harm, or by another individual prior to fatal injury. This can occur at any point during the act, such as after the initial thought or after the onset of behavior.
- **Preparatory acts** or preparation toward making a suicide attempt, taken before potential for harm has begun. This can include any action beyond a verbalization or thought, such as purchasing a gun or preparing for one’s death by suicide by giving away belongings.

Suicidal behavior also can include suicidal ideation, which is defined as having the desire to die, or thinking about engaging in behaviors to die.⁶² Suicidal ideation can be passive or active.⁶³ If it is active, suicidal ideation can be nonspecific, can include a method but no intent or plan, can include a method and intent but no plan, and can include method, intent, and plan.⁶⁴ For the purposes of this document suicidal ideation is referred to as suicidal behavior, unless specified.

Suicidal Ideation Definitions and Screening

Five levels of suicidal ideation – increasing in severity - are outlined within the Columbia-Suicide Severity Rating Scale:⁶⁵

Suicidal Desire – Person has a wish to be dead or not alive, or a wish to fall asleep and not wake up.

Suicidal Ideation (Thoughts) – without thoughts of method

Nonspecific thoughts about suicide or wanting to end one’s life, without thoughts of a method for an attempt. Example: Life is not worth living.

Suicidal Ideation: Includes method - no intent or plan

No specific plan with time, place, or method details worked out. Example: I’ve thought about driving off the road or overdosing, but never of acting on the thought.

Suicidal Ideation: Includes method and some intent - but no plan

Thoughts of an attempt method, with some intent to act. Example: I’ve thought about driving off the road and have thought about acting on it when feeling at my worst.

Suicidal Ideation: Includes method, intent, and plan

Thoughts of attempting suicide with details of a plan and some intent to carry it out. Example: I’ve started to work out plans for how to overdose and intend to carry it out.

The Columbia-Suicide Severity Rating Scale uses the following questions to screen for severity of suicidal ideation and is used to support decisions for services and referral based on risk:

1. Have you wished you were dead or wished you could go to sleep and not wake up?
2. Have you had any thoughts of suicide?
3. Have you been thinking about how you might do this? For example, “I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it ... and I would never go through with it.”
4. When you had these thoughts, did you have some intention of acting on them? As opposed to “I have the thoughts but I definitely will not do anything about them.”
5. Have you started to work out or have you worked out the details of how to attempt suicide? Do you intend to carry out this plan?

See www.cssrs.columbia.edu for downloadable measures designed for select settings and groups.

Assessing for Suicide Risk

The risk posed by suicidal ideation varies according to the intensity, duration, and pervasiveness of ideation; the controllability of symptoms; reasons for living; and history of past suicide attempts or non-suicidal self-injury.⁶⁶ As a result, the Columbia-Suicide Severity Rating Scale and other assessment measures prioritize evaluation of the intensity of suicidal ideation (e.g., asking about duration, controllability, deterrents, reasons for the thoughts) as well as evaluation of suicidal behavior (e.g., history of suicide attempt, interrupted or aborted attempt, preparatory behaviors, and intentional self-harm without desire or intent to die).⁶⁷ Suicide risk assessment is discussed in greater detail in subsequent sections that review best practices in collaborative assessment and management of suicide risk. Best practices in suicide risk assessment and management use a collaborative and transparent approach to assessing for suicide risk and to support delivery of additional services, referral, or safety planning.⁶⁸

Suicide Theory

Suicide is a complex public health challenge involving many biological, psychological, social, and cultural determinants.⁶⁹ Several theories about why people die by suicide seek to explain how multiple factors may increase risk in the context of profound emotional suffering. According to one predominant theory, known as the Interpersonal Theory for Suicide, three components must align to predict risk for suicide or a serious suicide attempt: thwarted belongingness, perceived burdensomeness, and acquired capability for lethal self-injury.⁷⁰

Thwarted Belongingness and Perceived Burdensomeness

The Interpersonal Theory for Suicide includes two components of the desire to die by suicide and depression: “thwarted belongingness” and “perceived burdensomeness.”⁷¹ Thwarted belongingness is described as a state of “unmet need to belong.”⁷² Both the theory and extensive research indicate that people have a fundamental need to belong and that, when that need is thwarted, it increases risk.⁷³ A sense of belonging can increase during times of national celebration and in times of national crisis, such as during wartime. One illustration of this involved the change in the national daily suicide rate following the attacks on September 11, 2001.⁷⁴ In the year following the attacks, suicide rates in entire U.S. communities showed an unprecedented decrease – but only on that day, not in the period before or after.⁷⁵ Similar findings are observed in times of national celebration.⁷⁶ Perceived burdensomeness is the false belief that “my death is worth more than my life.”⁷⁷ Unemployment, health problems, and incarceration are examples of situations in which a person may feel like they are a burden to others. This finding aligns with empirical research indicating that these situations increase risk for suicide.⁷⁸

Acquired Capability

The components described above are modifiable components of depression and reflect the desire to die. But the theory proposes that these factors are not on their own predictive of risk. Indeed, most people with depression do not go on to die by suicide. The theory instead suggests that people are most at risk when these components are present in combination with an acquired capability for self-injury, or “the ability to engage in suicidal behaviors acquired through life experiences that habituate pain tolerance and fearlessness about death.”⁷⁹ Such experiences may include exposure to physical pain, violence, and provocative life experiences, such as childhood trauma, witnessing a traumatic event, suffering from a chronic medical illness, or engaging in self-directed violence.⁸⁰ Indirect exposure to others’ pain and injury also may increase acquired capability, increasing risk among groups such as veterans, physicians, nurses, and first responders.⁸¹

Means Matter

While reducing access to lethal means is a central element in global and national suicide prevention plans, it remains poorly understood – and underutilized for reducing suicide in California.⁸² Suicidal behavior is often method-specific, and a person’s choice of means is driven by multiple factors. These include the lethality, accessibility, and acceptability of the method.⁸³ Eliminating or reducing access to a particular method during a crisis creates lifesaving time and opportunity for intervention.⁸⁴ These dynamics are critical because crises involving suicidal behavior tend to be transient, and characterized by extreme ambivalence about the wish to die or stay alive.⁸⁵ Research shows that when a person’s attempt is thwarted, he or she does not go on to die by suicide at other locations, times, or by other methods.⁸⁶ As such, the placement of time between thoughts of suicide and a person’s ability to obtain lethal means for an attempt represents a practical, lifesaving approach to prevent suicide.⁸⁷

Gun access – especially access to guns in the home – is a significant consideration in suicide prevention because the majority of people who die by suicide use a firearm.⁸⁸ While drug overdose is the most common method of suicide attempt, firearms are the most lethal.⁸⁹ Only about 15 percent of people who attempt suicide with a firearm will survive.⁹⁰ Using a highly lethal method of dying by suicide does not necessarily indicate a stronger desire to die.⁹¹ Death by suicide is the result of many contributing factors, including choice of means, preexisting health or behavioral health needs, and the amount of time lapsed before rescue or medical intervention, among others. Lethality of means increases with age and escalates with the number of suicide attempts.⁹²

Key resource: www.meansmatter.org

Inherent Challenges and Emerging Innovations

Due to the nature of suicide, there are several inherent barriers to preventing it, making the implementation of comprehensive suicide prevention efforts challenging.⁹³ These challenges are not immutable, but overcoming them will require a concerted effort.

Mental Health and Suicide Stigma

Harmful myths and stigma may discourage people from seeking help, prevent people from disclosing suicide risk, and hinder intervention and access to services. If left unaddressed, stigma can prevent multidisciplinary coordination across public and private industry partners, settings, and philosophies, and reduce the likelihood that suicide prevention will be included in public health strategies.⁹⁴ For example, though the majority of deaths by firearm occurs by suicide, suicide prevention and lethal means restriction are rarely discussed in gun safety campaigns and initiatives that promote safe gun storage.⁹⁵ Stigma also may affect public awareness of available services or effective practices to prevent suicide. Stigma likewise prevents people from seeking help for mental health needs and is tied to disparities in seeking services for mental health needs and health access.⁹⁶ Men, for example, are more likely to receive mental health services in emergency departments because of perceived stigma associated with receiving mental health care. Understanding these disparities may help to identify targeted strategies for prevention and education training.

Disparities in Health Care Access

The success of suicide prevention services traditionally has been dependent upon people at risk seeking the services they need. This reality poses a heavy burden on people who may be in crisis, and has persisted despite the effectiveness of screening protocols to guide triage and referral.⁹⁷ Services that specifically address suicide risk often are limited to select settings, such as a single community hospital, which limits the delivery of integrated health care services across settings.⁹⁸ Variability in clinical practices can stymie the delivery of effective programs, and rural communities commonly experience shortages in services, especially for people with complex needs.⁹⁹

While psychosocial treatments for suicidal behaviors are effective, a lack of access to specialized care providers trained in such methods may limit their widespread use.¹⁰⁰ Insurance coverage also can create barriers for people seeking to see specialists, while language and cultural factors pose additional challenges for people seeking providers able to understand them and provide care that can effectively reduce risk. Non-medical settings, such as the workplace or community centers, may be underutilized as opportunities to connect people with systems of care. These limitations may prevent services and effective approaches from being scaled statewide, or even within the same community.¹⁰¹ Uniform guidelines for establishing visible and easily accessible pathways to access services has the potential to bridge this gap. Such guidelines could include centralized online resource hubs, provider referral networks with clearly described eligibility criteria, and standard protocols for best practices in transferring mental health emergency calls answered by 911 dispatchers to mobile crisis units or teams.

Missed Detection

Despite detection efforts, people at risk for suicide may not be identified and receive the services they need when they need them.¹⁰² This challenge can be addressed by suicide prevention efforts that are integrated into entire systems to ensure people at risk do not fall through gaps. Nationally, as of July 1, 2019, all people seen in medical settings for a primary diagnosis or primary complaint of a behavioral health need, including those seen in emergency departments as well as outpatient and inpatient settings, are required to be screened for suicide risk.¹⁰³

Other major suicide prevention initiatives in healthcare are underway. The Zero Suicide Initiative is an international movement toward systems transformation dedicated to preventing suicide within healthcare systems, with free toolkits and training programs.¹⁰⁴ Studies show that the majority of those who die by suicide interact with their doctor and health care system in the weeks and months prior to death.¹⁰⁵ The Zero Suicide Initiative promotes a system of continuous quality improvement in which health and behavioral health care providers develop policies and implement practices known to prevent suicide.¹⁰⁶ The potential to eliminate suicide when best practices are used and those at risk are uniformly connected to evidence-based services has been demonstrated through the Henry Ford Health System's Perfect Depression Care program, upon which the initiative is based.¹⁰⁷ Essential elements of the initiative are:

1. **Lead** systemwide culture change committed to reducing suicides
2. **Train** a competent, confident, and caring workforce
3. **Identify** people in care settings with suicide risk via comprehensive screenings
4. **Engage** all people at risk of suicide using a suicide care management plan
5. **Treat** thoughts of suicide and behaviors using evidence-based treatments
6. **Transition** people through care with warm hand-offs and supportive contacts
7. **Improve** policies and procedures through continuous quality improvement

Recent innovations in technology also offer hope for improving the detection of suicide risk, presenting opportunities for greater precision as well as increased screening sensitivity and better triage of people into services.¹⁰⁸ Machine learning is a form of Artificial Intelligence that enables a computer to learn patterns without prior programming and to devise complex algorithms to improve the accuracy of prediction.¹⁰⁹ Data routinely collected through electronic health records may be helpful in predicting future suicidal behavior.¹¹⁰ An algorithm in one study of hospital admission data – age, gender identity, zip code, medication, and diagnostic history, for example – was 84 percent accurate in predicting whether someone who was seen at the hospital for either non-suicidal self-injury or suicide attempt would attempt suicide in the following week.¹¹¹ The algorithm was 80 percent accurate in its prediction for a two-year period.¹¹² Such suicide prediction modeling is being developed for use in large healthcare systems, such as the U.S. Department of Veterans Affairs and Kaiser Permanente.¹¹³

Machine learning also is being utilized by social media companies.¹¹⁴ For years, Facebook users have had the ability to report posts by friends and family who they believed to be at risk for suicide. In response to the posts, Facebook's Community Operations team connects the flagged Facebook user with resources. Facebook has expanded its suicide prevention efforts by using machine learning to identify "suicidal expression" in posts by people at risk by monitoring phrases they use or comments from family and friends. Whether content is flagged by friends and family or by machine learning, the response is the same – a Community Operations team member reaches out to the person at risk, and, in emergencies, works with first responders.


Challenges in Terminology and Uniformity

Definitions for suicidal behavior are not uniform, and, likewise, there are no standards for suicide risk assessments, which affect risk detection, disclosure of risk, and reporting.¹¹⁵ Despite calls for uniformity and national and state standards for screening, reporting, and data monitoring, there remain significant differences in how data are captured and how people are screened and referred to services.¹¹⁶ Clinical practice guidelines for suicide prevention also reflect a lack of consensus, which may affect uniform procedures in risk assessment, triage, and training.¹¹⁷ Differences in screening may hinder the ability to distinguish people at risk, preventing the delivery of effective programs and research of risk factors.¹¹⁸ In response to these challenges, the Centers for Disease Control and Prevention created uniform guidelines to aid precision and comparability in the prevention and monitoring of suicidal behaviors.¹¹⁹ Mandated screening and means restriction policies offer opportunities to aid detection given their universal use.¹²⁰

Barriers to Innovation

Despite advancements in suicide prevention, much is still unknown, and research exploring risk factors and treatments for suicidal behaviors remains a national and global priority. Specialists trained to conduct this research, however, are few relative to the need and priority. There is still much to understand about fundamental factors that contribute to risk for suicide and how risk changes over the lifespan, especially for specific groups.¹²¹ Risk factors change over time, and often are internal to each person. Identifying these internal factors is key to the detection of risk and intervention, as is the dissemination of information about how risk factors contribute to suicidal behavior and how those factors can be managed.¹²² Finally, monitoring dynamic risk factors requires substantial and expensive infrastructure critical to building and sustaining effective suicide prevention initiatives.¹²³

Research may be further hindered by funding and infrastructural barriers, and by methodological, ethical, and safety challenges inherent to conducting epidemiological studies or research among those at high risk for suicide. Research on the effectiveness of interventions specifically targeting suicide risk is scarce. Until recently, people at risk for suicide were excluded from clinical drug trials due to safety concerns. This limited the study of new treatments. The U.S. Food and Drug Administration now mandates assessment of suicide risk across all Central Nervous System drug trials.¹²⁴



Some communities experience higher rates of suicide than others; this may be in part attributable to high gun ownership and disparities in the access and use of health and behavioral health care.

Suicidal Behavior in California

The following section describes suicidal behavior specific to California. It presents the state's suicide prevalence and rates based on the most recent data available. California's trends in suicide rates and suicidal behavior are aligned with national statistics, though some deviations are noted below. Trends in population and vulnerable group suicide rates are significantly affected by the method used for suicidal behavior; more lethal means, such as firearms, are involved in more suicide deaths.¹²⁵

Suicide Data

In 2017, 4,323 Californians who lost their lives to suicide.¹²⁶ California's age-adjusted¹ suicide rate is 10.7 per 100,000 people – one of the lowest rates among states – compared to the national rate of 14.0 per 100,000 people.¹²⁷ California's relatively low suicide rate may be attributable to its policies regulating access to guns.¹²⁸ In general, states with high rates of gun ownership tend to have higher rates of suicide and accidental death by firearm, whereas states with lower rates of gun ownership have lower suicide rates.¹²⁹ While California's suicide rate is low compared to most other states, variability exists across counties. For example, Humboldt County has one of the highest suicide rates in California at 24.3 per 100,000 residents.¹³⁰ Santa Clara County has the lowest suicide rate in California at 7.5 per 100,000 residents.¹³¹ Variability in rates may be attributable to certain characteristics that increase risk for suicide, such as high gun ownership and less access to health care in rural communities.¹³²

While rates are generally higher in rural Northern California counties, 2017 data show that a greater *number* of suicides claim the lives of residents in Southern California, specifically Los Angeles (21 percent of total suicides), Orange (10 percent of total suicides), Riverside (8 percent of total suicides), San Bernardino (6 percent of total suicides), and San Diego (5 percent of total suicides) counties, consistent with their population density.¹³³ Half of all suicides in California in 2017 were reported in these five counties.¹³⁴ This concentration highlights the need for – and promise of – targeted, community-driven approaches and use of data to understand local and regional opportunities. (Note: suicide data that includes sexual orientation and gender identity are not currently collected and reported across the state.)¹³⁵

Suicide by Means

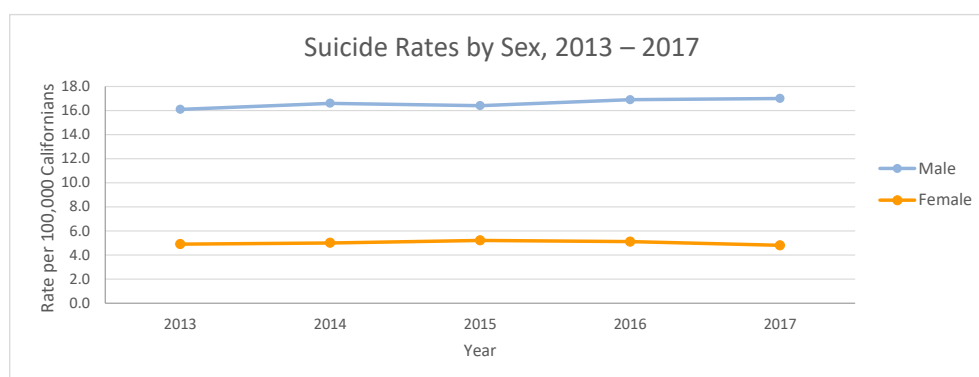
Firearm (37 percent of total suicides), hanging and suffocation (32 percent of total suicides), and poisoning, which includes overdose (16 percent of total suicides), are the three most common ways people died by suicide in 2017 in California.¹³⁶ These trends are consistent with national trends.¹³⁷ Californians aged 30 and younger were more likely to die by hanging or suffocation, while people older than 50 were more likely to die by firearm.¹³⁸ The trend of younger people dying by suffocation is consistent with national trends.¹³⁹ These differences in use of means highlights the opportunity to focus suicide prevention resources to target strategies that reduce access to certain means for certain at-risk groups.¹⁴⁰

¹Rates are adjusted using the 2000 US Standard Population weights and using 5 year age groupings for county and 10 year age groupings for the other variables. The age of the youngest suicide death is 10.

Suicide Rates by Sex

In 2017, males died by suicide at a rate more than three times higher than the rate of females in California.¹⁴¹ This statistic is consistent with national data showing that males are nearly four times more likely to die by suicide than females.¹⁴² This difference is largely explained by the use of more violent means among males.¹⁴³ In other words, while attempt rates are higher for females, males are more likely to die as a result of an attempt because they use a firearm. Research consistently demonstrates that regardless of age group or culture, males are more likely to die by suicide and females are more likely to attempt suicide.¹⁴⁴ Males dying by suicide at higher rates is consistent internationally, except for China, where females – particularly young, rural residents – die by suicide at greater rates than males.¹⁴⁵

Suicide rates are higher among males. Between 2013 and 2017, suicide rates increased slightly for males and remained relatively stable for females. Data on sexual orientation or gender identity is not currently collected. (See Graph 1.)

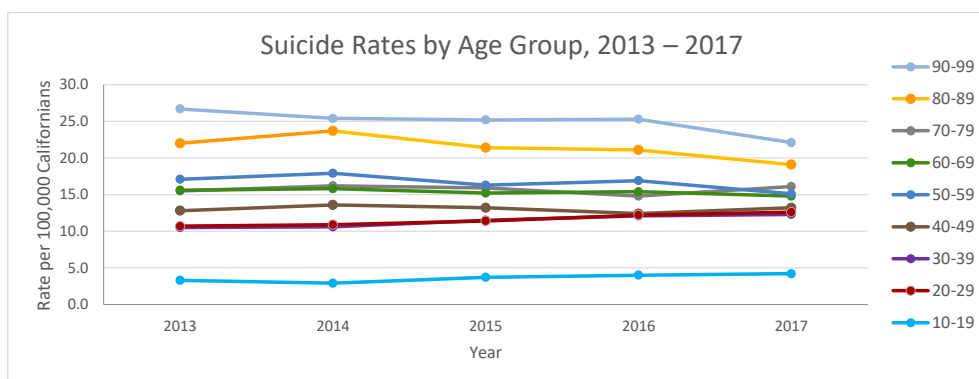


Graph 1. Data extracted from the California Department of Public Health's EpiCenter at <http://epicenter.cdph.ca.gov>.

Suicide Rates by Age Groups

Risk of dying by suicide increases with age. In 2017, the suicide rate peaked at 14.5 per 100,000 for people between the ages 25 and 29, increased through middle-age, and was highest among Californians aged 85 and older (20.7 per 100,000 people).¹⁴⁶ This pattern is consistent with national trends. Californian men aged 85 and older had the highest suicide rate of any age group, at 45.1 per 100,000 people.¹⁴⁷ People in younger age groups attempt suicide at higher rates compared to older age groups but survive their attempt in part because of the selection of less lethal means for suicide.¹⁴⁸

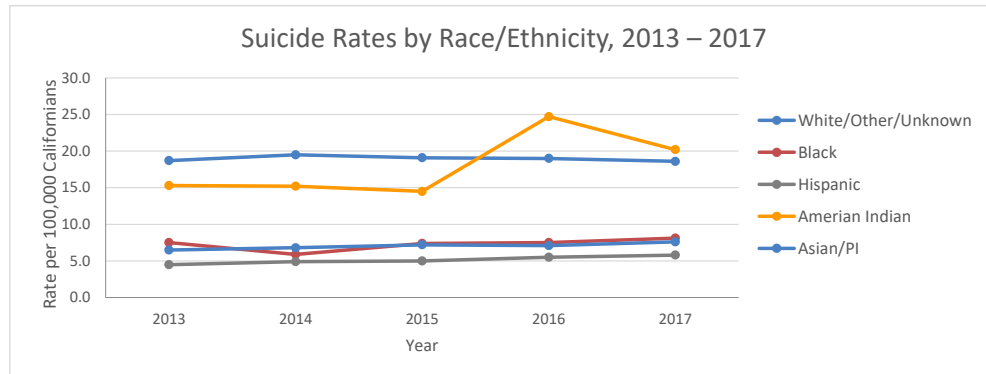
Suicide rates increase as Californian's age. Between 2013 and 2017, suicide rates remained relatively stable for most groups, with slight increases for Californians in the middle years. (See Graph 2.)



Graph 2. Data extracted from the California Department of Public Health's EpiCenter at <http://epicenter.cdph.ca.gov>.

Suicide Rates by Race/Ethnicity Suicide rates in California are highest among whites (17.1 per 100,000 people) and Native Americans (15.6 per 100,000 people).¹⁴⁹ Native Hawaiian/Pacific Islander Californians had the next highest rate in 2017, at 14.1 per 100,000 people.¹⁵⁰ All other racial/ethnic group suicide rates were under 10 per 100,000 people.¹⁵¹ This pattern is consistent with national trends, with white males accounting for nearly 70 percent of all suicide deaths in the U.S. in 2017.¹⁵²

Suicide rates are highest for white and Native American Californians. Between 2013 and 2017, suicide rates remained relatively stable for most groups. Suicide rates among Native Americans have increased. (See Graph 3.)



Graph 3. Data extracted from the California Department of Public Health's EpiCenter at <http://epicenter.cdph.ca.gov>.

Suicide by Military Service Status

In 2017, there were 640 suicides by Californians aged 18 years and older who had served in the U.S. Armed Forces, accounting for 15.3 percent of all suicides in California that year.¹⁵³ The majority of current and former service members who died by suicide were male (96.7 percent) and white (79 percent); and 43 percent were between the ages of 25 and 64 at the time of death.¹⁵⁴ Additionally, 40 percent were between the ages of 65 and 84 at death.¹⁵⁵

The majority – 65.6 percent – of Californians who served in the Armed Forces and died by suicide in 2017 used a firearm.¹⁵⁶ Data showing that service members are more likely than other at-risk groups to die by suicide using firearms highlights the need for prevention strategies to consider the means by which different vulnerable groups die by suicide.¹⁵⁷ Data collection does not distinguish between current and former service members, or veteran or active duty status.¹⁵⁸

Suicide in Law Enforcement Custody

State and local law enforcement agencies are mandated to report the number of deaths in custody along with arrest data, including death by suicide, to the California Department of Justice.¹⁵⁹ Custody settings include correctional housing, booking areas, holding cells, treatment units, and common areas, in addition to crime or arrest settings. Between 2005 and 2017, 922 people died by suicide in law enforcement custody.¹⁶⁰ The number of suicides in custody settings has decreased from an annual high of 83 in 2013 to 60 in 2017.¹⁶¹ Most people who died by suicide in custody were male (93 percent) and were classified as white (49 percent), Hispanic (31 percent), or African American (11 percent).¹⁶²

Other Suicidal Behavior Data

In 2017, 18,153 Californians visited or were admitted to an emergency department for intentional self-harm.¹⁶³ Less is known about the prevalence of thoughts of suicide, because data may be limited to national or local self-report surveys. According to one survey, an average of 1,115,000 Californians over the age of 18 – about 3.8 percent of all adults – reported having serious thoughts of suicide in the past year.¹⁶⁴ Another survey estimated that 19 percent of California 9th graders and 18 percent of California 11th graders seriously considered attempting suicide in the past year.¹⁶⁵

Data Limitations

There are many limitations to using current data to support suicide prevention efforts. The widely acknowledged underreporting of suicide as a manner of death on death certificates is one challenge.¹⁶⁶ Manner of death includes natural and unnatural death, which includes suicide, homicide, accidental, or undetermined; cause of death refers to the circumstances of death, such as a gunshot wound. Coroners inquire into and determine the manner and cause of death when suicide is known or suspected.¹⁶⁷ After a death, a coroner or medical examiner follows procedures and protocols to investigate by documenting and evaluating the setting in which someone died; evaluating the body of the decedent; and evaluating medical, mental health, and social history.¹⁶⁸ Underreporting of suicide can occur because of inconsistent death classification.¹⁶⁹ While one coroner might label a death a suicide, another coroner confronted with the same circumstances might rule it “undetermined” or “accidental.” Cultural and religious beliefs, as well as stigma, also may influence the accuracy of reporting and death records.¹⁷⁰

Several other barriers limit the use of suicide data for prevention efforts.¹⁷¹ One is the inconsistent use by local jurisdictions of electronic reporting in centralized state databases, such as those maintained by the California Department of Public Health and the Office of Statewide Health Planning and Development.¹⁷² Many death records remain in print form, which substantially delays reporting and real-time monitoring of suicide within and across counties.¹⁷³ Further, bridge and railway suicide deaths are not reported in a unified manner by individual sites to a centralized reporting system. Instead, information is housed across multiple agencies, such as the California Department of Transportation (CalTrans), local transit districts, federal rail authorities, the California Highway Patrol, local sheriff-coroners, and other private entities.¹⁷⁴ Compiling such data is crucial to evaluating public health risk and policy need, but a centralized reporting system is not in place.¹⁷⁵

Untimely data reporting and monitoring also may limit the ability of professionals to intervene when several suicides occur in proximity in place or time, known as a suicide cluster.¹⁷⁶ Inconsistent coding methods may compound the difficulty of drawing comparisons between years, settings, or at-risk groups. In addition, data tends to be restricted to suicide deaths, despite critical opportunities for prevention in data associated with both suicide attempts and “save data,” which describes a thwarted suicide attempt and subsequent connection to crisis services. For example, public data does not include how many people had repeat visits to the emergency department for suicidal behavior, discharge or follow-up care outcomes, or first-time suicidal behavior not requiring triage services. These challenges highlight the need to disseminate data collection, standardization, and monitoring best practices statewide.

People with behavioral health needs, particularly depression, are at the greatest risk for suicide, especially coupled with other factors, such as access to guns.

Risk and Protective Factors

Risk factors are characteristics that may make suicidal behavior more likely to occur, while protective factors are characteristics that make suicidal behavior less likely.¹⁷⁷ Importantly, such factors often occur in the context of health and behavioral health needs, interacting with other complex social, demographic, and situational dynamics. Factors that increase suicide risk, for example, are dangerous for people living with depression, but are manageable for other people.

Some risk factors are modifiable, while others – such as history of suicidal behavior or demographic characteristics – are not. Suicide prevention efforts are effective when they target high-risk settings or risk and protective factors that can be modified, such as increasing screening and access to services for depression and other behavioral health needs. Warning signs, by comparison, are behaviors that may indicate or signal acute risk for suicide, which may be similar to or distinct from risk factors.¹⁷⁸ See the next page for a list of risk and protective factors and warning signs.

Typically, risk can be elevated during times of acute or lasting transition, though the higher exposure is not limited to such periods. These transitions can include job loss, marital status changes, hospitalization, housing changes, and military service discharge or post-deployment. Risk appears to be additive – the more factors, the higher the risk – and it cuts across demographic, economic, social, and cultural boundaries. **Major risk factors for suicide are prior suicide attempt; substance abuse; mood disorder, such as depression; access to lethal means; and physical health needs.**¹⁷⁹

Protective factors include the absence of risk factors and increased connectedness to community, culture, spiritual faith, and other factors that reduce risk, such as access to health care and social support and safe storage of guns and medications. **Major protective factors for suicide are effective mental health care; connectedness to people, family, community, and social institutions; problem-solving skills; and contacts, such as postcards or letters, from service providers and caregivers.**¹⁸⁰

Some factors both increase and reduce risk. For example, prior suicide attempt increases risk in some and lessens risk in others, as many people who attempt suicide once never attempt again.¹⁸¹ This fact highlights the need to continuously evaluate and monitor the variability of risk and protective factors.

Cultural Considerations

Some risk and protective factors vary depending on the group targeted for suicide prevention efforts. For example, spirituality and religion are tied to reduced risk for suicidal behavior.¹⁸² Spirituality and religion are deeply rooted in the culture, values, and norms of most ethnic groups.¹⁸³ Both can reinforce and strengthen cultural identity, protecting against risk.¹⁸⁴ Both may provide congregational opportunities to connect with community members, especially in times of stress, loss, and despair, reducing isolation and increasing resiliency and belonging. This can further mitigate risk by fostering hope and connection, promoting a sense of personal purpose or meaning, and teaching coping skills through spiritual practice.¹⁸⁵

While religion is a protective factor for many communities, there are important differences among vulnerable groups. For example, religion may increase suicide risk among lesbian, gay, bisexual, and transgender people.¹⁸⁶ Adherence to religious doctrine that conflicts with sexual orientation and gender identity can create confusion, distress, and isolation. This may be further compounded when people cannot seek support for their conflict and distress among members of their faith-based community.

Risk Factors

Suicide risk factors at the individual level include:¹⁸⁷

- Prior suicide attempt(s)
- Thoughts of suicide with intent and planning (especially intense, pervasive, difficult to control)
- Perceiving few reasons for living
- Demographic factors (male sex, indigenous or white ethnicity, middle to older age)
- Unmet acute or persistent physical health and behavioral health needs, including chronic pain, disability, substance use, and mood disorders
- Access to lethal means and gun ownership, especially having guns in the home
- Social isolation and low sense of belongingness
- Feeling hopeless about the future
- Unstable mood or sleeping patterns, including insomnia and nightmares
- Hospitalization or incarceration
- New or ongoing financial or employment problems

Suicide risk factors at the relationship level include:

- End of a relationship or marriage, including by death or divorce
- Relational dissatisfaction and problems, including abuse
- Unstable or conflictual relationships

Suicide risk factors at the community level include:

- Lack of access to appropriate and affirmative health and behavioral health care
- Disconnection from culture and cultural practices

Suicide risk factors at the societal level include:

- Cultural beliefs or institutions that promote social isolation
- Sensationalistic media coverage, especially for youth
- Mental health stigma and discrimination

Protective Factors

Factors that reduce or protect against risk at the personal level include:¹⁸⁸

- Life skills for coping, especially during stressful events and life changes (including problem-solving skills, coping skills, ability to adapt to change)
- Coping skills and resource acquired after previous suicidal behavior
- Personal or religious beliefs that prohibit or discourage suicide
- High self-esteem and sense of worth
- Strong quality of life with a purpose for living
- High sense of belongingness

Factors that lessen or protect against risk at the relationship level include:

- Connectedness to family or family of choice
- Genuine support from family or family of choice
- Relationships that affirm sexual orientation and gender identity

Factors that lessen or protect against risk at the community level include:

- Access to appropriate and affirmative health and behavioral health care
- Connectedness to neighborhood, community, or social group
- Community members who check in with one another
- Social institutions that promote healthy and active lifestyles

Factors that lessen or protect against risk at the societal level include:

- Cultural or religious beliefs that prohibit or discourage suicide and value purposeful living
- Religious affiliation or spiritual community membership

Warning Signs

The following behaviors could indicate or signal suicide risk:¹⁸⁹

- Communicating a wish to die or plans to attempt suicide
- Expressing the experience of having thoughts of suicide that are intense, pervasive, or difficult to control
- Looking for a way to kill oneself, such as searching online or obtaining a gun
- Giving away possessions
- Drafting notes indicating intent or desire for suicide
- Communicating feeling hopeless or having no reason to live or persistent hopelessness
- Communicating feelings of guilt, shame, or self-blame
- Communicating feelings of being trapped or in unbearable pain
- Communicating being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly or engaging in risky activities
- Insomnia, nightmares, and irregular sleeping
- Withdrawing or feeling isolated
- Communicating or exhibiting anxiety, panic or agitation
- Appearing sad or depressed or exhibiting changes in mood
- Showing rage or uncontrolled anger or communicating seeking revenge

Vulnerable Groups

Members of some groups and occupations may be more vulnerable to suicide than others. Despite this increased vulnerability, most people in the groups described below will not die by suicide or engage in suicidal behavior. And, regardless of group membership, suicide most often occurs among people with behavioral health needs and is a symptom of depression.¹⁹⁰ The following list is not exhaustive; it is intended to demonstrate differences and trends among groups and to highlight suicide prevention resources. Communities must utilize the Public Health Model to document the problem of suicidal behavior and identify vulnerable community members, risk and protective factors, and effective interventions.

People in Middle and Older Age

Suicide rates among people in middle age – 35 to 64 years of age – are increasing.¹⁹¹ Between 1999 and 2010, suicide rates among people in middle age have increased nearly 30 percent, especially among people aged 50 to 59.¹⁹² In 2017, people of middle age represented 25.9 percent of the U.S. population but 35.1 percent of people who died by suicide.¹⁹³ Historically, older adults – or people over the age of 65 - have had the highest rates of suicide.¹⁹⁴ In 2017, this group represented 15.6 percent of the U.S. population but accounted for 18.2 percent of all suicides.¹⁹⁵ The high suicide rates among older adults may be driven by factors such as use of highly lethal means; unmet health and behavioral health needs, especially late-life onset of depression; personality traits and coping mechanisms; life stressors, such as the loss of loved ones; social disconnection; and impairments in functioning and disability.¹⁹⁶

KEY RESOURCE: Preventing Suicide among Men in the Middle Years: Recommendations for Suicide Prevention Programs| Developed by the Suicide Prevention Resource Center: http://www.sprc.org/sites/default/files/resource-program/SPRC_MiMYReportFinal_0.pdf.

People Discharged from Hospital Settings

People seen in emergency departments for self-injury, regardless of their intent to die, are 30 times more likely to die by suicide than people who do not self-injure.¹⁹⁷ People discharged from psychiatric hospitalization are at especially high risk for future suicide and suicidal behavioral. Suicide risk increases during the first week of admission to a psychiatric hospital and during the first week after discharge.¹⁹⁸ For veterans, one study showed that suicide risk may be elevated during the first three months following discharge from a psychiatric hospital.¹⁹⁹ Common challenges that increase risk following discharge include missed follow-up appointments for outpatient care; a lack of resources or connection to such resources; unsupportive relationships or social networks, resulting in isolation and shame; and referrals that do not match individual needs.

KEY RESOURCE: Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit| Developed by Knesper, D. J., American Association of Suicidology, & Suicide Prevention Resource Center: <http://www.sprc.org/sites/default/files/migrate/library/continuityofcare.pdf>.

Veterans

Veterans account for approximately 14 percent of all suicides in the U.S.²⁰⁰ More than half of the veterans who die by suicide are 55 years of age or older, but the suicide rate among veterans between the ages of 18 and 34 has increased by 11 percent, rising from a rate of 40.4 deaths per 100,000 people in 2015 to 45 deaths per 100,000 people in 2016.²⁰¹ Data show that nearly 70 percent of veteran suicides are by firearm, compared to less than 50 percent of all non-veteran suicides.²⁰² This fact underscores the importance of considering the means by which vulnerable group members die by suicide in any suicide prevention strategy.²⁰³ Veterans have unique risk and protective factors related to military service, in addition to factors previously mentioned.²⁰⁴ Protective factors include a strong sense of belongingness to a unit and resilience to withstand adversity.²⁰⁵ On the other hand, transitioning out of military service may increase suicide risk.²⁰⁶ Stressful experiences during this transitional period include a loss of purpose and sense of identity, difficulties securing employment, conflicted relationships with family and friends, and other challenges related to adapting to post-military life.²⁰⁷

KEY RESOURCE: National Strategy for Preventing Veteran Suicide (2018-2028) | Developed by the U.S. Department of Veterans Affairs: https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

Sexual Orientation and Gender Identity

Lesbian, gay, bisexual, transgender, queer, and questioning people may be at increased risk for suicide.²⁰⁸ Currently, it is difficult to evaluate risk for suicide among LGBTQ people because sexual orientation and gender identity are not reported in death records. Healthcare settings, such as hospitals and emergency departments, also do not report sexual orientation and gender identity of people seen for suicide-related services, making it even more difficult to evaluate suicidal behavior among this vulnerable group. Self-report surveys of suicidal behavior are the primary source of data. One survey of youth in primary care estimated that 20 percent of lesbian, gay, and bisexual youth have attempted suicide.²⁰⁹ Suicide risk also is elevated among transgender people.²¹⁰ One study showed that 40 percent of transgender people attempted suicide at least once in their lifetime, with 92 percent of those making the attempt before the age of 25.²¹¹ Studies indicate that as many as 50 percent of transgender and gender non-conforming youth have attempted suicide.²¹² Rejection of sexual orientation and gender identity by family and caregivers may significantly increase risk for suicide among LGBT youth, highlighting the need to include family-based interventions in suicide prevention efforts.²¹³

KEY RESOURCE: Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth | Suicide Prevention Resource Center: http://www.sprc.org/library/SPRC_LGBT_Youth.pdf.

Youth of Color

American Indian and Alaska Native youth and young adults have the highest rate of suicide of any cultural or ethnic group in the United States.²¹⁴ Suicide is the second leading cause of death for American Indian and Alaska Native children and adults ages 10 to 34.²¹⁵ A recent study found that African American children ages five to 12 – both boys and girls – are dying by suicide at twice the rate compared to white children.²¹⁶ This finding highlights the need for continuous evaluation using the Public Health Model, as new at-risk groups emerge. Youth attempt suicide at greater rates than people of other ages.²¹⁷ Racial and ethnic differences also are found among suicidal behavior.²¹⁸ Latina adolescents, in particular, report the highest rates of suicidal behavior of any youth group.²¹⁹ As many as one in seven Latina youth attempt suicide, a rate greater than any other youth group of the same age.²²⁰

KEY RESOURCE: To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults | Developed by the U.S. Department of Health and Human Services: <https://store.samhsa.gov/system/files/sma10-4480.pdf>.

Rural Community Residents

People living in rural communities are at greater risk for suicide than those in more urban or densely populated communities.²²¹ Many rural communities feature characteristics with risk factors for suicide, such as gun ownership, social isolation, and difficulty accessing health and behavioral health care and social services.²²² Even if services are available in rural communities, additional challenges can affect the quality and timeliness of access.²²³ These include:

- A shortage of health care providers to conduct preventative assessments and offer referrals and warm handoff to needed services, especially services focused on suicide risk
- Limited numbers of qualified, culturally competent providers and staff
- Transportation, particularly in areas where people must travel long distances to seek services
- Insurance coverage that is accepted by the practitioner or provider
- Language barriers that prevent people from communicating with service providers
- Privacy concerns, especially for residents seeking mental health services in small communities²²⁴

KEY RESOURCE: Understanding the Impact of Suicide in Rural America | National Advisory Committee on Rural Health and Human Services, Department of Health and Human Services: <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2017-impact-of-suicide.pdf>.

People Working in Certain Occupations

People in certain occupations are at increased risk for suicide.²²⁵ Characteristics of occupations where risk might be elevated include jobs that are socially isolating; involve a high level of stress; are low paying or cause an increasing student loan debt-to-income ratio; expose employees to violence or traumatic events; are fast-paced and require long hours; or are inconsistent, such as seasonal work.²²⁶ Construction and mining occupations carry particularly high risk, with the largest percentage – 20 percent in 2015 – of men who die by suicide working in those trades.²²⁷ Arts, design, entertainment, sports, and media occupations have the highest rates of suicide among both women and men. People in other occupations with increased risk include first responders, such as police, firefighters, and paramedics; physicians; nurses; and veterinarians.²²⁸

KEY RESOURCE: Comprehensive Blueprint for Workplace Suicide Prevention | National Action Alliance for Suicide Prevention: <https://theactionalliance.org/communities/workplace/blueprintforworkplacesuicideprevention>.

People in Correctional Settings

People in correctional settings have higher rates of suicide compared to their counterparts in the community.²²⁹ Correctional settings in California include prisons, jails, and juvenile detention facilities. Suicidal behavior may increase upon incarceration, but there is some evidence that people in custody may have experienced a history of suicidal behavior and other risk factors, such as unmet behavioral health needs, prior to becoming incarcerated.²³⁰ Risk may remain elevated after a person is released from prison or jail.²³¹ Elevated suicide risk also is found among people who work in correctional settings. One study found that correctional officers have a 39 percent higher chance of suicide compared to the average for other occupations.²³² This elevated risk for suicide may be due to work stress and its impact on family life, leading to separation and divorce.²³³

KEY RESOURCE: Suicide Prevention Resources for Adult Corrections | Developed by the Suicide Prevention Resource Center: <https://www.sprc.org/sites/default/files/resource-program/AdultCorrectionsResourceSheet.pdf>.

Women During the Perinatal and Postpartum Period

Suicide is a leading cause of death during pregnancy and one year postpartum, also known as maternal suicide, and suicidal ideation has been detected in the range of 13.1 percent to 33 percent of pregnant women.²³⁴ Risk factors for maternal suicide include sleep disturbances, depression, anxiety, a postpartum psychosis diagnosis, and a bipolar disorder diagnosis. Maternal suicide risk is not just limited to the immediate postpartum period.²³⁵ The highest risk for maternal suicide occurs at nine to 12 months postpartum.²³⁶

KEY RESOURCE: California's Maternal Mental Health Strategic Plan (MMH Task Force) (2017) <https://static1.squarespace.com/static/56d5ca187da24ffed7378b40/t/5b40f84503ce641f98dbd329/1530984521889/Report-CATaskForce-7.18.pdf>.

Research has demonstrated that lives can be saved from suicide and that public health approaches have the potential to prevent loss of life on a broad scale.

Best Practice in Suicide Prevention

The Institute of Medicine organizes suicide prevention activities along a continuum, ranging from universal to selective to indicated.²³⁷ Universal prevention efforts focus on the entire population and seek to deter suicidal behaviors by creating safe environments, increasing connectedness, building skills, and promoting mental health.²³⁸ Selective prevention efforts target people within vulnerable groups who have been identified as at greater risk for suicidal behaviors.²³⁹ Indicated prevention efforts focus on serving people engaged in suicidal behavior and providing timely intervention to prevent future suicidal behavior.²⁴⁰ Best practices reach across the social ecology, intersecting at person, relationship, neighborhood, and societal levels.²⁴¹ Certain suicide prevention activities with strong evidence of effectiveness have demonstrated significant return on investment. These include training for health professionals; early identification of behavioral health needs, particularly depression; and creating barriers to prevent people from accessing methods to die by suicide.²⁴²

Best practices can lead to successful outcomes only if strong infrastructure is in place. For the purposes of this plan, infrastructure refers to visible, multilevel leadership and networked partnerships; effective management of resources; and use of data for monitoring and improvement.²⁴³ Suicide prevention, as a public health challenge, is not unique in requiring infrastructure to support the delivery of best practices. An analysis of California's anti-tobacco initiative, for example, found that creating anti-smoking infrastructure was identified as the biggest challenge to the success of the effort.²⁴⁴ Many of the best practices described below already are in use in select settings or communities throughout California.

Universal Prevention Strategies

Universal suicide prevention strategies are broad and are intended to reduce risk in the general population. Best practices in this category focus on protecting the safety and health of the community through reducing access to lethal means, connecting people to social networks, building resiliency, safe reporting by the media following a suicide death, and increasing access to care. Research demonstrating the effectiveness of universal prevention strategies is scarce, limiting both knowledge about such strategies and investment in their development. The section below highlights best practices in universal suicide prevention.

Lethal Means Restriction

Lethal means restriction – or reducing someone’s access to the lethal methods by which to die by suicide – is one of the best empirically supported methods of reducing suicide.²⁴⁵ The effectiveness of reducing access to lethal means has been demonstrated in multiple countries and across a wide range of interventions.²⁴⁶ The United Kingdom saw a reduction in suicides following replacement of coal gas – which contains carbon monoxide – with natural gas.²⁴⁷ After Israel adopted a policy requiring soldiers to lock their weapons in storage when on leave, suicide deaths were reduced by 40 percent.²⁴⁸ A ban on certain chemicals in Sri Lanka was associated with a reduction in suicides involving pesticides in that country.²⁴⁹ Suicide deaths by carbon monoxide dramatically decreased following the implementation of strict controls on motor vehicle exhaust gas emissions in the U.S.²⁵⁰ And policies that limited the number of prescriptions written for certain medications, along with their pack size, resulted in fewer suicides involving those medications in several countries.²⁵¹

Conversely, the potential consequences of removing safety measures also has been documented. The removal of safety barriers from a central city bridge in Australia, for example, led to an immediate increase in the numbers and rate of suicide at the bridge.²⁵² Suicide deaths were reduced to zero at sites where barriers were removed and then reinstalled, as was the case in New Zealand.²⁵³ The effects of barrier installations are significant and immediate, and there is no evidence showing that their addition increases suicides at other locations or by other methods.²⁵⁴ In California, Caltrans is required to consider suicide risk in the design or redesign of bridges, and there are federal funds accessible for construction of suicide deterrent systems. However, there are no standards to guide prevention and policy at other sites.²⁵⁵

The most effective methods of lethal means restriction are physical deterrents, which include carbon monoxide emission controls in vehicles; locking screen doors, windows, and drawers; suicide deterrent systems on railways and bridges; firearm safety mechanisms, such as gun locks and safes; and overdose prevention, such as the use of naloxone or blister packaging of medications.²⁵⁶ Other effective methods include signage and connection to crisis services and means restriction counseling. Studies show that these methods can and should be combined with physical deterrents, where applicable.²⁵⁷

Focus on Common Lethal Means—As demonstrated above, policies restricting the availability and accessibility of the means by which people die by suicide has the potential to significantly reduce suicide rates by those means. In California (and nationally), where suicide most commonly occurs when firearms are used, access to and the availability of firearms increases risk for unnatural death, including suicide.²⁵⁸ Firearms that are loaded or unlocked are tied to increased risk for intentional and unintentional death.²⁵⁹ Policies that reinforce gun safety and safe storage practices have been found to reduce risk for injury and death. For example, state bans on the sale of handguns that do not adhere to safety standards – sometimes referred to as “junk guns” – have demonstrated population-level effects on reducing suicide rates.²⁶⁰ Some states have expanded temporary transfer laws to include a temporary transfer of a firearm from a person at risk to another person if such transfer is necessary to prevent imminent death or great bodily harm.²⁶¹ Finally, research has shown an association between risk-based gun removal laws and a reduction in suicides by firearm.²⁶² The Gun Violence Restraining Order is an example of a risk-based gun removal law in California.²⁶³ Granted by a court, such orders allow for the removal of all firearms and ammunition from certain people – those experiencing suicidal or homicidal thoughts or behaviors, for example – and prohibit purchase and ownership of firearms and ammunition during the duration of the order.²⁶⁴

In addition to policy changes to support means safety, programs to collaborate with gun shop and shooting range owners to prevent suicide among gun owners and their family members show promise. The Gun Shop Program, for example, was developed in New Hampshire after three people died by suicide by a firearm purchased at the same gun shop. Materials designed for and by gun shop owners were distributed to local shops and included information for identifying and interacting with a customer who may be at risk for suicide. Modeled after effective strategies in New Hampshire, the former Superior California Suicide Prevention Network developed best practice guidance on how to engage with community members on firearm suicide prevention messaging and approaches, such as increasing awareness of warning signs and increasing help-seeking by people at risk.²⁶⁵ Recognizing shared goals, the American Foundation for Suicide Prevention and the National Shooting Sports Foundation are collaborating to expand awareness of firearm safety measures to prevent suicide.²⁶⁶ In Washington state, the National Rifle Association and the Second Amendment Foundation supported legislation to increase suicide prevention training and messaging for firearm professionals.²⁶⁷

California Community Highlight: The Golden Gate Bridge's Suicide Deterrent System

California is home to several bridge and rail sites where people die by suicide in large numbers every year. The most well-known among these is the Golden Gate Bridge in San Francisco.

An average of 30 people die by suicide each year at the bridge. Since the bridge opened in 1937, more than 1,700 people have lost their lives. Most people who die by suicide at the bridge are male, white, under 40 years of age, and live in the Bay Area. Fewer than 35 people have survived their attempt.

In addition to the roughly 30 known suicides in 2017, 235 people were saved from falling by a variety of public and private agencies and citizens, including the Golden Gate Bridge Patrol, California Highway Patrol, iron workers on the bridge, tow truck operators, Bridgewatch Angels volunteers, and many others.

Nets made of marine-grade woven steel, supported by scaffolding, are being installed to prevent death and deter people from considering the bridge a means of dying by suicide. The barrier will cost an estimated \$211 million in federal, state, and local funding.

Gaining approval to install the bridge barrier was not easy and took years, even requiring a change to federal transportation laws to allow for funding of suicide prevention projects. Many opponents of the bridge barrier cited aesthetic concerns. The barrier is expected to be fully installed by early 2021.

For more information, please visit <http://www.bridgerail.net/>.

While firearms cause the most deaths by suicide, overdose is the most common method of suicide attempt.²⁶⁸ In addition to policies that restrict prescriptions and allowable volumes of medications, other policies that increase the use of harm-reduction interventions can prevent overdose by certain drugs. For example, medication-assisted treatment – specifically, the use of naloxone – may reduce suicide by opioid overdose. Naloxone is a medication that works almost immediately to reverse opiate overdose. It has few known adverse effects, no potential for abuse, and can be rapidly administered through intramuscular injection or nasal spray. While most professional first responders and emergency departments are equipped with naloxone, emergency service providers may not arrive in time to revive overdose victims. In recent years, California has made naloxone more accessible through a statewide standing order allowing the administration of naloxone by family members and friends in a position to intervene during an opioid-related overdose.²⁶⁹

Assessing Access to Lethal Means—Assessing access to lethal means and providing counseling to restrict such access are two best practices shown by evidence to reduce suicidal behavior.²⁷⁰ One study found that families of high-risk youth were significantly more likely to remove or secure lethal means in the home when counseled in the emergency department following suicidal behavior by a child.²⁷¹ Despite such evidence, people identified as having suicidal ideation, or those who have been discharged from healthcare settings after attempting suicide, are not counseled routinely on means safety.²⁷² Counseling on Access to Lethal Means (CALM) is a free resource available to identify people who could benefit from lethal means counseling, ask about their access to lethal methods, and work with them—and their families—to reduce access.²⁷³ Health care providers are well-positioned to assess for access to lethal means when such a step is relevant to health care, but many feel uncomfortable doing so. In one study, community-based mental health providers were more likely to assess for and reduce access to lethal means collaboratively with people at risk and their families after they received training in CALM.²⁷⁴

Connectedness

Connectedness is the degree to which a person or group is socially close, interrelated, or shares resources with others.²⁷⁵ Connectedness can protect a person who is facing adversity. Peer programs in the military, for example, have been shown to effectively reduce risk for suicide when social networks are created between military members and their peers.²⁷⁶ Although communities are not necessarily bound by neighborhoods, schools, or other institutions, these structured environments can be catalysts for reducing suicide risk among a broad population. School connectedness has consistently been shown to play a critical role in protecting adolescents against many negative outcomes, including suicidal behaviors.²⁷⁷ Groups that promote connectedness, such as the school-based Genders and Sexualities Alliance, show promise in reducing suicidal ideation and attempt among youth.²⁷⁸ Family connectedness can buffer against suicide risk. Family acceptance of sexual orientation and gender identity among youth has been demonstrated to protect against suicide risk, and can be modified using evidence-based approaches, such as the Family Acceptance Project’s Family Intervention Approach.²⁷⁹

Risk for suicide is reduced when people have trust in social networks and are engaged in community.²⁸⁰ Research shows that there is a relationship between connectedness and safety, namely that people are more likely to socially engage in environments that are safe, affirmative, supportive, and free of violence and discrimination.²⁸¹ Suicidal behavior may share risk and protective factors with other forms of violence,

such as domestic violence and the maltreatment of children and the elderly.²⁸² Shared risk factors include lack of social support, economic stress, and substance use.²⁸³ Shared protective factors include the coordination of community resources and services, connectedness, and family support.²⁸⁴ Prevention resources to create training, programs, and partnerships can be used collectively to respond to multiple forms of violence, including suicide.²⁸⁵ Addressing multiple forms of violence is a prudent approach, especially because different forms of violence overlap and intersect.²⁸⁶

Resilience and Skills Training

Resilience is the ability to withstand, adapt to, and recover from adversity, threats, and stress. Resilience is associated with coping, or people's individualized ability to manage both everyday stressors as well as more extreme stressors in their lives. Communities – including neighborhoods, schools, and organizations – can build resilience by strengthening cultural values and cultural identity; by reinstituting collective history, language, spirituality, and healing practices; and through collective action.²⁸⁷ Culture in this context can refer to racial/ethnic; vocational, such as first responder and culinary; and special population, such as military culture.

Effective life skill interventions include techniques that promote critical thinking, conflict resolution, stress management, and coping, and that help people safely manage challenges such as economic stress, divorce, physical illness, and aging. Best practice approaches to building universal life skills have been developed for school-aged children and youth. The Good Behavior Game, for example, is an early education classroom management technique that shows promise in reducing suicidal behavior for decades following program delivery.²⁸⁸ Life skills programs tailored to specific cultural norms and values also are supported by evidence of their effectiveness. One, the American Indian Life Skills Development curriculum, shows promise in reducing depression and suicidal behavior among Native youth.²⁸⁹

Responsible Media Reporting

Exposure to suicidal behavior by one person may facilitate the occurrence of subsequent, similar behaviors by others, especially among adolescents.²⁹⁰ Due to exposure, multiple suicides may occur within a particular time period or location, a pattern known as a suicide cluster.²⁹¹ Suicide clusters are rare and happen almost exclusively among youth.²⁹² The media may inadvertently increase suicide risk when reporting the details of a suicide.²⁹³ For example, extensive media coverage of suicide – in amount, duration, and prominence – is associated with increases in suicide rates.²⁹⁴ Harmful media practices, such as reporting details about the method used, also may increase risk for suicidal behavior in others, especially young people.²⁹⁵ Further, suicidal behavior using a particular method – even an uncommon method – may increase if that method is identified and described in media reports.²⁹⁶

Best practice for responsible reporting of suicide include communicating messages demonstrating that suicide is preventable, printing or airing stories of hope and resilience, providing links to helping resources, and refraining from airing or publishing reports that sensationalize suicide. Local media can partner in effective suicide prevention by disseminating the message that suicide is preventable through fictional story lines, real-life reporting, billboards, and public service announcements.²⁹⁷ Positive storylines about mental health and suicide can prompt media consumers to take direct action to seek or provide help.²⁹⁸ Such storylines also empower people to have open conversations with friends and family.²⁹⁹

CALIFORNIA COMMUNITY HIGHLIGHT: RESPONSE FOLLOWING SUICIDE CLUSTER

Between May 2009 and March 2015, nine people who were either incoming or current high school students or alumni of a single Santa Clara County school district died by suicide. The California Department of Public Health requested assistance from the Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration to investigate the deaths and explore how youth suicide in Santa Clara County, its school districts, and its cities could be prevented in the future.

Recommendations included:

1. Using multiple prevention approaches to address multiple risk factors
2. Ensuring access to evidence-based mental health care
3. Strengthening family relationships and family-based programs
4. Increasing students' connection to school and school-based programs
5. Identifying and supporting people at risk
6. Strengthening crisis intervention
7. Delivering services to loss survivors in the event of a student suicide
8. Launching prevention efforts involving other forms of violence
9. Reducing access to lethal means for youth at risk
10. Using safe messaging and reporting about suicide
11. Engaging in strategic planning for suicide prevention
12. Selecting and implementing evidence-based programs
13. Mandating continuous program evaluation

For more information, please visit

<https://www.sccgov.org/sites/phd/hi/hd/epi-aid/Documents/epi-aid-report.pdf>.

Access to Health and Behavioral Health Care

Services that deliver appropriate, timely, and accessible health and behavioral health care have the potential to prevent suicide. Best practices include administrative policies, such as full coverage of behavioral health needs in insurance policies and managed care, as well as policies that address provider shortages, especially in rural and underserved communities.³⁰⁰ Policies to address provider shortages include the use of financial incentives and the expansion of telehealth approaches that connect providers

and clients through phone, video, and internet-based technologies.³⁰¹ Mobile and telehealth approaches may increase access to health care, especially in physically isolated communities.³⁰² Research on telehealth approaches to suicide care is limited but promising.³⁰³

Clear messaging to create easy pathways to available services also shows promise for suicide prevention. Messaging that encourages people to seek help includes teaching early recognition of behavioral health needs and reducing the stigma associated with seeking help by normalizing the behavior among peers. Peer norm programs seek to normalize protective factors – including reaching out and talking to trusted people – and also promote peer connectedness.³⁰⁴ By leveraging the leadership qualities and social influence of peers, these approaches can be used to shift group-level beliefs and promote positive social and behavioral change.³⁰⁵ This approach has been especially successful in school settings but has also shown promise in the workplace and other settings.³⁰⁶

Selective Prevention Strategies

Selective prevention strategies are those focused on detection of risk and the screening of select subgroups that may develop risk for suicidal behaviors. Best practices in this category are effective strategies used to identify risk and intervene early, and to connect people to services. Best practices in selective suicide prevention are highlighted below.

Collaborative Care

Collaborative care is an integrated care model that has been tested in over 80 randomized control trials. While it has not specifically been shown to reduce suicide, studies have confirmed the benefits of collaborative care for people with risk factors for suicide, namely depression and anxiety.³⁰⁷ Under this model, traditional primary care is integrated with a team comprised of a care coordinator and a specialty behavioral health provider.³⁰⁸ This team creates a holistic plan for the person based on best practices, client-directed goals, and the monitoring of those goals, making adjustments as needed when progress is stalled. Two landmark studies demonstrate reduced suicidal ideation using collaborative interventions for older adults experiencing depression. The Prevention of Suicide in Primary Care Elderly: Collaborative Trial reduced suicidal ideation and depression among older adults through a collaborative approach between a person, a primary care physician, and a health specialist, such as a nurse, social worker, or mental health provider.³⁰⁹ Second, the Improving Mood—Promoting Access to Collaborative Treatment approach involves developing a care plan – with input from the person, primary care provider, care manager, and consulting psychiatrist – to reduce depression and suicidal ideation in older adults. Evaluation of this model demonstrated significant decreases in depression and suicidal ideation, in addition to improved functional and quality of life outcomes.³¹⁰

Depression Screening and Management by Physicians

The majority of people who die by suicide had contact with their primary care physician in the year prior to death, while almost half had contact in the month preceding death.³¹¹ Despite such contact, suicide risk is under-recognized and underserved in these critical primary care settings.³¹² Nearly 70 percent of people experiencing depression who see a primary care physician will report physical complaints, such as physical pain or sleep disturbances.³¹³ Training for primary care physicians on identification of suicide risk and treatment of depression and other risks, such as substance use, shows promise in preventing suicide, especially when delivered in collaborative care models.³¹⁴

Gatekeeper Training

Gatekeeper training is designed to train teachers, families, coaches, military commanders, supervisors, clergy, emergency responders, urgent care providers, and others in the community to identify people who may be at risk of suicide and to respond effectively, including facilitating connection to services.³¹⁵ Gatekeeper training focuses on increasing a person's ability to recognize warning signs of suicide and provide referral.³¹⁶ Some trainings include information on delivering brief interventions to support people at risk for suicide, such as reducing a person's access to lethal means.³¹⁷ Gatekeeper training may be implemented in a variety of settings to identify and support people at risk.³¹⁸ Such trainings have been shown to increase knowledge of risk factors and warning signs and increase confidence among people responding to someone expressing a desire to die.³¹⁹

CALIFORNIA COMMUNITY HIGHLIGHT: AVAILABLE GATEKEEPER TRAININGS

Below are several options for suicide prevention awareness and support trainings for gatekeepers. While not exhaustive, this list is intended to give the reader a starting point to explore available trainings.

Question, Persuade, Refer (QPR) | <https://qprinstitute.com/>.

Trainings by **Living Works** | <https://www.livingworks.net/>.

Trainings specific to school settings available through the **American Foundation for Suicide Prevention** | <https://afsp.org/our-work/education/more-than-sad/> and <https://afsp.org/our-work/education/signs-matter-early-detection/>.

Crisis Response

Crisis response can include a variety of crisis services, ranging from warm lines and crisis lines to crisis stabilization support and short-term crisis residential care.³²⁰ Best practice approaches for systematic crisis response include centralized call centers that use real-time coordination across systems, coordinated mobile crisis outreach and support, and crisis residential and stabilization services.³²¹ The delivery of coordinated crisis services also has been shown to reduce redundancies and costs associated with connecting people with an appropriate level of care to prevent suicidal behavior.³²²

Under effective models, suicide prevention hotline, text, and chat services provide 24-hour support to conduct suicide assessment and intervention, provide referrals to appropriate services, help people develop safety plans, and connect people with mobile crisis or emergency resources.³²³ The hotlines generally prevent suicide in two ways: They ensure the immediate safety of at-risk callers, and they link those who may be at risk of suicide with appropriate and available resources.³²⁴ Effective training and standards for practice are critical. A study of crisis line staff who received Applied Suicide Intervention Skills Training showed improved outcomes for callers, including reduced depression, a reduced sense of being overwhelmed, lower suicide risk, and increased hopefulness.³²⁵

CALIFORNIA COMMUNITY HIGHLIGHT: CALTRANS DISTRICT 7 AND DIDI HIRSCH COLLABORATION

Local transportation leaders are partnering with suicide prevention centers to create safe environments with physical deterrents and crisis services messaging and response. Caltrans District 7, which covers Los Angeles and Ventura counties, in partnership with Didi Hirsch Mental Health Services and regional first responders, are working to prevent suicide by identifying community sites used for suicidal behavior, constructing barriers, when feasible, and installing suicide hotline signage and cameras, where appropriate. The effort is supported by a committed network of partners, including first responders, facility and equipment owners, suicide prevention and crisis services, and local authorities. Coordination continues once a site is identified and fortified. For example, trained camera monitors identify a person at risk and alert first responders and crisis services.

For more information, please visit <http://didihirsch.org/>.

Indicated Prevention Strategies

Indicated prevention strategies focus on people engaged in suicidal behavior and people bereaved by the loss of a loved one to suicide. Best practices in this category focus on providing care that specifically targets suicidal behavior and following-up with people who have been discharged from healthcare settings after being served for suicidal behavior. Indicated prevention best practices also deliver coordinated, timely, and respectful services to suicide loss survivors.

Suicide Risk Assessment and Management

Best practice for screening and risk assessment in health and behavioral healthcare settings includes provider knowledge of risk and protective factors and warning signs, procedures for categorizing risk and making clinical decisions based on risk, evidence-based assessments and safety planning, documentation of risk level and action taken, and caring referral procedures.³²⁶ Standardization makes the entire process of identifying risk and connecting people to services transparent and collaborative for the provider and person at risk.³²⁷ Two steps are particularly critical to this collaborative process – obtaining informed consent and the use of a standardized decision-making process to routinize risk designations based on suicide attempt history, the severity of current symptoms of suicide risk, and the integration of risk factors.³²⁸ Standardizing risk assessment and management has the potential to reduce clinical or legal concerns about errors in judgment that might overestimate or underestimate risk.³²⁹ Suicide risk assessments help identify acute, modifiable, and treatable risk factors and help providers recognize when people need more structured methods for managing daily living.³³⁰

The Columbia-Suicide Severity Rating Scale is a common screening tool that uses a series of questions in plain language to help users identify whether a person is at risk for suicide, assess the severity and immediacy of the risk, and identify possible support.³³¹ The tool is suitable for all ages and special populations and is available in over 100 country-specific languages.³³² In healthcare settings, the Patient

Health Questionnaire (PHQ9) is an assessment that asks nine questions about depressive symptoms experienced in the prior two weeks, with one question devoted to thoughts of dying or being “better off dead.” The PHQ9A is the PHQ9 modified for adolescents ages 11 to 17.³³³ Finally, the Ask Suicide-Screening Questions is a tool used to identify a youth at risk in medical settings and takes less than one minute to complete.³³⁴ Positive screens obtained through the use of this tool prompt providers to conduct additional, in-depth assessments.³³⁵

Safety planning is a brief intervention that incorporates best practices in means restriction, problem-solving, social support, and emergency resources.³³⁶ Safety planning is not a “no-harm contract” or “contract for safety” that requires people at risk to promise a provider the person will not engage in suicidal behavior; research shows such “contracts” are not effective and actually can increase risk.³³⁷ The Safety Plan, developed by Barbara Stanley, Ph.D. and Gregory Brown, Ph.D., and Crisis Response Planning tools are evidence-based and commonly used in many settings. The Safety Plan includes methods for keeping homes safe; recognizing warning signs of suicide; identifying ways to cope with thoughts of suicide; and identifying friends, family, and mental health and emergency resources, such as the location of the nearest emergency department.³³⁸ Crisis Response Planning is a strategy used to develop written steps for a person at risk for suicide to take during times of crisis or when under stress. Using an index card, people list steps for identifying personal warning signs, along with coping strategies and social and professional support. Results of a randomized clinical trial show that Crisis Response Planning reduced suicide attempts by 75 percent compared to using safety contracts, or contracts in which a person vows not to self-injure.³³⁹

Treatment Interventions

Effective care that targets suicide risk specifically is effective when it is structured and integrates problem-solving skills; collaborative assessment; service planning; and caring, consistent follow-up.³⁴⁰ Below are behavioral and pharmacological interventions shown to be efficacious in the treatment of suicidal behaviors:

- **Dialectical Behavioral Therapy** is a cognitive behavioral treatment that combines therapy, skills training, and coaching and has been shown to be effective for treating suicidal behavior and non-suicidal self-injury at any age.³⁴¹ Dialectical Behavioral Therapy has been adapted for adolescents in a shorter format – from 16 weeks to 12 months – and includes skill modules to improve parent-child communication, among other skills.³⁴² In addition, nonclinical applications have been adapted for school settings and teach students in grades six through 12 mindfulness, emotional regulation, and interpersonal skills.³⁴³
- **Cognitive Behavioral Therapy for Suicide Prevention** is a cognitive behavioral treatment for people who have attempted suicide within the last 90 days.³⁴⁴ The primary goals of this intervention are to reduce suicide risk factors, enhance coping skills, and prevent future suicidal behavior.³⁴⁵ The therapy is designed to help people use more effective means of coping with stressors and problems that trigger suicide crises.³⁴⁶

- **Collaborative Assessment and Management of Suicidality** is a suicide-specific therapeutic framework that can be delivered with other treatments and across different settings, including community and inpatient settings.³⁴⁷ A psychotherapeutic framework that “amplifies active collaboration” between a service provider and a person at risk, it assesses for and addresses factors that are increasing risk.³⁴⁸ The alliance between provider and client is intended to support the person at risk’s motivation to live.³⁴⁹
- **The Attempted Suicide Short Intervention Program (ASSIP)** is a brief intervention specifically for attempt survivors.³⁵⁰ It emphasizes the therapeutic alliance between provider and survivor developed in an initial interview. Findings are promising. When combined with clinical treatment, ASSIP was able to reduce suicidal behavior over a two-year period for people who recently attempted suicide.³⁵¹ ASSIP also has been demonstrated to reduce health care costs.³⁵²
- **Pharmacological interventions** can reduce suicide risk by addressing mental health needs.³⁵³ Antidepressants, such as selective serotonin reuptake inhibitors, can alleviate depression and associated suicide risk.³⁵⁴ Lithium for the treatment of mood disorders and clozapine for the treatment of schizophrenia have been shown to reduce suicide among people with these needs.³⁵⁵

Innovations in this area continue, and largely target highly treatable risk factors – such as insomnia – with low-risk interventions to prevent suicide.³⁵⁶ Non-mental health interventions show promise for targeting risk. One example are services that address sleep disturbances, which may reduce risk and can be delivered through brief, targeted interventions.³⁵⁷ Repetitive transcranial magnetic stimulation (rTMS) also shows promise in addressing suicidal ideation. This approach uses a magnet to target and stimulate specific areas of the brain and is typically used to treat depression and anxiety. In one study, 40 percent of people served with bilateral rTMS therapy reported no longer experiencing thoughts of suicide.³⁵⁸ In addition, ketamine is a pharmaceutical drug recently approved for therapeutic use to rapidly reduce depressive symptoms and suicidal ideation.³⁵⁹ Studies show acute suicide risk is almost immediately reduced with administration of ketamine, and beneficial effects can extend up to 10 days.³⁶⁰

Emergency Department Interventions

Emergency departments play a key role in suicide prevention efforts.³⁶¹ Statistics show that 20 percent of people who die by suicide visited an emergency department within a month of death, and 60 percent of survivors of suicide attempt sought medical care for their injuries in emergency departments. National data suggest that interventions in the emergency department may decrease suicide deaths by 20 percent.³⁶² The Emergency Department Safety Assessment and Follow-Up Evaluation study evaluated an emergency department intervention that combined universal screening for suicide risk; secondary assessment by a physician; resources at discharge, including a safety plan; and follow-up telephone calls over a year-long period. The study found significant decreases in suicidal behavior among people who received the intervention.³⁶³

The effectiveness of delivering follow-up care – also referred to as caring contacts – to people discharged from hospital settings after suicidal behavior is backed by strong evidence.³⁶⁴ One of the most empirically successful approaches to suicide prevention was the “caring letters study,” in which contact after

discharge significantly reduced suicide among people who were hospitalized for depression or suicide risk.³⁶⁵ People who participated in the study were contacted using low-cost methods, such as postcards and short, caring notes, at least four times a year for five years.³⁶⁶ Suicide rates were compared with people who received no contact following discharge during the same period.³⁶⁷ People in the contact group had a lower suicide rate in all five years of the study.³⁶⁸ Another study demonstrated significant return-on-investment for commercial insurance and managed care plans when people released from hospital or emergency departments for suicidal behavior received follow-up phone calls.³⁶⁹ Likewise, follow-up calls from crisis line providers are not only cost-effective, but have been shown to reduce future suicidal behavior for people discharged from health care settings.³⁷⁰

CALIFORNIA COMMUNITY HIGHLIGHT: WELLSPACE HEALTH

California communities are linking suicide prevention centers with healthcare systems to deliver best practices. One example is WellSpace Health in Sacramento. WellSpace Health delivers integrated health and behavioral health care and operates the Suicide Prevention Crisis Line serving Northern California counties. One program, the Primary Care Follow Up Suicide Prevention program, integrates screening for suicide risk in primary care and refers people to 24-hour crisis lines through the electronic health record. The program also provides 30 days of follow-up, risk monitoring, emotional support, resource linkage, and safety planning. Another initiative, the Emergency Department Follow-Up program, reaches out to people at risk who are nearing discharge from hospital settings within 24 hours of discharge, delivering follow-up services that include emotional support, risk assessment, safety planning, and monitoring.

For more information, please visit

<https://www.wellspacehealth.org/services/behavioral-health-prevention/suicide-prevention>.

Postvention

Postvention efforts are organized prevention activities directed toward suicide loss survivors, or people who have lost a loved one to suicide. These survivors may include family, friends, clinicians, physicians, coworkers, and crisis line volunteers. Loss survivors sometimes encounter stigma associated with suicide, a reaction that may not accompany other manners of death and can act as a profound barrier to overcoming grief.³⁷¹ Activities that may carry benefits for loss survivors include services to address grief and distress associated with suicide loss, services that specifically mitigate negative effects of exposure to suicide, and services that prevent suicide by people at risk following exposure to suicide.³⁷² Face-to-face bereavement support groups are the most studied intervention for loss survivors, while bereavement services that take a family-oriented approach show promise.³⁷³ With this model, family members can explore together their individual responses following a suicide and assess the family's collective response.³⁷⁴ Family members may become more engaged in the healing process because the family support system is also being served and potential miscommunication or dysfunction is reduced.³⁷⁵

Five Year State Workplan

The workplan below outlines the next steps to implement state objectives identified in the Strategic Aims and Goals section of this plan. Next steps identified below are designed to support local and regional implementation and statewide advancement of objectives.



GOAL 1: ENHANCE VISIBLE LEADERSHIP AND NETWORKED PARTNERSHIPS

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 1A Establish centralized, visible state-level leadership by creating the Office of Suicide Prevention within the California Department of Public Health to provide strategic guidance, deliver technical assistance, develop and coordinate trainings, monitor data, conduct state-level evaluation, and disseminate information to advance statewide progress.</p>	<p>By July 1, 2021, the State should create the Office of Suicide Prevention under the California Department of Public Health.</p> <p>By December 31, 2021, the Office of Suicide Prevention should develop a plan to facilitate regional quarterly meetings across the state to share resources, best practices, and lessons learned in developing strategies to deliver a continuum of crisis services to prevent suicidal behavior.</p> <p>By July 1, 2022, the Office of Suicide Prevention should develop a strategy for leveraging federal grant and block grant funding and private investment in suicide prevention strategies.</p> <p>By July 1, 2022, the Office of Suicide Prevention should develop a strategy for evaluating the State’s suicide prevention plan and report annually on incremental progress toward each goal, including progress toward short-term targets and long-term outcomes.</p> <p>By July 1, 2023, the Office of Suicide Prevention should host and maintain an online clearinghouse to support implementation of best practices and technical assistance.</p>
<p>OBJECTIVE 1B Engage private and public partners by creating the California Suicide Prevention Council to advance suicide prevention efforts with strategic planning and dissemination of best practices in their respective sectors.</p>	<p>By July 1, 2021, the State should create the California Suicide Prevention Council and appoint councilmembers. The Office of Suicide Prevention should provide administrative support to the council.</p> <p>By December 31, 2021, the California Suicide Prevention Council should hold its first meeting and develop a strategic work plan. The work plan should include how the council will support the state strategies outlined in this plan.</p> <p>By July 1, 2022, the California Suicide Prevention Council should form sector-specific or strategy-specific subgroups to focus expertise within the council and develop guidance to support suicide prevention efforts in specific sectors.</p>



GOAL 2: INCREASE DEVELOPMENT AND COORDINATION OF SUICIDE PREVENTION RESOURCES

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 2A Accelerate the development and management of suicide prevention resources in communities across California, and support capacity building to use best practices in suicide prevention by disseminating guidance and resources.</p>	<p>By July 1, 2021, the State should create incentives for local and regional suicide prevention planning and implementation, including offering grants to support capacity building to deliver best practices prioritized in the state’s plan.</p> <p>By July 1, 2021, the State should amend existing legislation requiring public schools with students in grades K through 12 to develop a suicide prevention policy by including a provision of oversight by the Department of Education. The amendment should require schools to submit policies to the department for review and dissemination, and the department should deliver technical assistance and support to schools without policies. The department also should examine barriers to suicide prevention identified by schools – including liability issues, privacy laws, security measures, and legal requirements for parental consent – and develop recommendations to address them. The department should be required to collect aggregated data on suicide risk assessments conducted by schools, including student demographics (grade, sex, race/ethnicity, sexual orientation, and gender identity) and suicide risk level data.</p> <p>The Department of Education should evaluate the effectiveness of current school policies and revise its model policy based on best practices. In addition, the department should develop a strategy for evaluating policies on an ongoing basis, through metrics such as reductions in suicidal behavior, increases in connection to services, and increases in students and school personnel seeking help.</p> <p>By July 1, 2021, the State should amend existing legislation requiring public schools with students in grades K through 12 to develop a suicide prevention policy by expanding this mandate to colleges and universities.</p> <p>By July 1, 2022, the Office of Suicide Prevention should disseminate information to support local suicide prevention planning and implementation, which may include methods such as holding regional learning collaboratives and communities of practice to share resources and data, best practices, and lessons learned.</p>



GOAL 2: INCREASE DEVELOPMENT AND COORDINATION OF SUICIDE PREVENTION RESOURCES

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 2B Identify opportunities to implement the integration of suicide prevention strategies across systems and programs. The state should seek opportunities to promote communication and information sharing among private and public partners and provide guidance on incorporating suicide prevention messaging into diverse settings, strategies, and public health campaigns.</p>	<p>By July 1, 2022, the Office of Suicide Prevention and the California Suicide Prevention Council should develop and disseminate guidance to increase effective collaboration among public and private partners to integrate suicide prevention strategies across statewide programs and initiatives. This guidance must include disseminating information for increasing collaboration with people with lived experience with suicidal behavior and behavior health needs.³⁷⁶ This effort must include a description of legal and ethical challenges and barriers that may arise as services are integrated, such as challenges and barriers associated with sharing confidential information.</p>
<p>OBJECTIVE 2C Align efforts and investments to address multiple forms of violence that may share risk and protective factors with suicide, including strategies for reducing trauma in early childhood.</p>	<p>By July 1, 2022, the State, with leadership from the Department of Public Health and private and public partners, should conduct an environmental scan of population-based universal violence prevention strategies and programs across the state. This survey should include suicide prevention programs as well as those that address shared risk and protective factors for multiple forms of violence.</p> <p>By December 31, 2022, the State, with leadership from the Department of Public Health and private and public partners, should develop recommendations to help communities increase community cohesion and safety, especially for vulnerable groups, and highlight areas of California where programs are making an impact. The effort should focus on ways to increase key protective factors, including connectedness, resiliency, and economic opportunity, as well as other social determinants of health.</p> <p>By July 1, 2023, the State, with leadership from the Department of Public Health and private and public partners, should identify a common set of measures and indicators that could be used by programs addressing violence prevention to enhance alignment, track progress, and improve understanding of needs and gaps statewide.</p>



GOAL 3: ADVANCE DATA MONITORING AND EVALUATION

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 3A Establish centralized electronic reporting systems to capture data related to suicide deaths and suicidal behavior. The systems should include data by demographics – such as race/ethnicity, age, sex, gender identity, and sexual orientation – as well as vulnerable group membership, such as military service and women in the perinatal and postpartum period. Uniform coding procedures should be used.</p>	<p>By July 1, 2021, the State should authorize counties to utilize interagency death review team models to identify, review, and evaluate suicide death trends, circumstances, and outcomes to inform and strengthen local prevention strategies, including the sharing of confidential information while protecting privacy.</p> <p>By July 1, 2021, the State should create incentives for schools to regularly participate in the California Healthy Kids Survey to monitor trends in suicidal behavior among students. These should include allocating additional resources to create reports on student suicidal behavior that are specific to each school and additional incentives for collecting key demographic data, such as sexual orientation and gender identity.</p> <p>By December 31, 2021, the State, with leadership from the Department of Public Health, should expand the existing California Violent Death Reporting System (CalVDRS) to more counties to collect and analyze local and state suicide data by delivering technical assistance to local coroners and medical examiners. The assistance should enhance the timely and electronic reporting of suicide deaths and their circumstances – including contributing factors and the specific location of death if outside the home – to help identify and fortify the safety of sites used by people to die by suicide.</p> <p>The State should invest additional resources in technical assistance to increase participation by coroners, medical examiners and law enforcement agencies in the CalVDRS to provide more detailed information on circumstances surrounding violent deaths, including suicide. This detail should include standardized data on demographic characteristics, membership in a vulnerable group, utilization of mental health services prior to death, and social determinants, such as housing and employment status.</p> <p>By January 1, 2022, the State, with leadership from the Department of Public Health and the Department of Health Care Services, should identify additional data elements to be collected via the California Health Interview Survey. The additional data should focus on suicide risk and protective factors to improve monitoring of suicidal behavior across the state.</p>


GOAL 3: ADVANCE DATA MONITORING AND EVALUATION

State Objective	Implementation Schedule, 2020 – 2025
OBJECTIVE 3A <i>continues</i>	<p>By July 1, 2023, the State, including private and public partners, should develop and implement a strategy to improve the standardization of coding and reporting of suicidal behavior, including the development of guidelines for determining intent to die by suicide. The state also should develop a plan to deliver training and technical assistance to hospital representatives to improve the identification, coding, and reporting of suicidal behavior for people seen in emergency departments and admitted to hospitals.</p> <p>By December 31, 2023, the State, including private and public partners, should create a mechanism for centralized and electronic reporting of the number of people screened for suicide risk in hospitals and emergency departments, and data documenting how those who were positively identified at various levels of risk were triaged into services. For example, data in electronic health records could be extracted and aggregated prior to submission to a centralized database. This effort also should explore opportunities to expand the State’s participation in the Centers for Disease Control and Prevention’s National Syndromic Surveillance Program BioSense Platform, a database that collects and analyzes near real-time data and trends on people receiving services in emergency departments.³⁷⁷</p>
OBJECTIVE 3B Develop a data monitoring and evaluation agenda on suicide deaths and suicidal behavior, including data elements documenting interrupted or aborted suicide attempts and crisis service interventions (“save data”) that resulted in the de-escalation of desire and intent to die by suicide. The agenda should include guidance to support state and local data and information sharing, including methods for sharing confidential information among diverse partners while adhering to state and federal privacy and security laws.	<p>By December 31, 2021, the Office of Suicide Prevention should create a task force, including people with lived experience and other subject matter experts, to develop a data monitoring and evaluation agenda on suicidal behavior, including data elements documenting interrupted or aborted suicide attempts and crisis service interventions that resulted in the de-escalation of desire and intent to die by suicide. The agenda should include guidance on local program evaluation and should identify measures to monitor state-level outcomes. The agenda should create and implement methodology for using suicide death and suicidal behavior data to evaluate the proportion of suicidal behavior that results in death, and should describe how trends in high-risk groups and lethal means used will be monitored. The task force should identify opportunities for expanding research exploring community-defined practices that reduce suicide risk in diverse cultural groups and should disseminate findings directly to affected communities and the public.</p>



GOAL 3: ADVANCE DATA MONITORING AND EVALUATION

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 3B <i>continues</i></p>	<p>By July 1, 2023, the task force should develop for the Governor and Legislature a proposal to create a centralized, electronic database and reporting standards to capture data on interrupted or aborted suicide attempts and crisis service interventions that resulted in the de-escalation of desire and intent to die by suicide. The data must include the type of intervention used and should include the type of services referred and the duration between incident and entry into services. Data sources include, but are not limited to, first responders, emergency and health care providers, crisis service providers, and bridge and transportation representatives. The proposal must include an estimate for costs associated with the centralized database, as well as reporting standards.</p>
<p>OBJECTIVE 3C Standardize policies and procedures for investigating and reporting suicide as a cause of death. These should include uniform definitions of suicide, as well as protocols for working with suicide loss survivors and informing health officials in the context of a suicide cluster. Protocols should include clear requirements for how cause of death is determined, how investigations are conducted, and how information is reported, and by whom, within a certain time following death. Training on methods for minimizing misclassification and accelerating timely reporting also should be provided.</p>	<p>By July 1, 2023, the Office of Suicide Prevention should form a task force to develop and disseminate best practices in suicide death investigation procedures, including guidance for coroners and medical examiners for documenting behavioral issues, hospitalizations, medications, histories of suicidal behavior, and family behavioral health history.</p> <p>Guidance should include methods for sharing data with local or state death review teams with the goal of identifying opportunities for improvement in prevention strategies. The input also should include guidelines for coroners and medical examiners for identifying and reporting sexual orientation and gender identity of people who die by suicide and should include recommendations for any necessary modifications to existing reporting systems to enable reporting on sexual orientation and gender identity of people who die by suicide.</p>



GOAL 4: CREATE SAFE ENVIRONMENTS BY REDUCING ACCESS TO LETHAL MEANS

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 4A Create a research and policy agenda to advance the goal of creating safe environments by reducing access to lethal means.</p>	<p>By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 2. Exploring opportunities to 1) clarify criteria for when a firearm should be returned to the gunowner after it was transferred specifically to prevent a suicide attempt under current law; and 2) for strengthening gun violence prevention measures, such as expanding eligibility for obtaining Gun Violence Restraining Orders and expanding requirements for background checks at the point of firearm sale, were identified as a priority in the drafting of this plan.</p>
<p>OBJECTIVE 4B Monitor state-level trends in lethal means used for suicidal behavior and develop a statewide strategy for technical assistance to expand efforts to reduce access to the lethal means identified.</p>	<p>By December 31, 2021, the Office of Suicide Prevention should enter into data use agreements to receive suicide-related data from state departments to monitor the use of lethal means in suicidal behavior and evaluate trends. The office should use the data to tailor technical assistance resources. Information on reducing deaths by suicide and suicidal behavior using ligatures outside of correctional and hospital settings was identified as a need in the preparation of the state suicide prevention plan.</p> <p>By July 1, 2022, the State, with leadership from the Department of Public Health, should develop and implement a technical assistance strategy to expand information on practices for reducing access to lethal means and availability of methods that can prevent injury due to suicidal behavior and death by suicide, including policies to restrict access to guns and policies to increase use of gun locks, gun and medication safes, devices to dispose of unused medication, and medications to counteract overdose, such as naloxone for opioid overdose.</p>



GOAL 4: CREATE SAFE ENVIRONMENTS BY REDUCING ACCESS TO LETHAL MEANS

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 4C Disseminate information regarding federal funding available to support suicide barriers in the design or redesign of bridges and other sites where deaths by suicide may occur.</p>	<p>By December 31, 2022, the Office of Suicide Prevention should create an online clearinghouse of strategies and resources for reducing access to lethal means, including information on available private and public funding. The online clearinghouse should include methods to accelerate dissemination and implementation of best practices, such as quick factsheets and “how to” guides. The online clearinghouse should include information on new approaches to reducing access to lethal mean as they emerge.</p> <p>By December 31, 2023, the Office of Suicide Prevention should form a task force to review and make recommendations for modifying buildings, bridges, and other structures if such modifications are needed to prevent suicide at identified locations. The office should partner with the California Coastal Commission, the Office of Historic Preservation, transportation leaders, and others to address “line of sight” and other aesthetic concerns that may impede modifications that improve safety.</p>



GOAL 5: EMPOWER PEOPLE, FAMILIES, AND COMMUNITIES TO REACH OUT FOR HELP WHEN BEHAVIORAL HEALTH NEEDS EMERGE

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 5A Create a research and policy agenda to advance the goal of empowering people, families, and communities to reach out for help when behavioral health needs emerge.</p>	<p>By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 2.</p>



GOAL 5: EMPOWER PEOPLE, FAMILIES, AND COMMUNITIES TO REACH OUT FOR HELP WHEN BEHAVIORAL HEALTH NEEDS EMERGE

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 5B Integrate social-emotional learning programs into private and public education curricula to strengthen communication and problem-solving skills, emotional regulation, and conflict resolution skills among children and youth.</p>	<p>By July 1, 2024, the State, with leadership from the Department of Education, the State Board of Education, and the Instructional Quality Commission, should develop standards for social emotional learning and require implementation of such standards in schools.</p>



GOAL 6: INCREASE CONNECTEDNESS BETWEEN PEOPLE, FAMILY MEMBERS, AND COMMUNITY

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 6A Create a research and policy agenda to advance the goal of increasing connectedness between people, family members, and community.</p>	<p>By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 2.</p>
<p>OBJECTIVE 6B Identify and promote opportunities to foster positive and supportive relationships.</p>	<p>By July 1, 2023, the Office of Suicide Prevention should develop and disseminate guidance on creating or expanding social support as a means of normalizing protective factors, such as reaching out for help for behavioral health needs and proactive problem-solving. Guidance should include how social support can be developed in diverse settings, including schools, workplace, and community settings. Guidance should include specific strategies to reduce risk for vulnerable group members. Guidance should include opportunities to leverage self-help groups, especially those supporting vulnerable group members, such as Alcoholics Anonymous, and support groups, such as the National Alliance on Mental Illness' Connection Recovery Support Group. Guidance should include measures of effectiveness specific to reducing suicide and suicidal behavior and methods for evaluation.</p>



GOAL 7: INCREASE THE USE OF BEST PRACTICES FOR REPORTING OF SUICIDE AND PROMOTE HEALTHY USE OF SOCIAL MEDIA AND TECHNOLOGY

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 7A Create a research and policy agenda to advance the goal of increasing use of best practices in reporting of suicide and to promote healthy use of social media and technology.</p>	<p>By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 2.</p>
<p>OBJECTIVE 7B Increase awareness of best practices for reporting on suicides by collaborating with journalism associations and organizations to disseminate information and resources to journalism and media partners.</p>	<p>By July 1, 2022, the Office of Suicide Prevention should create a task force with media and journalism outlets and organizations that publish journalism ethics codes to develop a process for promoting and incentivizing the use of best practices for reporting of suicide. This effort should produce guidance on increasing awareness of best practices for reporting and messaging about suicide in the media and for partnering with media and entertainment industry representatives. It also should include a strategy for dissemination of resources.</p>
<p>OBJECTIVE 7C Integrate into college and university journalism curricula best practices for communicating about suicide through various forms of media and entertainment.</p>	<p>By July 1, 2024, the Office of Suicide Prevention should form a task force to develop recommendations for integrating best practices for communicating about suicide in the media in college and university journalism programs.</p>
<p>OBJECTIVE 7D Identify and disseminate best practices for using and consuming social media and technology to improve wellbeing, destigmatize mental health needs, and increase help-seeking for behavioral health services.</p>	<p>By July 1, 2024, the State, including private and public partners, should develop a process for disseminating information and resources on the healthy use of social media, tailored to age-group and setting, as well as information and resources for parents and caregivers.</p>



GOAL 8: INCREASE DETECTION AND SCREENING TO CONNECT PEOPLE TO SERVICES BASED ON SUICIDE RISK

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 8A Create a research and policy agenda to advance the goal of increasing detection and screening to connect people to services based on suicide risk.</p>	<p>By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 3. Improving compliance with state and federal parity laws and timely access to health and mental health care, and ensuring insurance coverage of preventative services were identified as key policy areas identified during the drafting of this plan.</p>
<p>OBJECTIVE 8B Adopt the Zero Suicide Initiative within health and behavioral health care systems.</p>	<p>By January 1, 2023, the State, in consultation with private and public partners, should form a task force to make recommendations for implementing the Zero Suicide Initiative framework into public and private health and behavioral health care systems across California. This effort should include the identification of state funds that may be needed to build capacity for technical assistance and training. As part of this initiative, the department should partner with California health systems currently implementing the Zero Suicide Initiative, such as Kaiser Permanente.</p>
<p>OBJECTIVE 8C Expand resources to support health care providers increase access and linkage to behavioral health services and culturally appropriate support services for people identified as needing such services. This strategy includes providers in correctional settings.</p>	<p>By July 1, 2022, the State, in consultation with private and public partners, should create incentives to expand the use of Collaborative Care in health care systems. Options may include expanding the scopes of practice for physician assistants and nurse providers specifically trained in suicide prevention risk assessment, management, and referral; creating guidance and reducing barriers for billing health plans for services; and reducing documentation burdens.</p>



GOAL 8: INCREASE DETECTION AND SCREENING TO CONNECT PEOPLE TO SERVICES BASED ON SUICIDE RISK

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 8D Increase standardized training offered to health and behavioral health care providers in suicide risk assessment and management best practices. Enhance uniform suicide risk assessment and management in health and behavioral health care settings to align with Joint Commission guidelines and the Zero Suicide Initiative. Such settings include state and local correctional facilities.</p>	<p>By December 31, 2022, the Office of Suicide Prevention should disseminate guidance on screening for suicide risk for at-risk groups, including people exposed to physical and sexual abuse, victims of domestic or other interpersonal violence, families and youth in the child welfare system, LGBTQ-identified and questioning youth, and people in detention settings or on probation or parole supervision.</p> <p>By July 1, 2023, the State, in consultation with private and public partners, should develop a strategy for delivering training in best practices for suicide risk assessment and management to all health care providers. Because health care providers are at increased risk for suicide themselves, trainings should include a component on best practices for provider wellness, including methods of reducing burn-out, compassion fatigue, and vicarious trauma.</p>
<p>OBJECTIVE 8E Invest in technology in health and behavioral health care systems to improve uniform suicide risk assessment and management. Goals include identifying people at risk and triaging those at risk into appropriate services and culturally appropriate support.</p>	<p>By July 1, 2023, the Office of Suicide Prevention should form a task force to develop and disseminate guidance on the use of technology to support suicide risk assessment and management, and to improve the triaging of people in high-risk settings, including health care systems. This effort also should assess the use of administrative data to detect and monitor suicide risk when screening is not feasible. For example, school administrative data indicating risk might include absences, excessive tardiness, and significant changes in academic performance and behavior in school.</p>



**GOAL 9: DELIVER A CONTINUUM OF CRISIS SERVICES
WITHIN AND ACROSS COUNTIES**

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 9A Develop and implement a strategy to coordinate the delivery of crisis services, including an assessment of current crisis services infrastructure and private and public funding for services.</p>	<p>By July 1, 2022, the State, with leadership from the Department of Health Care Services and private and public partners, should form a task force to develop a strategy for evaluating crisis services and to determine the extent to which crisis services prevent suicidal behavior. Based on its findings, the task force should make recommendations for standardizing crisis service delivery systems across the state. The recommendations should address training and capacity barriers, and the evaluation plan should be implemented by July 1, 2023.</p> <p>As part of this effort, the State should assess the current capacity for training and technical assistance and determine what additional assistance is needed to systematically improve crisis services statewide, including opportunities to expand bilingual and bicultural crisis providers. The department should explore the possibility of implementing the Crisis Now Model across California.³⁷⁸ The department also should develop a process to monitor quality assurance and quality control of crisis services, including how the state will regularly track data, targets, and measures and report to the public. After assessing need and identifying private and public funding sources, the department should make recommendations to the Governor and Legislature about any additional resources required to ensure the crisis services network is sufficiently funded. The department should consider the use of a tool, such as the Crisis Resource Need Calculator, for its assessment.</p> <p>By December 31, 2022, the Office of Suicide Prevention should develop and disseminate guidance on planning and coordinating crisis services for schools, colleges, and universities to prevent suicidal behavior among students. The guidance should include information about how schools could formally connect to crisis services and supports in the community.</p> <p>By December 31, 2022, the Office of Suicide Prevention should develop and disseminate guidance on integrating best practices in suicide prevention in crisis intervention training as well as co-responder models, in which law enforcement and mental health providers respond jointly to behavioral health crises. The best practices should include assessment and referral to services based on suicide risk and on increasing safety by reducing access to lethal means.</p>



GOAL 9: DELIVER A CONTINUUM OF CRISIS SERVICES WITHIN AND ACROSS COUNTIES

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 9B Create a research and policy agenda to advance the goal of promoting a continuum of crisis services within and across counties.</p>	<p>By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 3.</p>
<p>OBJECTIVE 9C Create uniform standards for suicide and crisis hotlines in the state, including standards for training and core competencies for call responders; protocols for performance and quality assurance monitoring; and procedures for making referrals to services, including emergency services.</p>	<p>By December 31, 2021, the Office of Suicide Prevention should develop a strategy for collecting crisis services data and monitoring the quality, timeliness, and effectiveness of services to reduce suicidal behavior.</p> <p>As part of this effort, the office should develop uniform standards for suicide prevention hotlines and centers, including standards on training for hotline staff and performance targets. One option is the adoption of minimum standards set by an accrediting organization, such as the American Association of Suicidology or the National Suicide Prevention Lifeline. The office should identify incentives for adhering to uniform standards, such as making adherence a condition for state funding.</p>


GOAL 10: DELIVER BEST PRACTICES IN CARE TARGETING SUICIDE RISK

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 10A Create a research and policy agenda to advance the goal of delivering best practices in care targeting suicide risk.</p>	<p>By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 4. Implementing the Federal Parity Law and ensuring health insurance coverage for services to address suicide risk – specifically, mental health and substance use disorder services – were identified as key policy goals during the drafting of this plan.</p>
<p>OBJECTIVE 10B Create a process to certify providers trained in delivering best practices in suicide risk assessment and management and in interventions specific to preventing suicide. Certification could include minimum education, training, and continuing education requirements, and should include a review and approval process. This strategy includes providers in correctional settings.</p>	<p>By July 1, 2023, the State, in consultation with private and public partners, should create incentives for behavioral health licensing entities to develop a certification for providers who deliver best practices suicide risk assessment, management, and treatment and to develop a database of all certified providers that is accessible to the public.</p> <p>California’s mental health licensing entities include the Medical Board, the Board of Psychology, and the Board of Behavioral Sciences.</p>
<p>OBJECTIVE 10C Create a strategy to increase health and behavioral health care workforce capacity to deliver suicide-related services.</p>	<p>By December 31, 2022, the Office of Suicide Prevention should develop an online resource center to support continuing education for health and behavioral health care providers in best practices in suicide prevention interventions and therapies.</p> <p>By December 31, 2024, the State, in consultation with private and public partners, should require education and training in best practice therapies targeting suicide risk in all medical and clinical education training curricula.</p>



GOAL 11: ENSURE CONTINUITY OF CARE AND FOLLOW-UP AFTER SUICIDE-RELATED SERVICES

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 11A Create a research and policy agenda to advance the goal of ensuring continuity of care and follow-up after suicide-related services.</p>	<p>By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 4.</p>
<p>OBJECTIVE 11B Establish a program to deliver training on lethal means restriction counseling to health care providers, and distribute gun and medication lock boxes and locks to hospitals, with prioritized distribution to families and caregivers of people discharged following a suicide attempt.</p>	<p>By July 1, 2023, the State, in consultation with private and public partners, should create a program to support training for health care providers and hospitals on distributing means safety products, such as lock boxes for guns or medications, and education to families and caregivers of people discharged after receiving services for a suicide attempt. This effort should consider challenges and opportunities for integrating information on lawful options for transfer and removal of firearms and ammunition in the home to keep a person at risk safe from future injury and death.</p>
<p>OBJECTIVE 11C Ensure delivery of best practices for continuity of care following discharge after suicide-related services in emergency departments and hospital settings, including the routine, standardized use of follow-up cards, texts, and emails.</p>	<p>By July 1, 2023, the State, in consultation with private and public partners, should require all hospitals and emergency departments to develop policies and protocols for delivering counseling on lethal means restriction; distributing means safety products, such as lock boxes for guns or medications; and sending follow-up messages to people discharged after receiving services for a suicide attempt. This effort should include an assessment of the readiness of health care professionals to discuss lethal means restriction and disseminate resources to support restriction, and should make recommendations for training and other support. This effort should explore the effectiveness of different types of messaging, such as handwritten and electronic forms.</p>



GOAL 11: ENSURE CONTINUITY OF CARE AND FOLLOW-UP AFTER SUICIDE-RELATED SERVICES

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 11C <i>Continues</i></p>	<p>Protocols and practices must include provisions detailing how informed consent will be obtained and how follow-up care will reflect a collaborative, transparent approach with the person at risk to prioritize outpatient care. Protocols and procedures must include brief interventions involving best practices in safety planning and lethal means counseling. Follow-up care must be linguistically and culturally respectful. Protocols and practices should include methods for tracking linkages to referrals to services, when possible.</p> <p>By July 1, 2023, the Office of Suicide Prevention should form a task force to develop and disseminate best practice guidance and make recommendations for comprehensive aftercare for people discharged from hospital settings. This effort should standardize a process for delivering follow-up, establishing care linkages prior to discharge, and ensuring ongoing monitoring and support. Guidance should highlight California’s suicide prevention hotlines and centers by establishing a connection between such resources and suicide attempt survivors prior to discharge, and requiring routine follow-up to ensure connections to services. Guidance should include opportunities to increase “rapid referrals” and identify incentives for health care providers. These referrals involve people who either are being treated in an emergency department or are approaching hospital discharge; the goal is to connect them from inpatient care to outpatient services within 24 to 48 hours after discharge.</p> <p>By July 1, 2023, the State, in consultation with private and public partners, should create incentives for outpatient behavioral health care providers to enter into agreements with hospitals to accept referrals and develop a process for confirming timely outpatient appointments prior to discharge.</p> <p>By July 1, 2024, the Office of Suicide Prevention should partner with schools, universities, and colleges to identify challenges and opportunities for safely transitioning students back into schools after hospitalization for suicidal behavior and develop and disseminate best practice guidance.</p>



GOAL 12: EXPAND SUPPORT SERVICES FOLLOWING A SUICIDE LOSS

State Objective	Implementation Schedule, 2020 – 2025
<p>OBJECTIVE 12A Create a research and policy agenda to advance the goal of expanding support services following a suicide loss.</p>	<p>By December 31, 2021, the Office of Suicide Prevention should form a task force of subject matter experts to create a research and policy agenda to advance the goals outlined in Strategic Aim 4.</p>
<p>OBJECTIVE 12B Assess and expand effective resources available to suicide loss survivors and develop capacity statewide to deliver appropriate and respectful services following a suicide loss. The resources should include information and training for bereavement service providers on topics specific to suicide and to grief that is unique to suicide loss.</p>	<p>By July 1, 2022, the Office of Suicide Prevention should develop a statewide directory of survivor support service providers across settings, including in schools, workplaces, health care offices, faith communities, tribal communities, and correctional facilities.</p> <p>By January 1, 2023, the Office of Suicide Prevention should form a task force to evaluate services delivered to people bereaved by suicide loss, identify gaps in services, and disseminate findings.</p> <p>By July 1, 2024, the task force should make recommendations for implementing best practices in local team-based responses following a suicide loss in a community or specific setting, including how to manage privacy and information and data sharing among members of the team.</p> <p>By July 1, 2024, the task force should develop guidance for coroners, medical examiners, and law enforcement for supporting people bereaved by suicide. The guidance should include methods for reducing stigma and shame; for responding to cultural differences following a suicide loss; and for supporting people delivering services to loss survivors.</p>
<p>OBJECTIVE 12C Ensure written postvention – a planned response for the delivery of services after a suicide - policies and procedures are developed, adopted, and disseminated to staff in all settings where people are receiving behavioral health services and supports.</p>	<p>By July 1, 2022, the Office of Suicide Prevention should develop and disseminate guidelines for postvention policies and procedures in the event of suicide by a person receiving services in behavioral health care settings. Guidelines should consider materials developed by the American Association of Suicidology’s Clinician Survivor Task Force and others, and should identify and address legal and ethical concerns, such as maintaining confidentiality of the client who died by suicide while the clinician receives suicide bereavement services.</p>

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Get Help Now

If you or someone else needs support, a trained crisis counselor can be reached by calling the National Suicide Prevention Lifeline at **800-273-TALK (8255)** or by texting TALK to **741741**.

- Personas que hablan español, llamen a the Lifeline al **888-682-9454**.
- For teens, call the TEEN LINE at **310-855-4673** or text TEEN to **839863**.
- For veterans, call the Lifeline at **800-273-TALK (8255)** and **press 1**.
- For LGBTQ youth, call The Trevor Project at **866-488-7386** or text **START** to **678678**.
- For transpeople, call the Trans Lifeline at **877-565-8860**.
- For people who are deaf or hard of hearing, call the Lifeline at **800-799-4889**.
- For law enforcement personnel, call the COPLINE at **800-267-5463**.
- For other first responders, call the Fire/EMS Helpline at **888-731-FIRE (3473)**.



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AGENDA ITEM 3

Action

November 21, 2019 Commission Meeting

Mental Health Student Services Act Request for Proposal

Summary: The Commission will consider approval of the outline for the Mental Health Student Services Act (MHSSA) Request for Proposal (RFP), for a competitive bid process to distribute \$75 million to support School/County Partnerships in the implementation of programs as described in the Act.

Background: In November of 2017, the Commission authorized the allocation of up to \$30 million of SB 82 funds to incentivize county-school partnerships consistent with the goals of SB 82, namely improving access to care, including crisis-oriented services.

The SB 82 county-school partnership procurement led to the funding of four school-based entities, each receiving a total of \$5.3 million to operate the programs for a four-year term. Humboldt County, Placer County, Tulare Office of Education, and California Association of Health and Education Linked Professions JPA in San Bernardino were selected from among 17 applications. Additionally, five counties were awarded SB 82 funds from the 0-21 category to operate school-based Triage programs. As a result of the high level of interest in school-county partnerships the legislature passed and the Governor signed the 2019 Budget Bill, Senate Bill 75, which included the MHSSA provision.

Senate Bill 75, Mental Health Student Services Act (MHSSA), provides \$40 million one-time and \$10 million ongoing funding for the purpose of establishing additional mental health partnerships between county behavioral health departments and school districts, charter schools, and county offices of education.

The MHSSA requires the Commission to award grants to county mental health or behavioral health departments to fund partnerships between educational and county mental health agencies.

Community Engagement: In September, October and November of 2019, the Commission held a series of four listening sessions regarding the MHSSA. Outreach included behavioral health agencies, school-based agencies, associations and community organizations, as well as the California Department of Education stakeholder list of educators and community-based organizations. These sessions provided an opportunity for stakeholders to participate in the formation of priorities for school-based mental health funding, and the preparation of the RFP to establish mental health partnerships between County Behavioral Health Departments, school districts, charter schools, and County Offices of Education.

Listening sessions were held in Sacramento, El Cerrito, Fresno, and Los Angeles. Over 230 people participated in the sessions which included representatives from behavioral health departments, school districts, education associations, parents, students, teachers, and community-based organizations.

There were several common themes throughout the listening sessions. Many stated that established partnerships would be more prepared to respond to the RFP but that favoring those partnerships would be a deterrent for those that do not yet have a partnership system in place. There was concern expressed that the incentive for matching funds would be challenging for rural or small counties and school districts. There were also recommendations for grouping grant applicants by county size.

Presenter: Tom Orrock, Chief of Commission Operations and Grants

Enclosures: (1) Proposed Outline of Request for Proposal (RFP) for the MHSSA grants; (2) Senate Bill 75 Bill Text

Handouts: A Power Point will be provided at the meeting.

Proposed Motion:

- The Commission approves the proposed outline of the MHSSA Request for Proposal.
- The Commission authorizes the Executive Director to initiate a competitive bid process.



Outline of Mental Health Student Services Act (MHSSA) Request for Proposals

Background

The Mental Health Services Oversight & Accountability Commission administers the Senate Bill 82 Investment in Mental Health Wellness Act which provides local assistance funds to expand mental health crisis services. The first round of grants was funded in 2014 and ran for four years. Prior to the release of the Request for Applications for the second round of grants, children's advocates expressed concern that the perception among providers was that the Triage funding was for adult programs only. As a result of those concerns, the Legislature modified the authorizing statute to clarify that Triage funds can be used to provide services that are specific to serving children and youth in schools and other settings. Senate Bill 833 amended the Investment in Mental Health Wellness Act to specifically authorize the triage grants to provide a complete continuum of crisis intervention services and supports for children aged 21 and under and their families and caregivers. It also provided an additional \$3 million dollars for this purpose. Of the \$3 million, half was designated for crisis intervention services for children and youth; the other half was designated for providing training for parents and caregivers of youth in crisis.

In 2016, the Commission authorized staff to release SB 82 funds, with 50 percent of those funds dedicated to children and youth aged 21 and under. Additionally, the Commission set aside approximately \$20 million for four School-County Collaboration Triage grant contracts with the aim of 1) providing school-based crisis intervention services for children experiencing or at risk of experiencing a mental health crisis and their families/caregivers, and 2) supporting the development of partnerships between behavioral health departments and educational entities.

Under that funding program Humboldt County, Placer County, Tulare County Office of Education, and California Association of Health and Education Linked Professions Joint Powers Authority in San Bernardino will receive \$5.3 million over four years. The four School-County partnership programs are supporting strategies to 1) build and strengthen partnerships between education and community mental health, 2) support school-based and community-based strategies to improve access to care, and

3) enhance crisis services that are responsive to the needs of children and youth, all with particular recognition of the educational needs of children and youth.

In addition to the four School-County partnership grantees, the commission awarded Triage contracts to counties to operate school-based Triage programs in Berkeley, Humboldt, Riverside, Sacramento, and San Luis Obispo, under the non-school designated funds dedicated to children and youth.

The MHSSA

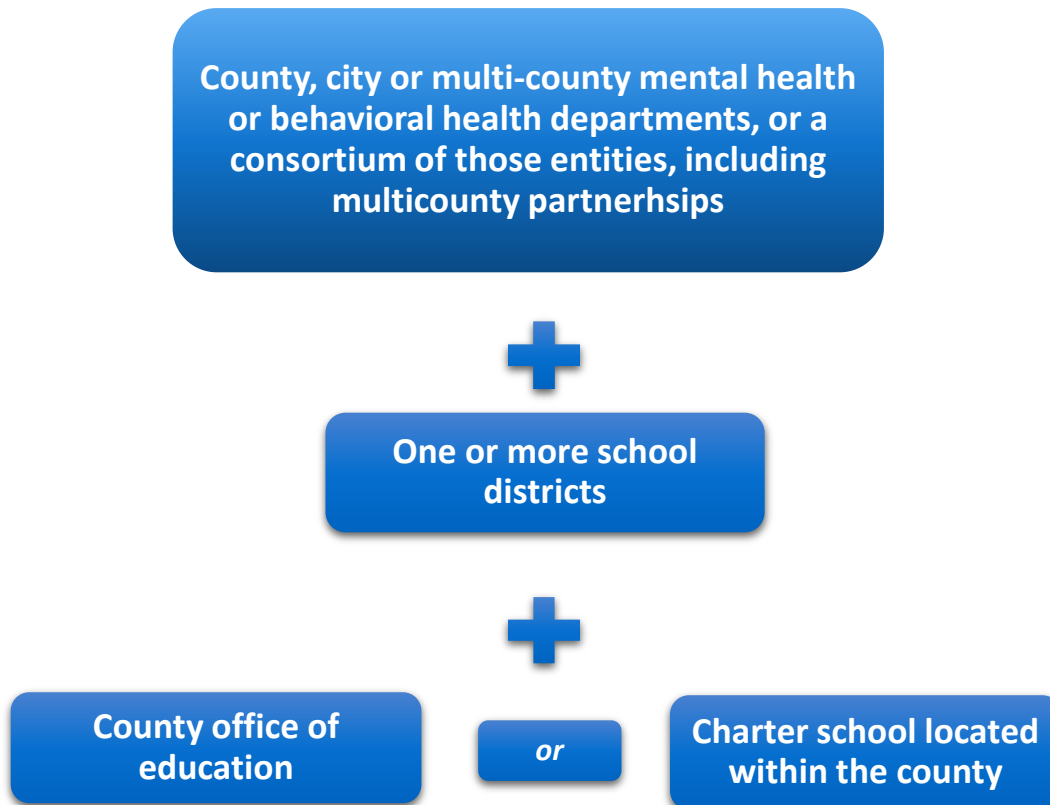
As a result of the high level of interest in School-County Collaboration Triage grants the Legislature passed and the Governor signed Senate Bill 75, which established the Mental Health Student Services Act (MHSSA), and provides \$40 million one-time and \$10 million ongoing funding for the purpose of establishing additional mental health partnerships between county behavioral health departments and local education agencies.

The MHSSA incentivizes partnerships between behavioral health departments and education agencies for the purpose of increasing access to mental health services in locations that are easily accessible to students and their families. The MHSSA is a competitive grant program. The Commission will award grants to county mental health or behavioral health departments to fund the partnerships between educational and county mental health agencies. Grants awarded shall be used to provide support services that include, at a minimum, services provided on school campuses, suicide prevention services, drop-out prevention services, placement assistance and service plan for students in need of ongoing services, and outreach to high-risk youth, including foster youth, youth who identify as LGBTQ, and youth who have been expelled or suspended from school. Grants may be used to supplement, but not supplant, existing financial and resource commitments. Funding also may be used to hire qualified mental health personnel, professional development for school staff and other strategies that respond to the mental health needs of children and youth, as determined by the Commission.

Eligibility

County, city, or multi-county mental health or behavioral health departments, or a consortium of those entities, including multi-county partnerships, may, in partnership with one or more school districts and a County Office of Education or charter school located within the county, apply for a grant. An educational entity may be

designated as the lead agency to submit the application, while the county, city or multicounty mental health department, or consortium, shall receive the grant funds. Allocation of grant funds require that all school districts, charter schools and the County Office of Education be invited to participate in the partnership, to the extent possible, and that applicants include with their application a plan developed and approved with the participating educational partners.



Stakeholder Engagement

The Commission held listening sessions in Sacramento, El Cerrito, Fresno, and Downey regarding the MHSSA. Over 230 people participated in the sessions, which included representatives from behavioral health departments, school districts, education associations, parents, students, teachers, and community-based organizations. These sessions provided an opportunity for stakeholders to participate in the formation of priorities for school-based mental health funding, and the preparation of the RFP to establish mental health partnerships between County Behavioral Health Departments, school districts, charter schools, and County Offices of Education.

There were several common themes throughout the listening sessions. Many stated that established partnerships would be more prepared to respond to the RFP but that favoring those partnerships would be a deterrent for those that do not yet have a partnership system in place. There was concern expressed that the incentive for matching funds would be challenging for rural or small counties and school districts. There were also recommendations for grouping grant applicants by county size.

Funding

Available funding includes \$40 million one-time and \$10 million per year ongoing to support the goals of the MHSSA.

Staff recommends allocating \$75 million in the first round of funding for the MHSSA. The Commission would fund those grants from the \$50 million awarded this fiscal year and \$10 million from the next three fiscal years, for a total of \$80 million. Of those funds, approximately \$5 million would be set aside for implementation by the Commission.

Grant Cycle

Grants will be approved for a grant cycle of up to four years, with funds allocated annually, in quarterly installments contingent on fulfilling reporting requirements.

Grant Apportionment

Staff recommends the Commission apportion funds based on county population, defined as follows:

- Small is less than or equal to 200,000 population (30 counties)
- Medium is greater than 200,000-750,000 population (15 counties)
- Large is greater than 750,000 population (14 counties)

Recommendations for funding levels for each designation include:

KEY ACTION DATES		
	Existing Partnerships (two years or more)	New or Emerging Partnerships (less than two years)
RFA Release	December 2, 2019	December 2, 2019
Intent to Apply	December 9, 2019	December 9, 2019
Application Due Date	February 14, 2020	April 30, 2020
Intent to Award	March 26, 2020	June 2020

APPORTIONMENT	
Small County (less than or equal to 200,000 population)	6 Grants @ \$2.5M ea = \$15M total
Medium County (greater than 200,000-750,000 population)	6 Grants @ \$4M ea = \$24M total
Large County (greater than 750,000 population)	6 Grants @ \$6M ea = \$36M total
Total Grants and Funding	18 Grants = \$75M Awarded (\$45M to existing partnerships, and \$30M to new or emerging partnerships)

Collaborative applications between two or more counties and/or City Behavioral Health Departments will be apportioned based on their combined populations.

Allowable Costs

Grant funds must be used as stated in the proposal approved by the Commission, as follows:

1. Allowable costs include personnel, administration and program costs.
 - a. If funding is used for personnel at least 90 percent of the personnel costs must be for personnel who are dedicated to delivering services.
 - b. The amount budgeted for administration costs shall not exceed 15 percent of the total budget grant amount and includes any administrative costs associated with contracted personnel.

- c. Program costs include, but are not limited to, training, technology (e.g., telehealth), facilities improvements, and transportation.
2. Grant funds may be used to supplement existing programs but may not be used to supplant existing funds for school-based mental health services.
3. Grant funds cannot be transferred to any other program account for specific purposes other than the stated purpose of this grant.

Program Plan

The Program Plan must demonstrate the Applicant's ability to meet all specified qualifications, requirements, and standards set forth in the RFP. The Program Plan will include, among other things, a description of the current School/County partnership and Governance Structure, the Local Control and Accountability Plan from all participating LEAs, and the proposed grant program. The Program Plan must address the following goals:

- Prevent mental illness from becoming severe and disabling
- Improve timely access to services for the underserved
- Outreach to families, employers, primary care providers, and others to recognize early signs of potentially severe and disabling mental illnesses
- Reduce the stigma associated with mental illness
- Reduce discrimination against those with mental illness
- Prevent negative outcomes in the targeted population

The Program Plan must include a description of the following:

- The need for mental health services
- Proposed use of funds, to include at a minimum, providing personnel or peer support
- How funds will be used to facilitate linkage and access to ongoing/sustained Services

The Program Plan must include a description of the partnership's ability to:

- Obtain federal Medicaid or other reimbursement
- Collect information on the health insurance carrier for each child or youth
- Engage a health care service plan/insurer in the mental health partnership
- Administer an effective service program
- Connect children and youth to a source of ongoing mental health services
- Continue to provide services under this program after grant funding is expended

Program Implementation Plan

During the course of the first round of triage grants, several counties experienced delays in implementing their approved programs. In order to mitigate similar delays in this grant cycle, the Commission will require the proposer to submit a Program Implementation Plan as a part of the proposal.

The purpose of the Program Implementation Plan is to illustrate the critical steps in starting the proposed programs and to identify any challenges associated with implementation. By requiring the Program Implementation Plan to be completed prior to submission, counties and school entities will be better equipped to begin serving students within 180 days of approval.

Program Communications Plan

It is the intent of the Act to increase access and linkage to mental health services for students and their families. An important aspect of increasing access and linkage to mental health services is to increase the community's awareness of those services. As a result, the Commission will require that the partnership entities to provide information on their website(s).

Budget Requirements

Applicants must provide budget information, as indicated, on the Budget Worksheet, which will be provided with the RFP. Budget detail is required for personnel costs, program costs and administration.

Program Evaluation

Awardees are required to collect and provide data on the metrics specified by the Commission in order to determine program successes.ms.

Small Designation
(≤ 200,000)

County	Population
Alpine County	1,162
Amador County	38,294
Berkeley City	123,328
Calaveras County	45,117
Colusa County	22,117
Del Norte County	27,401
El Dorado County	191,848
Glenn County	29,132
Humboldt County	135,333
Imperial County	190,266
Inyo County	18,593
Kings County	153,710
Lake County	65,071
Lassen County	30,150
Madera County	159,536
Mariposa County	18,068
Mendocino County	89,009
Modoc County	9,602
Mono County	13,616
Napa County	140,779
Nevada County	98,904
Plumas County	19,779
San Benito County	62,296
Shasta County	178,773
Sierra County	3,213
Siskiyou County	44,584
Sutter-Yuba County	175,406
Tehama County	64,387
Trinity County	13,688
Tuolumne County	54,590

Medium Designation
(> 200,000 – 750,000)

County	Population
Butte County	226,466
Marin County	262,879
Merced County	282,928
Monterey County	445,414
Placer County	396,691
San Luis Obispo County	280,393
San Joaquin County	454,593
Santa Barbara County	274,871
Santa Cruz County	441,307
Solano County	500,675
Sonoma County	558,972
Stanislaus County	479,112
Tri-City	224,022
Tulare County	222,581
Yolo County	226,466

Large Designation
(> 750,000)

County	Population
Alameda County	1,669,301
Contra Costa County	1,155,879
Fresno County	1,018,241
Kern County	916,464
Los Angeles County	10,253,716
Orange County	3,222,498
Riverside County	2,440,124
Sacramento County	1,546,174
San Bernardino County	2,192,203
San Diego County	3,351,786
San Francisco County	883,869
San Mateo County	770,385
Santa Clara County	774,485
Ventura County	1,954,286

WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 5. COMMUNITY MENTAL HEALTH SERVICES [5000 - 5952]

(Division 5 repealed and added by Stats. 1967, Ch. 1667.)

PART 4. THE CHILDREN'S MENTAL HEALTH SERVICES ACT [5850 - 5886]

(Part 4 repealed and added by Stats. 1992, Ch. 1229, Sec. 2.)

CHAPTER 3. Mental Health Student Services Act [5886- 5886.]

(Chapter 3 added by Stats. 2019, Ch. 51, Sec. 67.)

5886.

(a) The Mental Health Student Services Act is hereby established as a mental health partnership competitive grant program for the purpose of establishing mental health partnerships between a county's mental health or behavioral health departments and school districts, charter schools, and the county office of education within the county.

(b) The Mental Health Services Oversight and Accountability Commission shall award grants to county mental health or behavioral health departments to fund partnerships between educational and county mental health entities.

(1) County, city, or multicounty mental health or behavioral health departments, or a consortium of those entities, including multicounty partnerships, may, in partnership with one or more school districts and at least one of the following educational entities located within the county, apply for a grant to fund activities of the partnership:

(A) The county office of education.

(B) A charter school.

(2) An educational entity may be designated as the lead agency at the request of the county, city, or multicounty department, or consortium, and authorized to submit the application. The county, city, or multicounty department, or consortium, shall be the grantee and receive any grant funds awarded pursuant to this section even if an educational entity is designated as the lead agency and submits the application pursuant to this paragraph.

(c) The commission shall establish criteria for the grant program, including the allocation of grant funds pursuant to this section, and shall require that applicants comply with, at a minimum, all of the following requirements:

(1) That all school districts, charter schools, and the county office of education have been invited to participate in the partnership, to the extent possible.

(2) That applicants include with their application a plan developed and approved in collaboration with participating educational entity partners and that include a letter of intent, a memorandum of understanding, or other evidence of support or approval by the governing boards of all partners.

(3) That plans address all of the following goals:

- (A) Preventing mental illnesses from becoming severe and disabling.
- (B) Improving timely access to services for underserved populations.
- (C) Providing outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.
- (D) Reducing the stigma associated with the diagnosis of a mental illness or seeking mental health services.
- (E) Reducing discrimination against people with mental illness.
- (F) Preventing negative outcomes in the targeted population, including, but not limited to:
 - (i) Suicide and attempted suicide.
 - (ii) Incarceration.
 - (iii) School failure or dropout.
 - (iv) Unemployment.
 - (v) Prolonged suffering.
 - (vi) Homelessness.
 - (vii) Removal of children from their homes.
 - (viii) Involuntary mental health detentions.

(4) That the plan includes a description of the following:

- (A) The need for mental health services for children and youth, including campus-based mental health services, as well as potential gaps in local service connections.
- (B) The proposed use of funds, which shall include, at a minimum, that funds will be used to provide personnel or peer support.
- (C) How the funds will be used to facilitate linkage and access to ongoing and sustained services, including, but not limited to, objectives and anticipated outcomes.
- (D) The partnership's ability to do all of the following:
 - (i) Obtain federal Medicaid or other reimbursement, including Early and Periodic Screening, Diagnostic, and Treatment funds, when applicable, or to leverage other funds, when feasible.
 - (ii) Collect information on the health insurance carrier for each child or youth, with the permission of the child or youth's parent, to allow the partnership to seek reimbursement for mental health services provided to children and youth, where applicable.

(iii) Engage a health care service plan or a health insurer in the mental health partnership, when applicable, and to the extent mutually agreed to by the partnership and the plan or insurer.

(iv) Administer an effective service program and the degree to which mental health providers and educational entities will support and collaborate to accomplish the goals of the effort.

(v) Connect children and youth to a source of ongoing mental health services, including, but not limited to, through Medi-Cal, specialty mental health plans, county mental health programs, or private health coverage.

(vi) Continue to provide services and activities under this program after grant funding has been expended.

(d) Grants awarded pursuant to this section shall be used to provide support services that include, at a minimum, all of the following:

(1) Services provided on school campuses, to the extent practicable.

(2) Suicide prevention services.

(3) Drop-out prevention services.

(4) Outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as lesbian, gay, bisexual, transgender, or queer, and youth who have been expelled or suspended from school.

(5) Placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services.

(e) Funding may also be used to provide other prevention, early intervention, and direct services, including, but not limited to, hiring qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth, as determined by the commission.

(f) The commission shall determine the amount of grants and shall take into consideration the level of need and the number of school-age youth in participating educational entities when determining grant amounts.

(g) The commission may establish incentives to provide matching funds by awarding additional grant funds to partnerships that do so.

(h) Partnerships currently receiving grants from the Investment in Mental Health Wellness Act of 2013 (Part 3.8 (commencing with Section 5848.5)) are eligible to receive a grant under this section for the expansion of services funded by that grant or for the inclusion of additional educational entity partners within the mental health partnership.

(i) Grants awarded pursuant to this section may be used to supplement, but not supplant, existing financial and resource commitments of the county, city, or multi-county mental health or behavioral health departments, or a consortium of those entities, or educational entities that receive a grant.

(j) (1) The commission shall develop metrics and a system to measure and publicly report on the performance outcomes of services provided using the grants.

(2) (A) The commission shall provide a status report to the fiscal and policy committees of the Legislature on the progress of implementation of this section no later than March 1, 2022. The report shall address, at a minimum, all of the following:

(i) Successful strategies.

(ii) Identified needs for additional services.

(iii) Lessons learned.

(iv) Numbers of, and demographic information for, the school-age children and youth served.

(v) Available data on outcomes, including, but not limited to, linkages to ongoing services and success in meeting the goals identified in paragraph (3) of subdivision (c).

(B) A report to be submitted pursuant to this paragraph shall be submitted in compliance with Section 9795 of the Government Code.

(k) This section does not require the use of funds included in the minimum funding obligation under Section 8 of Article XVI of the California Constitution for the partnerships established by this section.

(l) The commission may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis in order to implement this section. Contracts entered into or amended pursuant to this subdivision are exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(m) This section shall be implemented only to the extent moneys are appropriated in the annual Budget Act or another statute for purposes of this section.

(Added by Stats. 2019, Ch. 51, Sec. 67. (SB 75) Effective July 1, 2019.)

AGENDA ITEM 4

Action

November 21, 2019 Commission Meeting

Outline for Stakeholder Request for Proposals

Summary: The Commission will consider approval of an outline and authorization for the release of six Request for Proposals (RFP) to support advocacy, training, and outreach efforts on behalf of Clients/Consumers, Diverse Racial and Ethnic Communities, Families of Clients/Consumers, LGBTQ , Parents of Children and Youth, and Veteran Communities.

Background: The Commission provides funding to support the advocacy activities of local and statewide organizations under Welfare and Institution Code Section 5892(d). These contracts are funded by Mental Health Services Act State Administration dollars and focus on supporting advocacy, training and outreach activities to address the mental health needs of eight specific populations:

- Clients and Consumers
- Diverse Racial and Ethnic Communities
- Families of Consumers
- Immigrant and Refugee Communities
- LGBTQ Communities
- Parents and Caregivers
- Transition Age Youth
- Veteran Communities

Six of the current contracts will expire on September 30, 2020 and are the subject of the proposed outline.

Current Funding Available:

<u>Stakeholder Groups</u>	<u>Contract Amount</u>
Clients/Consumers	\$2,010,000.00
Diverse Racial and Ethnic Communities	\$2,010,000.00
Families of Clients/Consumers	\$2,010,000.00
LGBTQ Communities	\$2,010,000.00
Parents and Caregivers	\$2,010,000.00
Veteran Communities	\$2,010,000.00
Total	\$12,060,000.00

Informational Surveys: Development of the proposed outline for the six RFPs began in the summer of 2019 as Commission staff released surveys to ascertain the needs of the six populations and the focus and work of organizations who are currently assisting with their access to mental health services. The surveys assessed the number of statewide and local organizations, and the types of services offered. Information gathered included

the most critical mental health needs, services provided, areas served, how organizations are funded, and their current level of collaboration with other organizations. The 48 survey responses helped to guide the RFP development efforts and are summarized below.

Clients and Consumers

Surveys submitted by clients/consumers and the organizations which provide services to them indicate that the most critical needs are advocacy where decisions are made, collaboration with law enforcement and mental health organizations, access to relevant and competent care, and the expansion of recovery focused approaches. Respondents indicated that needs are identified through listening session, focus groups, surveys, and county data sets. These methods help to inform the work of organizations which advocate on behalf of consumers. All surveys indicated a range of collaboration with other organizations including mental health organizations, consumer run organizations, state organizations, and mental health networks. Several counties were represented in the survey responses as well as nine statewide organizations.

Diverse Racial and Ethnic Communities

Respondents serving diverse racial and ethnic communities determined the critical needs for these populations are funding for capacity building programs, culturally and linguistically competent healthcare providers, advocacy and representation in legislation, and employment and placement services. These needs were found through respondents' own client surveys, locally held community forums and symposiums, listening sessions and focus groups, coalitions, and use of state and county data. Respondents also partner with experts within their communities and work closely with peer navigators and family members. Respondents highlighted the importance of working with county behavioral health agencies and law enforcement agencies, community-based organizations, peer intervention programs, local education and training programs, and the University of California campuses. Surveys indicated that members of diverse, racial and ethnic communities were best reached through trusted local community leaders and organizations, family members, local affiliates, cultural brokers, and peers.

Families of Clients/Consumers

Entities representing families indicated that the most critical needs of family members are affordable housing and education, access to crisis and stabilization services, and an increase in family-serving workforce. Respondents determined these needs among family members by holding listening sessions, correspondence with family members and their providers, and through self-reporting online. Survey respondents reported to collaborate with other community serving agencies, service provider agencies, local schools, coalitions, academic institutions, and county offices. Respondents received feedback from families through listening sessions, teleconferences, local mental health events, county boards of supervisors, legislative staff, and social media.

LGBTQ Communities

It was determined through the surveys that the LGBTQ population's most critical needs include access to affordable housing, inclusive and affirming services, culturally competent staff and providers, protections from discrimination, access to safe spaces, and legislative policies designed to decrease disparities. These critical needs were identified by working directly with community members at local drop-in centers and shelters, outreach and engagement with local government, and gathering feedback from the local organizational partners. Respondents indicated that they collaborate with entities which included mental

health agencies and service providers, local schools, advocacy organizations, faith-based organizations, law enforcement, and County Offices of Education. Respondents found that reaching members of the population was most effective through community events and trainings, community networks, social media, and word of mouth.

Parents/Caregivers

Parent/Caregiver surveys indicated that the most critical need of the population is training and education for parents on how to effectively address the mental health needs of their children. The need for materials and resource guides was indicated as a helpful tool for parents and caregivers who are seeking information on available services and supports. Surveys indicate that parents and caregivers without appropriate transportation and housing face significant barriers in accessing care. Service organization representatives who responded to the survey indicated that the most effective method to determine the needs of the population are community advocacy events, parent/caregiver organization meetings and focus groups. Respondents listed several state and local organizations with whom parents and caregivers are working with including county mental health departments, local service providers, faith-based organizations, and school districts. Surveys indicated that time constraints and the demanding role of parents and caregivers requires support to be provided through social media and websites which direct parents to services and event announcements.

Veteran Communities

The veteran surveys indicated several areas where advocacy, training, and outreach would benefit the population. Housing, access to military informed mental health care, employment assistance, legal services for those involved in the criminal justice system, and suicide prevention were among the most often mentioned critical needs. Veteran organizations identify needs through surveys, data collection, and from personal interaction with veterans. All respondents indicated that they collaborate with other veteran organizations around the state. Also, veteran organizations collaborate with county, state, and federal agencies to provide advocacy on behalf of the population. Survey respondents indicated that local outreach and engagement events, social media, family member interactions, and working with veteran service providers were the most effective tools for reaching veteran populations.

Community Engagement: More than 50 stakeholders attended listening sessions that were held for each population to gather information about how funds should be spent, consistent with the needs of the six populations. Though each group expressed issues unique to their community, the feedback provided expressed in the listening sessions were consistent with the survey findings.

Listening Session findings indicated the need for:

- Increased access to relevant, culturally competent mental health services
- Stakeholder inclusion in local level decision making processes
- Stakeholder representation and engagement in the local mental health planning process
- Stigma and discrimination reduction
- Expansion of peer, parent, and family support
- Work force training and education

In addition to the surveys and listening sessions, Commission staff reviewed the State of the Community Reports and other deliverables from current contractors. This review

reinforced that both state and local level advocacy efforts are necessary to effectively guide the focus of mental health efforts across the state to address the unique needs of the eight populations.

State and Local Collaboration: The Commission's 2019 contract award to support advocacy efforts for Immigrant and Refugee populations was guided by input received from outreach efforts and led to the decision to contract directly with five grassroots, local level Immigrant and Refugee organizations.

In the most recent Transition Age Youth (TAY) contract award a variation of previous funding models was used which required the state level organization to sub-contract and collaborate with 15 local level advocacy groups.

The recommended outline for the six Stakeholder RFPs encourages partnership between the state level contractor and local level entities to provide advocacy, training and education, and outreach and engagement on behalf of the specific populations.

The Commission is requested to approve the proposed outline of the scope of work for six stakeholder contracts for

- Clients/Consumers
- Diverse Racial and Ethnic Communities
- Families of Clients/Consumers
- LGBTQ Communities
- Parents and Caregivers
- Veteran Communities

The Commission is requested to authorize the release of the Request for Proposals for the work as summarized in the proposed outline enclosure.

Enclosures: (1) Proposed Outline of Request for Proposals for six Stakeholder Contracts.

Presenters:

- Tom Orrock, Chief of Stakeholder Engagement and Grants

Handouts: A Power Point will be provided at the meeting.

Proposed Motion:

- The Commission approves the proposed outline of the scope of work for the RFPs.
- The Commission authorizes the Executive Director to initiate a competitive bid process.



**Proposed Outline of Request for Proposals (RFPs)
for the Stakeholder Advocacy Contracts
November 21, 2019 Commission Meeting**

The following is the recommended outline for the Stakeholder Advocacy RFPs, including minimum qualifications. There will be six (6) contracts awarded through six separate RFPs. Each contract will include a 39-month contract term. These contracts will be awarded to a statewide advocacy organization to provide state-level advocacy, training and education, outreach and engagement, and to partner with and support community entities which may include non-profit organizations, community networks, or local partners within a county or region.

The six RFPs will be designed to support advocacy on behalf of:

- Clients/Consumers
- Diverse Racial and Ethnic Communities
- Families of Clients/Consumers
- LGBTQ Communities
- Parents/Caregivers
- Veteran Communities

The lead contract holder, referred to as the statewide advocacy organization, will hold five county or regional events each year for a total of fifteen community advocacy events over the course of the three-year, three-month, contract term. The statewide organization also will hold one statewide event each year. The statewide advocacy contractor will be selected through a competitive process and will develop a Community Engagement Plan which outlines how they intend to meet the community level engagement requirements. Those requirements can be met through their organization, or through one or more partnerships with local entities. The Community Engagement Plan must include local/regional and statewide convenings, and other advocacy activities with community leaders including county representatives, stakeholders and others. Incentive points will be given for proposals that include local partnerships.

Recommended Funding

The total amount available for each statewide advocacy organization is \$670,000 per year, or \$2,010,000 over three-years and three months. Total funding anticipated to be committed to this work is \$12,060,000.

Each contract will be for three-years, three-months (39 months), with the last 3 months of the contract allotted for the completion of a final State of the Community Report. Funding will be designated to support local advocacy and to assist with event deliverables, follow-up activities, data collection, and recommended action items for inclusion in the annual State of the Community Report.

Outline for the RFP

The statewide advocacy contractor will be responsible for the following:

- Plan and conduct community events and invite county representatives, stakeholders and others with the goal of informing the Community Program Planning (CPP) process.
- Provide post-event follow-up information to county representatives, stakeholders and others which includes the outreach strategies used in the creation of the event and a summary of findings.
- Provide state-level, statewide advocacy for mental health policies which support the stakeholder community's wellness.
- Provide training and technical assistance to local partnering community organizations to increase capacity for ongoing advocacy efforts in each county or region.
- Write a State of the Community report each year which includes:
 - Demographic information on the population served
 - Barriers to accessing mental health care
 - Programs and services needed to address mental health needs of the population
 - Innovative approaches
 - An overview of the number of individuals from the population receiving mental health services, to the extent available
 - Legislation and policy agendas
 - Post-event results
 - Recommendations for action by specific state and local agencies.
- Plan and implement a state level event each year in collaboration with the identified local community entities.

Statewide Advocacy Contractor Responsibilities

The statewide advocacy contractor may conduct all of the activities through their organization, or partner with one or more community advocacy entities in each region which serve the population, to provide technical assistance and support, and to conduct training, outreach activities and advocacy meetings. The statewide advocacy contractor also will be responsible to represent the needs of the population through state-level advocacy and policy engagement.

Minimum Qualifications

The following minimum qualifications must be met.

Statewide Advocacy Contractor

All eligible bidders must:

1. Be an established state-level organization which has been in operation for 2 years and has experience with programs and services related to the unique mental health needs of California's Stakeholder population for which a proposal is being submitted.
2. Have experience and capacity to partner with local community-based organizations working on mental health issues for the specific population stated in the RFP.
3. Be a non-profit organization, registered to do business in California.
4. Have program staff *or* board members that include more than 50 percent stakeholders of the population to be served. For the Clients/Consumers contract, bidders must have more than 50 percent staff *and* board members who are consumers. For the Families contract, bidders must have more than 50 percent staff *and* board members who are family members.



RFP Tentative Timeline

- December 2, 2019: RFP released to the public
- January 24, 2020: Deadline to submit proposals for Veterans, Clients/Consumers, and Families
- January 31, 2020: Deadline to submit proposals for Parents/Caregivers, Diverse Racial and Ethnic Communities, and LGBTQ
- February 27, 2020: Commission issues Notice of Intent to Award

AGENDA ITEM 5

Information

November 21, 2019 Commission Meeting

UCLA Community Wellness and Outcomes Progress Report

Summary: In 2018, the UCLA Center for Health Services and Society (CHSS) began a two-year contract with the Commission to develop a plan to identify, gather, maintain, display, and disseminate key metrics of community mental wellness, including the seven negative outcomes that may result from mental health challenges and unmet needs in California cited in the Mental Health Services Act. To accomplish this, CHSS will analyze, identify, recommend and deliver data sources and elements to support the Commission's capacity to monitor mental wellness at the state and county levels over time. Dr. Sheryl Kataoka and Dr. Bonnie Zima, Co-Principal Investigators, will provide a progress update on the project.

Background: The goals of the project are:

- 1) Identify data sources that will allow MHSOAC to develop a statewide dashboard to track county-level estimates on the seven negative outcomes outlined in the Act as well as other disparities and other key concepts.
- 2) Explore definitions of the various outcomes and concepts and describe how they relate to each other
- 3) Assist MHSOAC in identifying and accessing the existing outcomes data suitable for building display dashboards
- 4) Assist MHSOAC in raising public awareness and reducing stigma through the development of fact sheets and data briefs.

Drs. Kataoka and Zima will provide an overview of the project, the status of each goal, accomplishments to date, and the preliminary findings on three outcomes: Suicide, Unemployment, and Removal from Home. The UCLA team welcomes feedback on decision points to effectively address the Commission's priorities.

Presenter(s):

- **Sheryl H. Kataoka, MD, MSHS**, Professor-in-Residence, UCLA Center for Health Services and Society
- **Bonnie T. Zima, MD, MPH**, Professor-in-Residence, Associate Director, UCLA Center for Health Services and Society

Enclosures (5): (1) Presenter Biographies; (2) PowerPoint Presentation; (3) Draft Chapter on Suicide and Suicidal Behaviors; (4) Draft Chapter on Removal from Home; (5) Draft Chapter on Unemployment.

Presenter Biographies

Sheryl H. Kataoka, MD, MSHS, is Professor-in-Residence and Dena Bat-Yaacov Endowed Chair in Childhood Psychiatry and Biobehavioral Sciences at the UCLA Semel Institute for Neuroscience and Human Behavior, where she has served as the Training Director of the Child and Adolescent Psychiatry Fellowship for the past 11 years. As a child psychiatrist and health services researcher, Dr. Kataoka has spent nearly 20 years studying ways to address disparities and improve access to mental health services in urban, low-income public schools. She has documented racial disparities in unmet need for child mental health services nationally and has engaged in community-partnered research that merges evidence-based treatments with local knowledge about community populations and systems. These community partnerships have led to innovative ways of delivering guideline-based care in schools, and to new quality improvement efforts both locally and nationally.

Dr. Kataoka has been involved in developing universal and selected prevention programs for students who have been exposed to trauma, experiences that have repercussions in their educational attainment and emotional wellbeing. Her evaluations of the *Cognitive Behavioral Intervention for Trauma in Schools (CBITS)* have indicated that when students are taught resilience-building skills, not only do they see improvements in their mental health but also in their academic success. As Dr. Kataoka works to transform educational settings to be safe, nurturing environments, she has been developing online resources for teachers and schools to support the school system in understanding the impact of traumatic stress on the adults and students in the school community. Dr. Kataoka focuses on a public health approach to sustainable, pragmatic solutions in addressing trauma- and resilience-informed mental health services in schools and has been working to create supportive learning environments where all students can thrive.

Dr. Kataoka has been a national leader, co-chairing the Schools Committees for both the American Academy of Child and Adolescent Psychiatry and the National Child Traumatic Stress Network. In 2018, she testified before the Federal Commission for School Safety as an expert on the role of psychiatry in schools. As a National Academy of Sciences committee member, Dr. Kataoka also contributed to the newly released publication *Fostering Healthy Mental, Emotional, and Behavioral Development Among Children and Youth*. **One of the primary recommendations of this NAS report is to coordinate data monitoring efforts for surveillance of health indicators to share with communities**, which is the primary purpose of this MHSOAC-contracted project.

Bonnie T. Zima, MD, MPH is Professor-in-Residence in the UCLA Department of Psychiatry and Behavioral Sciences, and Associate Director of the UCLA Center for Health Services and Society. Dr. Zima's research is dedicated to improving the quality of child mental health care, with priority placed on children enrolled in Medicaid-funded outpatient programs and underserved, at risk child populations. Her research spans national pediatric hospitalization resource utilization and costs, validity of national quality measures, pediatric integrated care models, pediatric workforce development, and use of telehealth and mobile health technologies.

She is Principal Investigator (PI) of a five-year study to pilot test integrated care models for children in two federally qualified health care centers in Chicago, an ongoing study that developed and pilot-tested MH2™, Mobile Health for Mental Health, a web-based application to optimize stimulant medication treatment for children with ADHD. Dr. Zima is also Co-Investigator on a three-year PCORI-funded randomized trial of a telehealth intervention to improve access to community-based child mental health programs from pediatric primary care clinics, a 5-year SAMHSA-funded intervention to improve pediatric work force training related to child complex trauma, lead child psychiatrist on the California Performance Outcomes Measures Study, and core PI for a recently funded five-year study examining the impact of child crisis intervention programs in 16 California counties. Her research has received all three national research awards from the American Academy of Child and Adolescent Psychiatry (AACAP).

In addition, Dr. Zima is a Member of the U.S. Child and Adult Core Set Annual Review Workgroup, Center for Medicaid and CHIP Services, Vice Chair of the American Psychiatric Association (APA) Council on Quality Care, standing member of the Behavioral Health and Substance Abuse Steering Committee for the National Quality Forum, and AACAP Committee on Research. She is Consulting Editor for the *Journal of the American Academy of Child & Adolescent Psychiatry*, Deputy Editor for the *Journal of Child and Adolescent Psychopharmacology*, and Distinguished Fellow of AACAP and APA.

The Community Wellness and Outcomes Project: Reporting on Outcomes that Matter for Communities

**Prepared for the Mental Health Services Oversight and
Accountability Commission
Project Update
November 21st, 2019**

Acknowledgments

The UCLA Team would like to extend our gratitude to

- MHSOAC Commissioners and Staff
- The Community Partnered Advisory Group, whose breadth of experience and feedback have been invaluable
- The individuals who have participated in the project thus far and provided critical data for the report

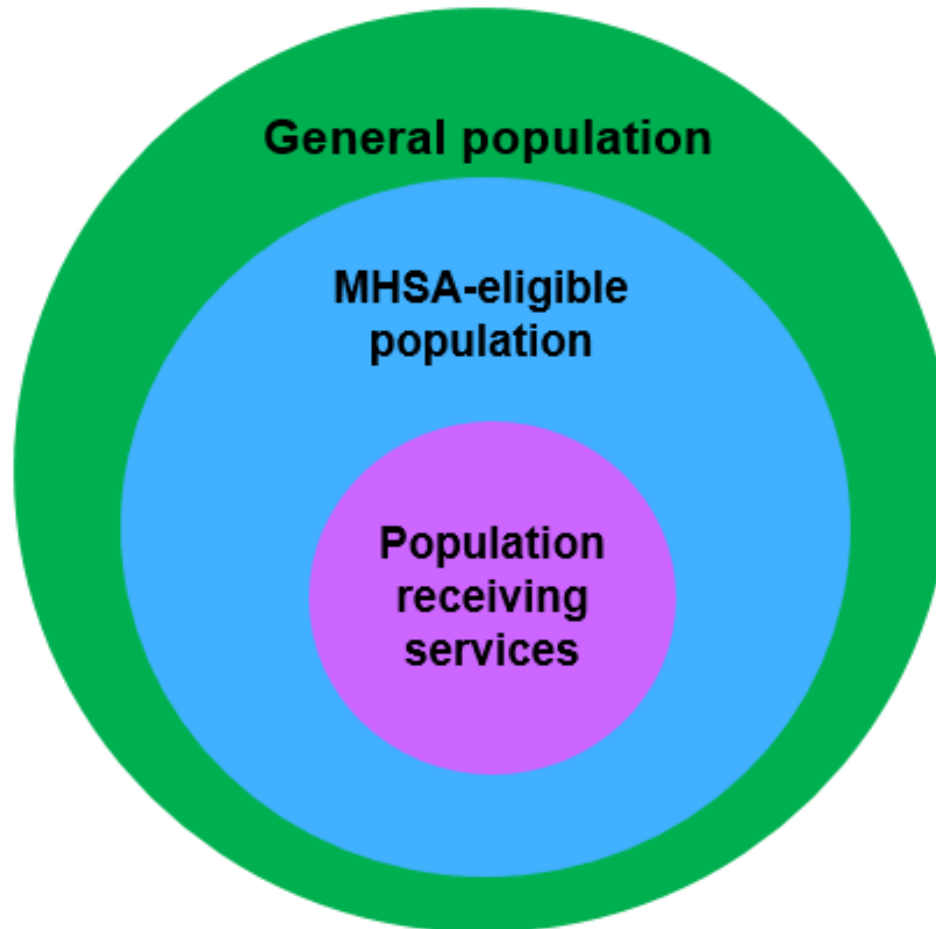
MHSA: Objective and Outcomes

- **Objective:** to reduce the long-term, adverse impact of serious mental illness
- **7 negative outcomes** of untreated, undertreated or inappropriately treated mental illness:
 - Suicide
 - Incarceration
 - School failure
 - Removal of children from their homes
 - Unemployment
 - Prolonged suffering
 - Homelessness

Significance of Tracking Outcomes

- How do we know if these MHSA outcomes are getting better in our state? Counties?
 - Systematically collect and monitor outcomes
 - Measure prevalence and monitor changes over time
 - Identify disparities and at-risk populations
- Leads to public health action and identification of areas of need for MHSA services

Populations of Interest



Primary Objectives

- **To identify publicly available data sources** that can allow MHSOAC to develop a statewide dashboard to track estimates on the 7 negative outcomes outlined in the MHSA and additional outcomes related to mental health services
- This future **dashboard** is envisioned as an early step in building capacity to improve the measurement and reporting of mental health care needs



Project Deliverables

1. Outcomes Report

- a. Includes 7 chapters, each on one of the 7 negative outcomes
- b. Audience: county administrators, researchers, others interested in methods and reasoning behind dashboard indicators

2. Data library, management plan, suggestions on visualizations

3. Data fact sheets and briefs

- a. Audience: general public

Data Sources: Eligibility Criteria

- Publicly available, downloadable, free
- Includes the State of California, may include some or all counties in CA
- Includes at least one of the 7 MHSA outcomes
- May include data elements important in tracking of the outcome

Draft Results: Suicide, Removal From Home and Unemployment



Suicide Data Elements

- **Suicide rate:**
 - Deaths caused by self-directed injurious behavior with any intent to die as a result of the behavior
- **Suicide attempt:**
 - Non-fatal, self-directed, potentially injurious behavior with the intent to die. A suicide attempt may or may not result in injury
- **Suicide ideation:**
 - Serious thoughts about dying by suicide

Suicide Rates: *EpiCenter* (California Dept. of Public Health)

- **Where does data come from?**
 - Data from several injury-related searchable databases for California
 - Includes data from death certificates, hospitalizations ER admissions
- **What measures of suicide does it include?**
 - Death by Suicide; Suicide Attempt
 - By 5 most common means
- Available by county, year, gender, age, and race/ethnicity

Age-Adjusted Death Rate due to Suicide

Measurement Period: 2015-2017 ▼

8.0

deaths/ 100,000 population

Source: [California Department of Public Health](#)

Measurement period: 2015-2017

Maintained by: Conduent Healthy Communities Institute

Last update: May 2019

COMPARED TO



CA Counties



CA Value
(10.4)



US Value
(13.6)



Prior Value
(7.8)



Trend

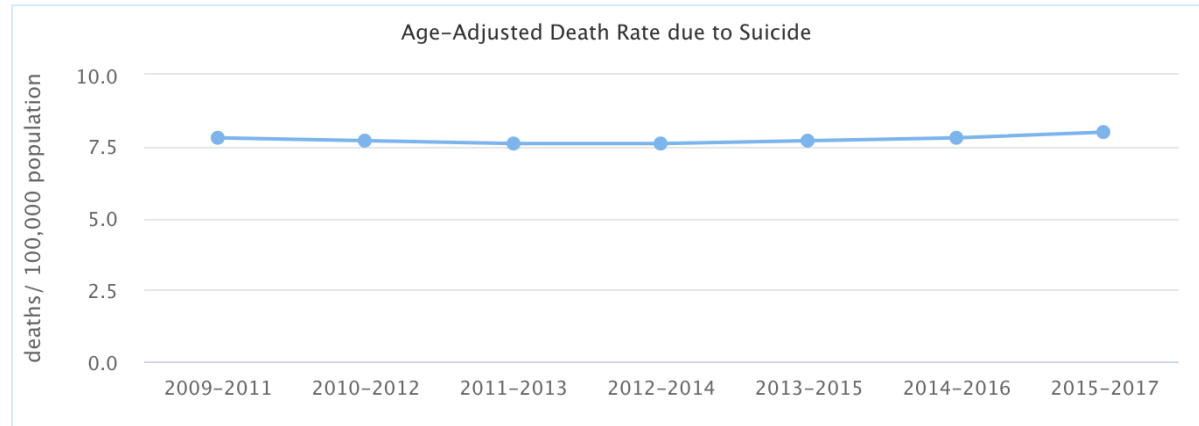


HP 2020 Target
(10.2)

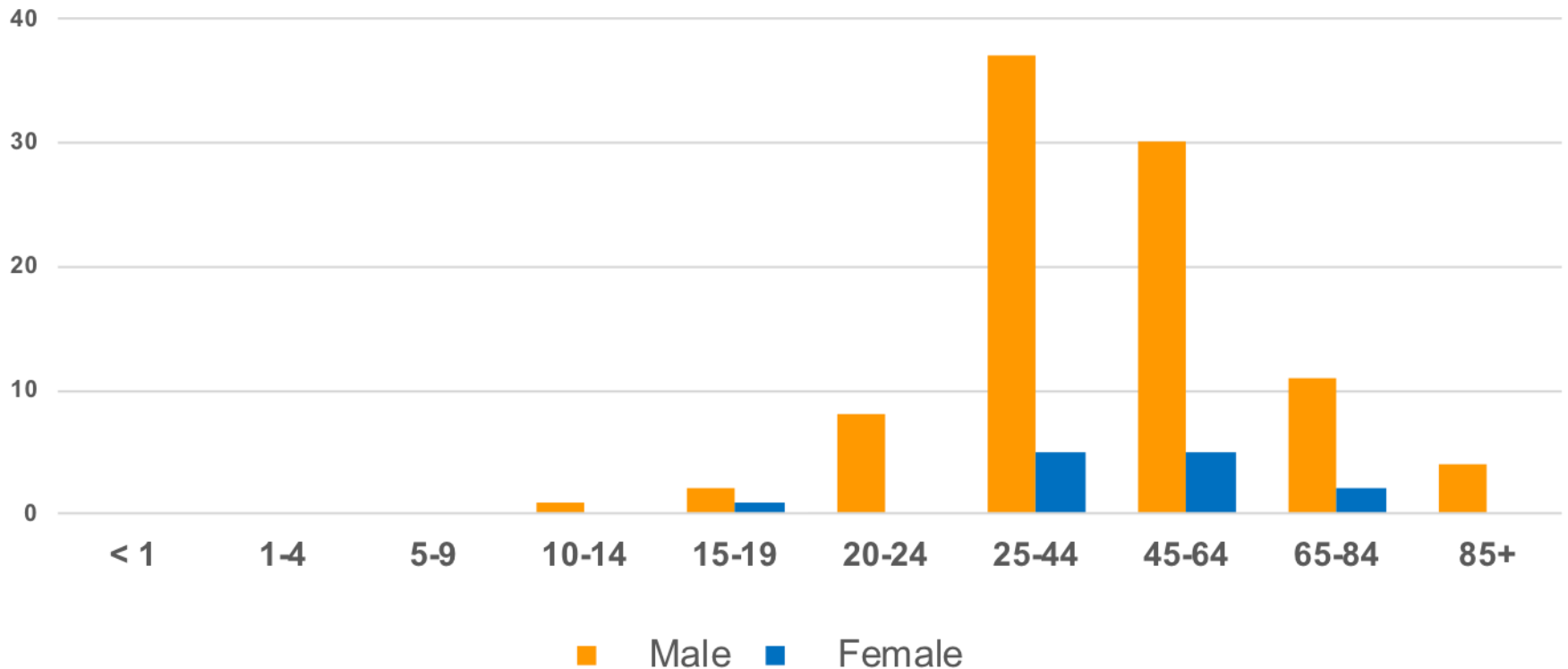
Graph Selections

INDICATOR VALUES

Change over Time



Self-Inflicted Suicide Deaths, by age and sex County Y, 2017

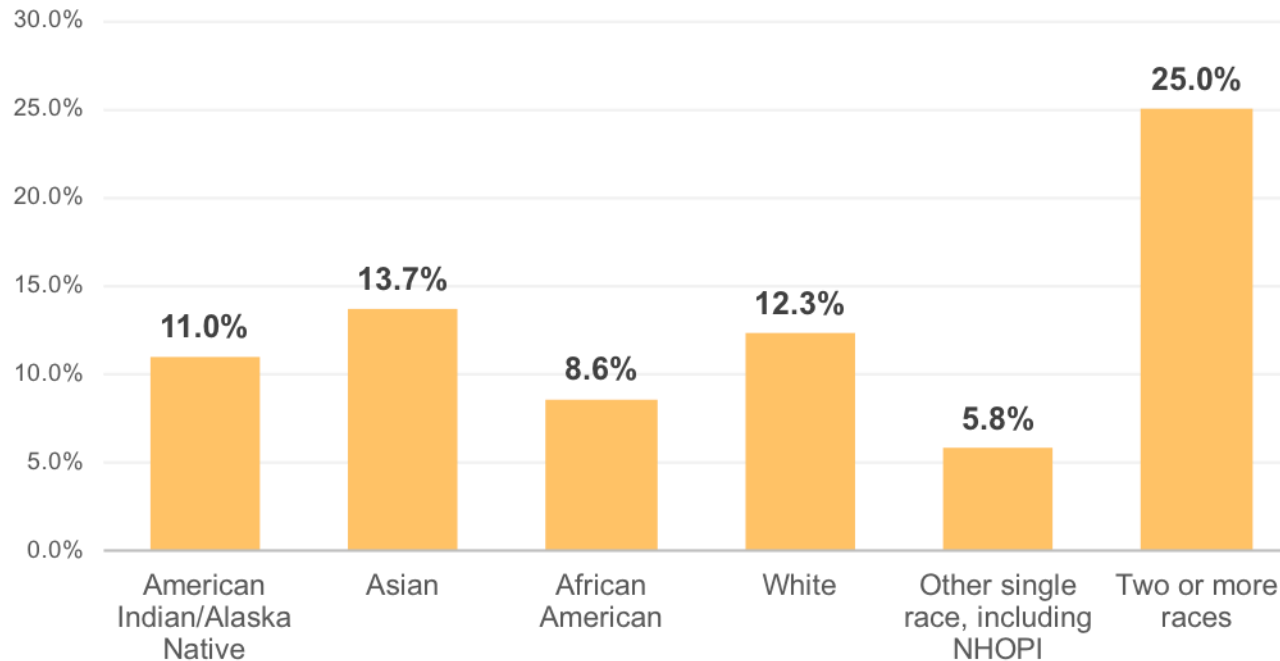


Source: CDPH Vital Statistics Death Statistical Master Files

Suicide Behaviors: *CHIS* ***(California Health Interview Survey)***

- **Where does data come from?**
 - Household survey of adults and adolescents drawn from a random sample of California addresses
- **What measures of suicide behavior does it include?**
 - Lifetime and past-year suicide attempt
 - Lifetime, past-year, and recent suicide ideation
- Available by county, year, gender, age, and race/ethnicity, clinical and social circumstances, and special populations

Ever seriously thought about committing suicide by race County X, 2016-2018



Source: 2016, 2017, 2018 California Health Interview Survey

Removal from Home: Data Elements

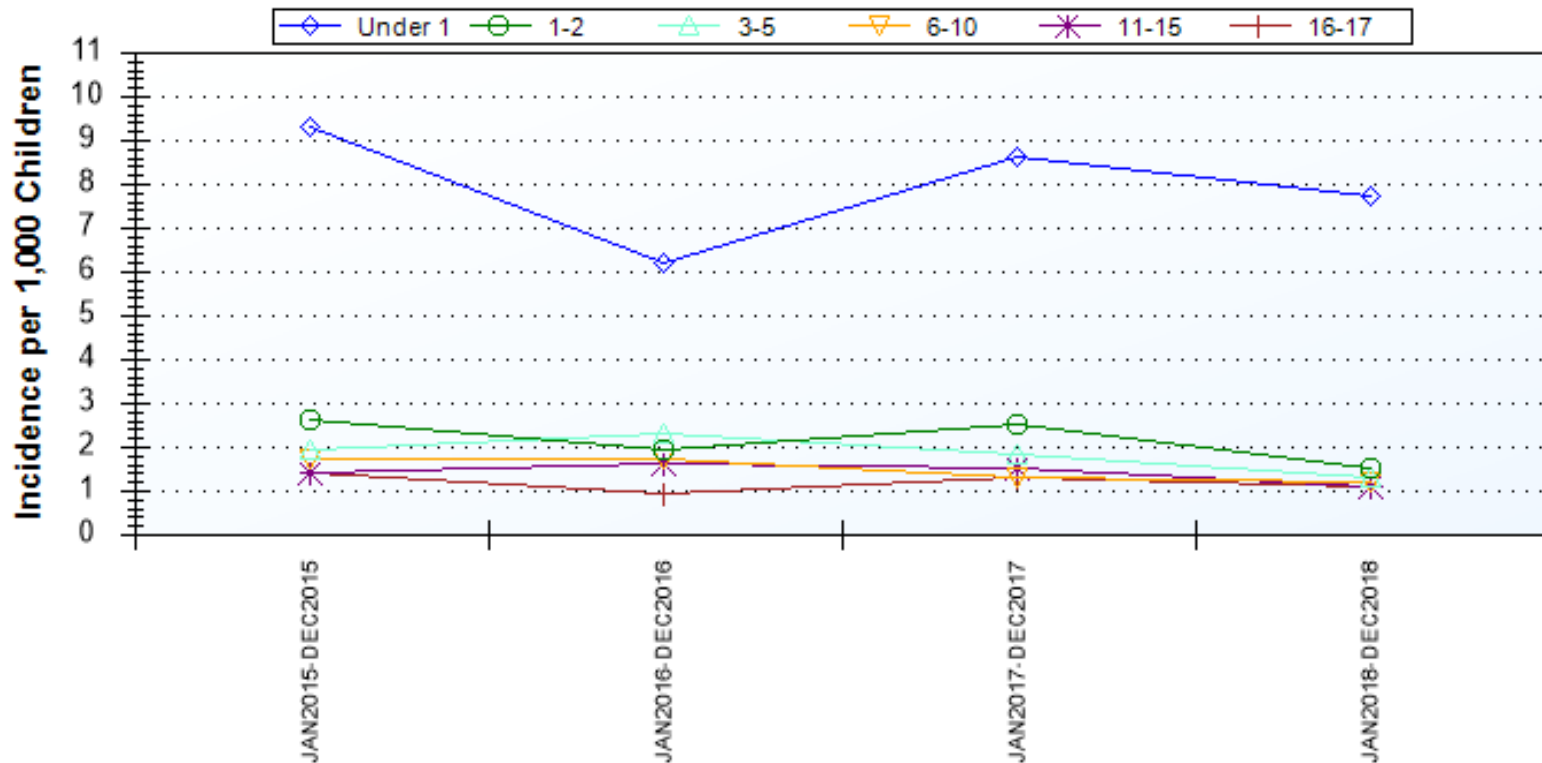
- **Referrals**
 - Reports of suspected child abuse and neglect
- **Repeat referrals**
- **Substantiated allegations**
 - CPS investigation determines that maltreatment occurred.
- **Removal from home**
 - Child is removed from the home and placed in out-of-home or substitute care.

Removal from Home: *CCWIP* (*CA Child Welfare Indicators Project*)

- **Where does data come from?**
 - Data are from the Child Welfare Services/Case Management System (CWS/CMS), CA's child welfare administrative data system.
- **What measures of removal from home does it include?**
 - Referrals
 - Repeat referrals
 - Substantiated allegations
 - Removal from home
- Available by county, year, gender, age, and race/ethnicity.

Children with Entries to Foster Care, Child Population (0-17), and Incidence Rates
 Incidence per 1,000 Children
 Agency Type=Child Welfare
 Selected Subset: Episode Count: All Children Entering

Contra Costa



Based on an unduplicated count of entries during time period.
 Data Source: CWS/CMS 2019 Quarter 2 Extract.
 Population Data Source:
 2000-2009 - CA Dept. of Finance: 2000-2010 - Estimates of Race/Hispanics Population with Age & Gender Detail
 2010-2018 - CA Dept. of Finance: 2010-2060 - Pop. Projections by Race/Ethnicity, Detailed Age, & Gender.
 Program version: 2.00 Database version: 7033C6B4

Unemployment: Data Elements

- Unemployment rate
- Employee absenteeism due to mental illness or emotional distress
- Level of psychological distress among employed, unemployed, and those not in the labor force

Unemployment: *BLS* (*Bureau of Labor Statistics*)

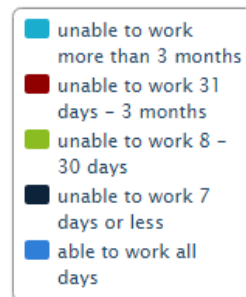
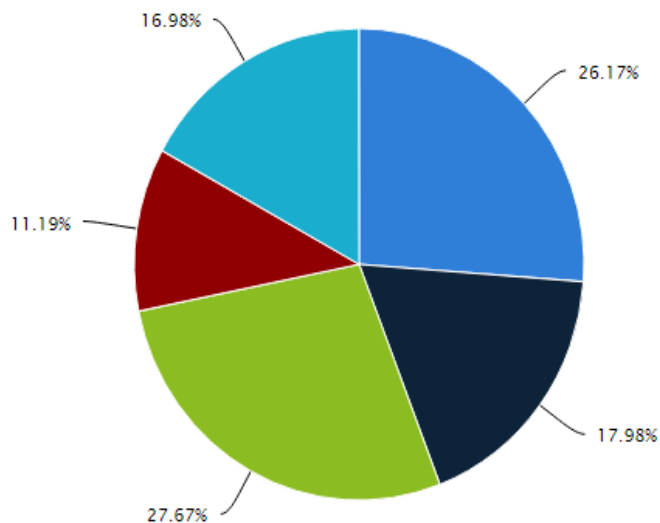
- **Where does data come from?**
 - Current Population Survey
 - Current Employment Statistics Survey
 - State unemployment insurance systems
 - American Community Survey
- **What measures of unemployment does it include?**
 - Unemployment rate
- Available by county, year, gender, age, and race/ethnicity.

Unemployment: *CHIS* (*California Health Interview Survey*)

- **Where does data come from?**
 - Household survey of adults and adolescents drawn from a random sample of California addresses
- **What measures of unemployment does it include?**
 - Unemployment rate
 - Employee absenteeism due to mental illness or emotional distress
 - Level of psychological distress among employed, unemployed, and those not in the labor force
- Available by county, year, gender, age, and race/ethnicity, clinical and social circumstances, and special populations

Employee Absenteeism due to Mental Problems

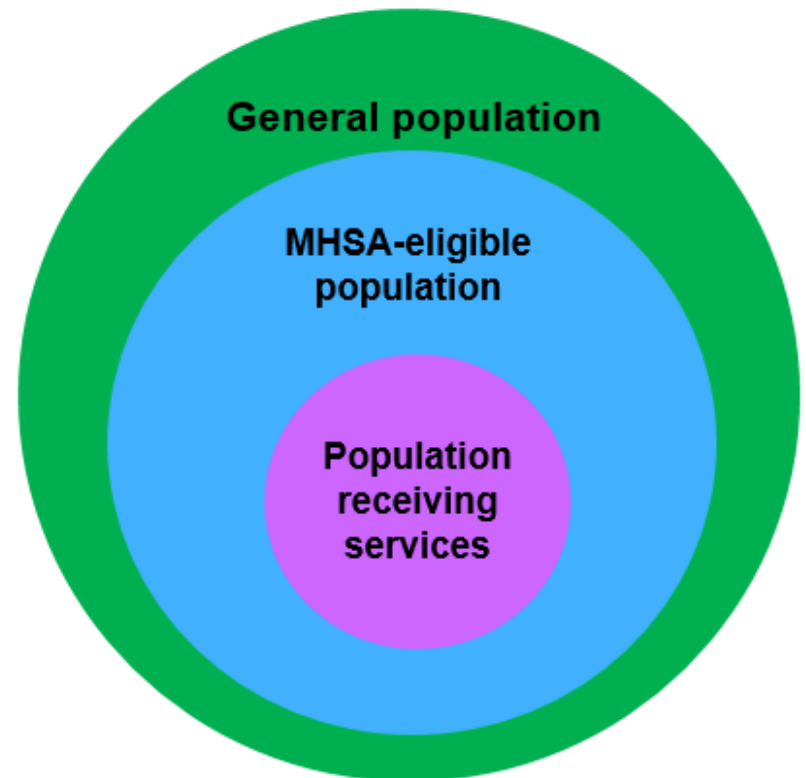
Number of days unable to work due to mental problems
Source: UCLA Center for Health Policy Research



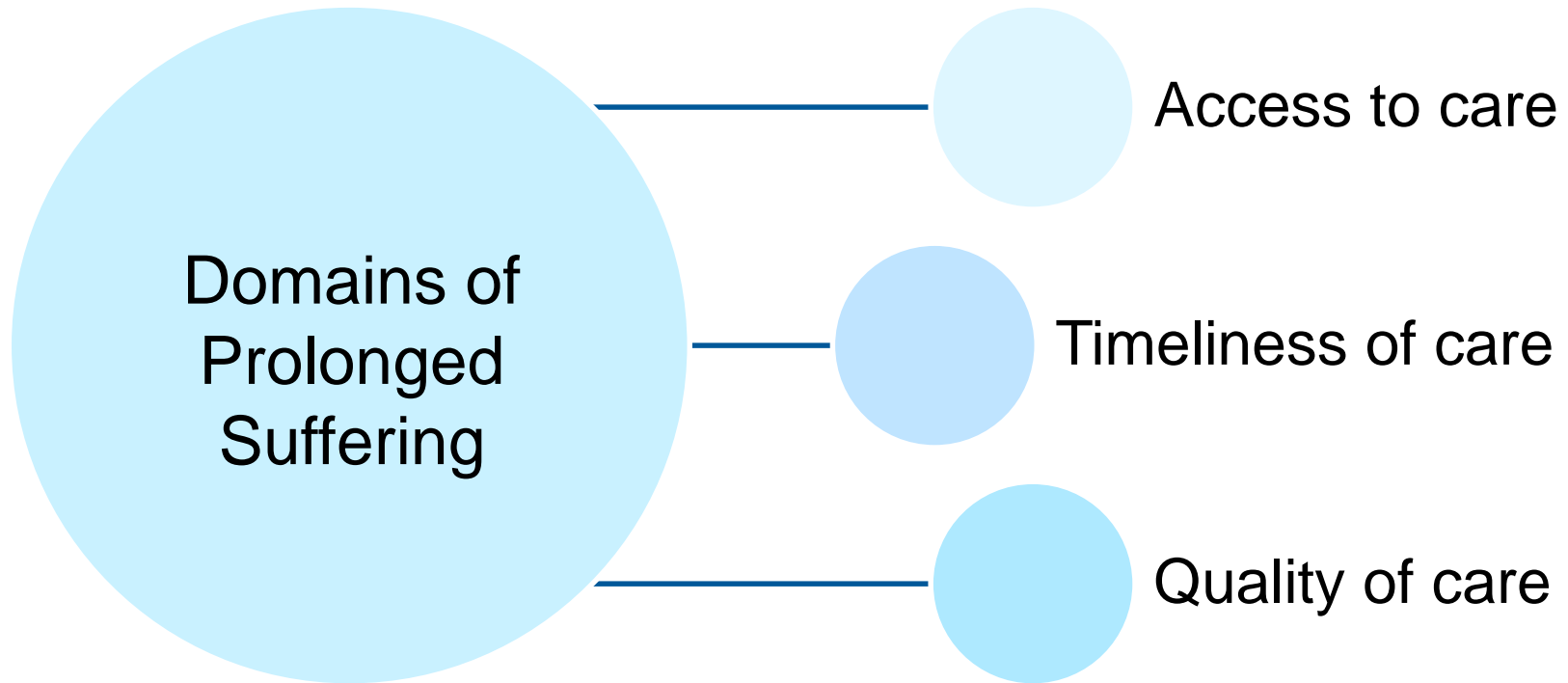
- 17% unable to work more than 3 months
- 11% unable to work 1-3 months
- 28% unable to work 8-30 days
- 18% unable to work 7 days or less
- 26% able to work all days

Decision Points

- Population levels to address?
 - Variation by outcome?



Decision Points



Next Steps

- Next 4 outcomes:
 - School failure
 - Incarceration
 - Homelessness
 - Prolonged suffering
- Synthesis of findings across outcomes
- Development of final rating system
- Create data library and management plan
- Create the data fact sheets and briefs

Questions?

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ADDITIONAL SLIDES FOR DISCUSSION

Data Elements

- Geographic level
 - Census tract & county
 - All counties & state
 - Some counties & state
 - State only
- Frequency of data collection
 - More than annual; Annual; or Less than annual
- Demographics
 - Age
 - Gender

Data Elements

- Racial and Ethnic Groups
- Immigrant
- Undocumented
- Refugee
- LGBTQ
- Disability
- Urban/Rural
- Military Status
- Unemployed
- Homeless
- Poor and Near Poor
- Justice-Involved
- Child Welfare-Involved
- Mental Health Problem

Data Elements

- Clinical circumstances
 - Clinical severity
 - More than one disorder
 - Substance use/abuse disorder
 - Physical health
- Social circumstances
 - Discrimination
 - Educational attainment
 - Financial, housing, and food insecurity
 - Trauma exposure

DRAFT:

Data Sources for Measuring and Monitoring Suicide and Suicidal Behaviors

Deliverable 2E.

Prepared for:

The Mental Health Services Oversight and Accountability Commission
Community Wellness and Outcomes Project

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November 4th, 2019

Preface

This chapter on ***Data Sources for Measuring and Monitoring Suicide and Suicidal Behaviors*** is part of a larger report for the Mental Health Services Oversight and Accountability Commission (MHSOAC) from the Community Wellness and Outcomes Project, comprised of researchers from the UCLA Center for Health Services and Society. The central objective for the Community Wellness and Outcomes Project is to identify data sources that will allow MHSOAC to develop a statewide dashboard to track county-level estimates on the 7 negative outcomes outlined in the Mental Health Services Act (MHSA) of California. This dashboard is envisioned as an early step in building capacity to improve the measurement and reporting of mental health care needs, the services delivered to meet those needs, and the outcomes of those services.

To identify metrics that are best suited to assess the seven negative outcomes, MHSOAC has contracted UCLA to make recommendations of key indicators and data sources to be included in the dashboard by using data from a statewide survey of county administrators, focus groups of stakeholders, and literature reviews of each outcome.

Products of the Community Wellness and Outcomes Project will include:

- Outcomes Report
- Data library, data management plan, and suggested data visualizations
- Data fact sheets and briefs

The **Outcomes Report** is designed to be the technical reference for the dashboard and will describe the methods and findings of the project. The primary audience for the report will be county administrators, mental health researchers, and others interested in the methodology and reasoning behind the dashboard indicator and data source selections.

The **data library, management plan, and visualizations** of the recommended indicators and data sources will assist MHSOAC in creating, maintaining, and updating the dashboard.

The **data fact sheets and briefs** will inform the general public about population-level outcomes associated with mental health challenges and unmet needs. These documents serve as the public-facing references and will explain why the recommended measures are critical to addressing the seven negative outcomes.

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Introduction

According to the Centers for Disease Control, **“Suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities”** (CDC, 2019b).

The goal of this chapter is to provide a brief overview of the importance of measuring suicide for population health surveillance. We briefly define suicide and then provide ways that suicide has been measured in counties and states, as well as at the federal and international levels. The chapter concludes with recommendations for state- and county-level surveillance of suicide in the general population, including recommendations for publicly available data sources and key data elements. This chapter presents the preliminary findings of a mixed methods study of suicide measurement in California. Data consist of a literature review, observations of mental wellness events in six California counties, a survey of county administrators, and an environmental scan of surveillance of suicide at the global, national, state, and local levels.

Importance of Collecting and Tracking Data on Suicide and Suicidal Behaviors

Population surveillance data are critical for informing evidence-based policies and program planning. Reliable and accurate data over multiple time periods provide stakeholders the opportunity to track and monitor changes in response to policy initiatives and program efforts. The CDC highlights that **surveillance should also include “data that are uniform and consistent across systems.”** Consistent data allow public health and other entities to better gauge the scope of the problem, identify high-risk groups, and monitor the effects of prevention programs and policies” (Stone et al., 2017). Collecting and tracking population-level data on outcomes of suicidality is imperative to addressing death by suicide as a major public health issue.

A statewide standardized system of measurement that can be compared across communities and over time will improve the state and local leaders’ ability to pinpoint areas of need, stimulate specific programs and services, and address disparities. In addition to providing a complete and accurate understanding of suicidality outcomes by county and state, such data would offer important insights into best practices to detect suicide risk, prevent suicidal behavior, and alleviate pain and suffering caused by mental health conditions.

Why Measure Suicide and Suicidal Behavior?

Suicide is one of the most devastating, yet preventable, negative outcomes that can result from serious mental health needs. More than 47,000 people in the United States died by suicide in 2017 (CDC), and in 2015, 46% of those who died by suicide in the United States had a known mental health condition (CDC, 2018). Although research strongly suggests that serious mental health needs, especially when untreated or inappropriately treated, is a significant risk factor for suicidal behaviors (Trout et al., 2017; Blanco et al., 2008; Chesney, Goodwin, & Fazel, 2014), access to mental health care is remarkably low for those experiencing mental health conditions. For example, only 41% of adults in the United States who have any mental health issues and 63% of those with severe mental health needs receive care, according to a 2017 Substance Abuse and Mental Health Services Administration survey (SAMHSA, 2018a). A systematic review of deaths by suicide in Europe, Australia, and the United States revealed that approximately 19% of individuals had mental health care contact in the month before their death and that lifetime rates of contact with mental health services averaged 53% for those who ultimately died by suicide (Luoma, Martin, & Pearson, 2002).

As the tenth leading cause of death in the United States and second leading cause of death in those aged 10 to 34 years old, suicide is a major public health issue affecting every age, racial, and socioeconomic demographic population. From 1999 to 2017, the national suicide rate grew by 33%, increasing from 10.5 to 14.0 per 100,000 (Hedegaard, Curtin, & Warner, 2018). While the California suicide rate is lower than the current national rate at 10.9 per 100,000 (CDC & National Center for Health Statistics [NCHS], 2019), certain populations are more significantly impacted. The following section describes the prevalence of suicidality in populations that experience higher rates of suicidality than national or state averages.

Vulnerable Populations

Several vulnerable populations that are known to have elevated risk for suicide include:

- **Veterans** - In 2016, the Veteran suicide rate was 30.1 per 100,000, which is 1.5 times greater than non-Veteran adults after adjusting for age and gender. Veteran suicide rates are continuing to rise alarmingly, with the rates for women veterans increasing twice as fast as that of men (62.4% versus 29.7%) (Department of Veterans Affairs, 2017, 2018).
- **Rural populations** - The disparity between suicide rates in rural versus urban California counties (20.1 versus 11.1 per 100,000 in 2017) has grown since 1999 (Hedegaard, Curtin, & Warner, 2018).

- **Males** - In the United States, male suicide mortality rates are disproportionately greater than female rates (22.38 and 6.12 per 100,000), however females have a greater rate of suicide attempts across all age groups (SAMHSA 2018b).
- **Native and White populations** - In 2016, non-Hispanic American Indians/Alaskan Natives and non-Hispanic Whites had the highest suicide rates of any racial or ethnic groups in California (20.1 per 100,000 for AI/AN and 18.4 for Whites), over double that of African Americans (7.0), Asian Pacific Islanders (6.7), Hispanic Whites (5.8), and Hispanic American Indians/Alaska Natives (1.8). (CDC & NCHS, 2019).
- **Two-Spirit and lesbian, gay, bisexual, transgender and queer (LGBTQ) individuals** - There are very little data on population-level rates of suicide mortality among Two-Spirit and LGBTQ populations, in part because much of the general mortality research uses death records, which do not always indicate sexual orientation and gender identify. Suicide rates among Two-Spirit and LGBTQ First Nations people are not known, but rates of risk factors indicate that they are more vulnerable to suicide risk than heterosexual First Nation people (SPRC, 2012). Gay and bisexual men are three to six times more likely to have at least one lifetime suicide attempt compared to heterosexual men, while lesbian and bisexual women are twice as likely as heterosexual women (Haas et al., 2011). In 2016, 42.8% of lesbian, gay, or bisexual students and 31.9% of “not sure” students had considered suicide in the previous year, compared to 14.8% of heterosexual students (CDC, 2016). These data demonstrate a marked disparity for Two-Spirit and LGBTQ populations.

Transgender youth and adults are particularly vulnerable. Compared to cisgender adults, transgender adults are more than 3 times as likely (34% versus 10%) to have ever considered suicide and nearly six times as likely (22% versus 4%) to have ever attempted suicide (Herman, Wilson & Becker, 2017). A quarter to a half of transgender and non-binary adolescents said they had attempted suicide at least once, with the highest rate (50.8%) being female to male adolescents (Toomey et al., 2018). Discrimination is a major contributing factor: in one study, 60% of respondents who were refused medical care due to anti-transgender bias reported a lifetime suicide attempt (Haas et al., 2014).

- **Criminal justice-involved populations** – Rates of inmate and jail suicides are significantly higher than national averages (National Institute of Corrections [NIC], 2019), with jails experiencing far higher rates than prisons (46 versus 15 per 100,000 in 2013) (Noonan, Rohloff, & Ginder, 2015). In the juvenile justice system, greater justice involvement was found to be associated with increased suicidal ideation and behavior (Stokes et al., 2015).

Definitions

Suicidality exists on a continuum of outcomes based on the severity of suicidal thoughts and actions, intent to die, and the types of ideation experienced. Many definitions of suicidality exist (see Striving for Zero, 2019), which adds to the complexity of monitoring suicidality. In this report, we focus on the following suicide-related thoughts and behaviors as they were the ones most commonly identified by our literature review, environmental scan, and observations:

1. **Behaviors:** to be consistent with the MHSOAC's other work (MHSOAC, 2019), we will use the CDC's uniform definitions (see Crosby, Ortega and Melanson, 2011:21-23):
 - **Suicide** "is defined as death caused by self-directed injurious behavior with any intent to die as a result of the behavior."
 - **Suicide attempt:** "a non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt may or may not result in injury."
2. **Suicidal ideation** refers to any thoughts or plans focused on suicide:
 - **Active suicide ideation** describes thoughts about taking action to end one's life, including identifying a method, having a plan, or having intent to act. (Turecki & Brent, 2016)
 - **Passive suicide ideation** describes thoughts about death or wanting to be dead without any plan or intent. (Turecki & Brent, 2016)

Data Sources for Suicidality

We found several national and state-level data sources on suicide and suicide behaviors. This report covers those that have: 1) ongoing and reliable data collection, 2) recent data, and 3) estimates at the state-level and, in some cases, at the county-level or smaller geographic levels like city, census, congressional districts, etc. (see *Table 1-2*). *Table 3* compares information on demographic characteristics available in each data set.

National Data Sources on Suicide

CDC National Center for Health Statistics Compressed Mortality File (NCHS Compressed Mortality File)

The CMF contains a county-level national mortality database with a record for each death of a United States resident which can be compared to overall population

estimates from the US Census. All years of the CMF (1968-2016) are also accessible through CDC WONDER, an online interactive query database.

CDC National Violent Death Reporting System (NVDRS)

The NVDRS is a state-based surveillance system that is currently implemented in 40 states including California, as well as the District of Columbia and Puerto Rico (Stone et al., 2017). It aims to cover all 50 states in 2019 (CDC, 2019a). Descriptive data can be accessed using CDC Web-based Injury Statistics Query and Reporting Systems ([WISQARS](#)) for free. Researchers who meet specific criteria can access restricted data through the Restricted Access Database ([RAD](#)). The NVDRS combines data from death certificates, law enforcement reports, and coroner or medical reports to provide detailed information about the circumstances of violent deaths.

National Data Sources on Suicide Behaviors

National Survey on Drug Use and Health ([NSDUH](#))

Each year, NSDUH interviews 70,000 participants age 12 and older, providing real-time information on mental health, substance use, and other health-related issues in the United States. State and county data are reported using small area estimation (SAE) methodology in which state-level NSDUH data are combined with county and subcounty-level census data; sub-state estimates are calculated by combining county and census block group/tract-level data from the state. Data on serious thoughts of **suicide, suicide plans, and suicide attempts are collected for adults.**

Youth Risk Behavior Survey ([YRBS](#))

The YRBS is part of the Youth Risk Behavior Surveillance System, which monitors health related behaviors in youth. The YRBS is conducted by CDC and state, territorial, and local education departments, health agencies, and tribal governments. The surveys are conducted in odd-numbered years and distributed to high schools and middle schools. Thus, data are available by school and not by county. Information on suicide attempts, suicide ideation, and suicide plan are collected. Data sets and documentation are available upon request from the jurisdictions that conducted the surveys.

California Data Sources on Suicide

The following California data sources on suicide are maintained by the California Department of Public Health ([CDPH](#)), the state's public health agency. Its Office of Health Equity (OHE) includes the Health Research and Statistics Unit ([HRSU](#)), which collects and disseminates information regarding health and mental health disparities and inequities in California. CDPH-Vital Records ([CDPH-VR](#)) maintains death certificates for California; records can be requested online.

EpiCenter – California Injury Data Online

The EpiCenter provides data from several injury-related searchable databases for California, including the CalEVDRS (described below) and substance-use related injury data, and includes data from death certificates, hospitalizations and emergency department admissions. Population-level data are available by county, year, gender, age, and race/ethnicity. Injury data are available by cause and age, top five causes of injuries, and injury trends, including self-inflicted injury and suicide attempts.

California Electronic Violent Death Reporting System (CalEVDRS)

The California Electronic Violent Death Reporting System (CalEVDRS) is modeled after the CDC's NVDRS. CalEVDRS links data from the CA Department of Justice homicide reports, vital statistics death files, and coroner reports to provide detailed information on violent deaths, including death type (homicide, suicide, undetermined intent, legal intervention, or unintentional firearm death). Currently, data from 2005 to 2009 are available for 14 counties. CalEVDRS also tracks method of suicide, which includes hanging/suffocation, sharp instrument, firearms, poison, and fall/jump.

California Pregnancy-Associated Mortality Review (CA-PAMR)

The CA-PAMR aims to reduce preventable pregnancy-related deaths and associated health disparities. It comprises a comprehensive statewide maternal mortality examination that identifies deaths during pregnancy or within one year of the end of pregnancy and describes the causes, contributing factors, and opportunities to improve maternity care and support. Trends in maternal suicides are identified as a key finding, with a report forthcoming.

California Data Sources on Suicide Behaviors

California Health Interview Survey (CHIS)

CHIS is the nation's largest state health survey, asking questions on a wide range of health topics. More than 20,000 adults, teenagers, and children are interviewed via random-dial telephone surveys each year in all 58 counties. In addition to immigration health, health insurance coverage, and physical and mental health, CHIS covers mental health status; perceived need, access, and utilization of mental health services; functional impairment; stigma; and **suicide ideation and attempts**. Data and visualizations can be accessed free of charge through AskCHIS and AskCHIS Neighborhood Edition (AskCHIS-NE) by state, county, or service planning area (SPA). Public use data, confidential data, and technical assistance are also available.

California Healthy Kids Survey (CHKS)

The CHKS is a confidential, anonymous survey administered to students at grades five, seven, nine, and eleven measuring health risks and behaviors, school climate, protective factors, school connectedness, and school violence. Supplementary modules allow individual schools to ask in-depth questions about social emotional health, alcohol and other drug use, or LGBT school experiences. For example, Oakland includes questions on various trauma indicators (C. Sarikey, personal communication). State and district CHKS data is accessible through the [CalSCHLS dashboard](#), [kidsdata.org](#), and [Query CHKS](#). This source includes data on self-reported **suicidal ideation**.

California Office of Statewide Health Planning and Development (OSHPD)

CA OSHPD is the leading office in collecting and reporting data about California's healthcare infrastructure and outcomes. Data are submitted by nearly 6000 hospitals, primary care clinics, specialty clinics, hospices, long-term care facilities, and home health agencies. A number of counties in California utilize OSHPD data to report ER and hospital visit rates due to suicide, intentional self-inflicted injury, and mental health.

California Data Source on Both Suicide and Suicide Behaviors

[Kidsdata.org](#)

Kidsdata.org is a California based database that compiles data from trusted public sources such as the California Child Welfare Indicators Project, the CA Departments of Education, Justice, and Health Care Services, the Centers for Medicare and Medicaid Services, the U.S. Census Bureau and more. Data are also drawn from a number of surveys such as the California Health Interview Survey, California Healthy Kids Survey, and the American Community Survey. Kidsdata.org includes youth suicide and self-inflicted injury data. Data usage and reproduction of data visualizations are free of charge.

Surveillance and Monitoring of Suicidality

Efforts in suicide surveillance and monitoring have taken several forms. Data sources describe both death by suicide as well as suicidal behaviors. Dashboards provide stakeholders with a broad range of policy-relevant data in easy-to-interpret formats that allow for quick comparisons and assessment of change over time. In the following sections, we present projects and dashboards and tracking project at the national level, statewide level, and those specific to California.

Global and International Examples

Global Efforts: Surveillance and monitoring of suicide and suicidal behaviors are required for improved suicide prevention strategies. According to the World Health Organization (WHO), setting up a public health surveillance system is a core element of suicide prevention that is needed in all countries (2016). Quality data needs to be comprehensive, timely, and must include: data from vital statistics, hospital-based registries of suicide attempts, and nationally representative surveys collecting information about self-reported suicidality (WHO, 2018).

Canada: As an example of a comprehensive international effort, the Public Health Agency of Canada ([PHAC](#)) passed into law the *Federal Framework on Suicide Prevention* (“[the Framework](#)”) in December 2012. This Framework includes a set of indicators that were deemed necessary for comprehensive suicide surveillance to inform suicide prevention efforts. These indicators include measures of outcomes, risk, and protective factors at the individual, family, community, and societal levels (Skinner et al., 2017). Suicide-related outcomes being tracked include: mortality, hospitalizations and ER visits from self-inflicted injuries, as well as 12 month and lifetime metrics for suicidal thoughts, plans, and attempts. In addition, PHAC utilizes indicators of positive mental health such as psychological well-being, spirituality, social support, and community involvement. This framework, [the Positive Mental Health Surveillance Indicator Framework](#), provides important data on positive outcomes and associated risk and protective factors that inform the implementation of wellness programs.

PHAC found that comprehensive suicide surveillance requires continuous collaboration with and strong connections to other agencies in Canada, such as the Canadian Pediatric Surveillance Program, Veterans Affairs, and Indigenous Service. The data yielded from these collaborations have formed the basis of a strong network of suicide prevention and life promotion activities. These findings demonstrate the importance of active collaboration among California agencies.

U.S. National Dashboard Examples

National dashboards can be important resources for suicide surveillance and monitoring both across and within states. Dashboards eliminate the need for agencies to search for and analyze reliable, relevant, and up-to-date data. Dashboards enhance systems-level understanding of an outcome by comparing measures across populations, and help promote awareness of an issue by offering a usable, interactive interface that is available to the public. Here, we provide some examples of existing dashboards to inform MHSOAC’s goal of creating a live, user-friendly dashboard. *Table 4* compares demographic information that is available for each dashboard.

[CARES Engagement Network](#)

National data and reporting platform for communities, which includes California-wide data as well as data for each county. It provides surveillance data from the CDC on suicide mortality for all states and counties as well as customizable maps and reports. Outcomes by county, the state, and the nation can be compared. Data can be stratified by age, disability, urban vs. rural populations, race/ethnicity, SES, unemployment, poverty, educational attainment, food and housing insecurity, and other health behaviors and outcomes. Data can be downloaded or exported. While this dashboard succeeds in presenting the data in an interactive and clear manner, the data are not live.

[Live Stories: Statistics](#)

This interactive dashboard collects and analyzes data from trusted and reliable sources such as the U.S. Census, the CDC, and the Bureau of Labor Statistics. However, data on only age, race, and sex are provided for suicide. Furthermore, users cannot download data into a file.

[Kids Count Data Center](#)

A project of the Annie E. Casey Foundation, the Kids Count Data Center provides data on children and families, including data on teen death caused by accidents, homicide and suicide. In addition to providing national and state level data, the Kids Count Data Center also provides data by city and congressional district. While data on suicide attempt, ideation, and plan are available for certain states (Alaska and Montana), data is not provided for California.

Statewide or System-wide Examples

The Suicide Prevention Resource Center highlights several states, two Indian reservations, and one California corrections facility that all have successfully pursued efforts in suicide surveillance to help inform their own suicide prevention efforts.

The **California** Department of Corrections and Rehabilitation (CDCR) is a large state prison system, housing more than 120,000 male and female inmates in 35 facilities. By standardizing definitions of self-harm across facilities and creating a centralized tracking system of suicidal behaviors, CDCR is able to assess shared risk factors, improve prevention strategies for specific populations, and create an early warning system to identify at-risk inmates. (Suicide Prevention Resource Center [SPRC], 2017a)

Ohio used data from death certificates and records from state hospitals and mental health clinics and found that more than 67% of people who died by suicide in the state had visited a public behavioral health provider in the year prior to their death and 29% had done so in the month prior but that this percentage was significantly lower for individuals who were uninsured, lived in a rural area, had a substance abuse disorder or

used a firearm as the suicide method. (SPRC, 2015b) They used this information to develop an inter-agency task force to address specific areas of need including developing new treatment and outreach programs and mapping suicide rates geographically to determine which communities had highest need.

Vermont matches data from vital records office with information from their Department of Mental Health's Management Information System database to better understand the unmet mental health need for service members and veterans. They found that they needed to expand current funding from their Garrett Lee Smith (GLS) grant to include suicide prevention across the lifespan. (SPRC, 2016b)

Kentucky linked data between their Department for Behavioral Health, Development, and Intellectual Disabilities (DBHDID) and the Office of Vital Statistics to obtain a more accurate picture of suicide deaths by patients who had received services from their community mental health centers (CMHC) and psychiatric hospitals. They found that both service providers were serving very high risk populations: CMHC clients died by suicide at a rate of 80 per 100,000 and clients with at least one state psychiatric hospitalization admission had a rate of 340 (compared to the national average of 12). These findings led Kentucky to address gaps in suicide prevention and increase suicide care within these systems of care. (SPRC, 2015a)

Montana has had some of the highest suicide rates for four decades. To inform suicide prevention efforts, they examined data from death certificates, coroner and medical examiner reports, and health and behavioral health care records for every suicide death in the state. They found that 85% of suicide victims had a diagnosable mental health condition, within this population 70% were diagnosed with depression. This prompted a number of interventions such as gatekeeper trainings for first responders, depression screenings in community centers, and financial support toward culturally relevant prevention efforts. (SPRC, 2017b)

Centerstone is one of the nation's largest providers of prevention and treatment services for mental and substance use disorders. Centerstone of **Tennessee** combined data from their medical records with data from death certificates and coroner reports on deaths by suicide to better understand clients at risk of suicide and to ensure they are appropriately identified, treated, and monitored. From these efforts they were able to reduce suicide rates among their clients by 55% in one year. (SPRC, 2018)

The District of Columbia Syndromic Surveillance System provides daily information on emergency department (ED) visits at 8 hospitals in Washington D.C. and is able to detect suicide-related visits (a visit in which the patient presented with suicide ideation or attempt). A study found that the reporting of suicide-related terms in the chief complaint assessment alone would result in the underestimation of suicide-related ED

visits. Incorporating the report of suicide-related behaviors into the discharge diagnosis could help improve detection. (Kuramoto-Crawford, Spies, & Davies-Cole, 2017)

Example Programs for Native American Communities

As stated earlier, Non-Hispanic, American Indian/Alaska Natives currently have high suicide rates and are the ethnicity with the greatest increase in suicides between 1997 and 2017 for both genders, particularly between the ages of 15 and 44. (Curtin & Hedegaard, 2019). Below are two examples of suicide surveillance programs implemented within and benefitting Native American communities.

The **Fort Peck Indian Reservation** in **Montana** experienced a cluster of suicides in 2010, prompting a collaboration with the local hospital, research centers, the Sheriff's office, and Indian Health Services. Weekly data were compiled from each department and cross-walked to match contextual data with diagnostic details. Findings have led to modifications in surveillance, patient education, and service delivery, resulting in the steady decline of deaths by suicide and suicide attempts in adults and juveniles for this population. (SPRC, 2016a)

The **White Mountain Apache Tribe** (WMAT) Suicide Surveillance and Prevention System in **Arizona** is a unique database that gathers rich, in-depth data from community and clinical settings. Community members are trained and expected to report suicidal behaviors, resulting in growing participation of the surveillance system and spurring successful interventions. (SPRC, 2016c)

California Statewide Efforts

In August 2019, MHSOAC released the second draft of Striving for Zero: California's Strategic Plan for Suicide Prevention 2020-2025, which includes a plan to advance data monitoring and evaluation of suicidal behaviors in order to establish a suicide prevention infrastructure (MHSOAC, 2019). Their aims include:

- **Short-term Target:** By 2025, 80% of all suicide deaths will be electronically entered into CalEVDRS, with communities using publicly available timely aggregated data to strengthen suicide prevention strategies. Currently, data from 14 out of 58 counties are available on the CalEVDRS.
- **Long-term Outcome:** Increase the use of standardized data to guide suicide prevention state and local policy and planning, resource management, and investment.

California County Reports and Dashboards

County agencies in over half of California counties (36 counties) currently provide data on suicide rates and suicidal behaviors in their county reports or county dashboards (see *Table 5*). Most of these counties (89%) tracked suicide deaths, while a third tracked suicidal thoughts, one fourth tracked suicide attempts and 39% tracked self-harm or self-injury. The most common breakdowns of the data were by age (67%), gender (31%), and race or ethnicity (25%). Over one-quarter of California counties have population-level community health-related dashboards that provide a surveillance system for multiple health indicators including deaths due to suicide and suicidal behaviors (see *Table 6*). Three counties had zip-code level statistics and two counties included veteran metrics (death rates or suicide lifeline calls) on their dashboards. All but one of the county dashboards were made in partnership with and maintained by Conduent Healthy Communities Institute, an information system that helps local public health departments, hospitals, and community coalitions to measure community health indicators, assess community needs, and to inform community health improvement efforts (Conduent, [no date]). The one exception is Solano County, which created and continues to maintain their own community health dashboard.

Solano's efforts were initiated when the Director of Solano's County Health and Social Services Department needed accessible data to monitor changes and any potential negative impacts in seven program areas – Employment and Eligibility, Child Welfare Services, Mental Health, Public Health, Older Disabled Adult Services, Substance Abuse, and the Special Investigations program – and three administrative units. The dashboard facilitated much needed communication between and within the seven program areas and three administrative units to better understand program results – both strengths and areas of growth – and also allowed them to track progress in relation to strategic plan initiatives and provide essential data on areas needing improvement (Harrison, 2012).

All of the California county dashboards provide data on age-adjusted death rates due to suicide. All use the same data source, the California Department of Public Health, except for King's County, who provides similar data from the Centers for Disease Control and Prevention (see *Table 7*). Half of these counties utilize the California Health Interview Survey (CHIS) to provide data on suicidal ideation among adults. In addition, these counties also use data from the California Office of Statewide Health Planning and Development (OSHPD) to monitor rates of hospitalization and ER visits due to suicide and intentional self-injury. Many of these dashboards provide death rates, suicidal ideation, and suicide and intentional self-injury in medical settings, and disaggregate by age, gender, and race and ethnicity.

We identified five counties that were monitoring suicidality (see *Table 7*). King, Orange and Placer have the most comprehensive data which includes suicidal ideation among adults, rates of ER visits and hospitalizations due to suicide or intentional self-injury, and age-adjusted rates of death due to suicide. They are available at:

- [Kings Partnership for Prevention](#)
- [Orange County's Healthier Together](#)
- [Be Well Placer](#)

El Dorado and Riverside provide the same data as the other three counties but do not include rates of hospitalizations due to suicide or intentional self-injury. They are available at:

- [WELL Dorado: Wellness Happens Here](#)
- [SHAPE Riverside County \(Strategic Health Alliance Pursuing Equity\)](#)

Summary

There is need for a statewide standardized system to track and measure suicide behaviors and mortality and to provide data that can be compared across populations and communities, over time and linked to mental health care data. The benefits of such a system would include: improved state and local leadership ability to identify areas of need, stimulate specific programs and services, and address disparities; insights into best practices to detect suicide risk and prevent suicidal behavior; and more general insights into strategies to alleviate the suffering caused by undiagnosed, misdiagnosed, or under-treated mental health needs that can lead to suicidality.

This report examined the currently available data sources on death by suicide and suicidal behavior internationally, within the U.S. and within California, as well as presenting some examples of existing county-level suicide prevention and outreach efforts.

National:

- Suicide mortality data: CMF and NVDRS are both surveillance systems that collect state-level mortality statistics across the US.
- Suicidal behavior data: NSDUH and YRBS use surveys to track suicide attempts, ideation and thoughts. NSDUH samples across all ages, while YRBS focuses on youth and only aggregates by school.

California:

- Suicide mortality data: CalEVDRS (14 counties), EpiCenter (statewide) and CDPH track deaths by suicide by drawing from a variety of different data bases

such as death certificates, coroner reports, and hospital records. All can aggregate by gender, race/ethnicity, and type of death. CA-PAMR focuses specifically on pregnancy-related mortality, while KidsData focuses specifically on children.

- Suicidal behavior data: CHIS and CHKS are both surveys that include information about suicide ideation and attempts. KidsData compiles information from multiple California Databases. While CHIS is all-ages, CHKS and KidsData both focus specifically on children and youth.

In contrast to searchable databases, which provide valuable research data, public dashboards provide aggregate information in a clear format that allows comparison of measures across populations and can facilitate promoting awareness of an issue among the general public.

National dashboards: CARES provides CDC data while Live Stories: Statistics and Kids Count Data Center combine data from multiple sources.

State dashboards outside of California: In addition to general population data or mental health care data, we found examples that focused specifically on inmates (California), service members and veterans (Vermont), as well as two dashboards focusing on Native American communities Assiniboine and Sioux (Fort Peck reservation, Montana), and Apache (White Mountain, Arizona), as well as dashboards that connected suicide deaths with mental health care services. These dashboards are being used to by the state to identify contexts or populations of high risk, in order to develop targeted suicide prevention interventions.

State dashboards within California: Within California, over half the counties have publicly available reports or dashboards that include suicide-related. One quarter of counties have surveillance systems that track health indicators including deaths by suicide and suicidal behaviors; most of these systems are maintained by an outside contractor.

Examples of prevention and outreach efforts in California include: suicide prevention training programs for providers, staff, and the community; outreach and awareness programs, particularly in schools; and resources specifically intended for individuals who are at risk (such as older adults) or in crisis.

Common barriers to successful surveillance and reporting include the possibility of misclassification when reports are filled out by a third party (e.g. for death records), community lack of trust in the data gathering institution, mental health and suicide stigma, and lack of a centralized source of data or robust data sharing system. Regardless of the dashboard or database selected, awareness of these factors is crucial in being able to understand and use the reported data.

[[Final recommendations TBA --- Of the dashboards and databases we examined, three model counties stood out as having the most comprehensive data: Kings, Orange and Placer. Additionally, the [CARES Engagement Network](#) looks to be a promising dashboard, as it provides data on suicide rates for 100% of California counties (CARES 2019). Data are age-adjusted death rates by gender, age, and race and ethnicity per year and this interface provides data in tables, maps, charts, and graphs over time.]]

Discussion

Suicide and suicidal behaviors are an important public health concern in California and nationally, which demonstrates the need for evidence-based suicide prevention, intervention, and care. Collecting surveillance data on suicide and suicidal behaviors at the county and local-levels are crucial to understanding the well-being and needs of a community. Additionally, the methods of data collection are also relevant in order to account for and reduce under/mis-reporting for vulnerable populations.

Barriers to Suicide Surveillance

Common barriers to successful suicide surveillance include inconsistent and inaccurate reporting (e.g. of ethnicity or gender identity) by third parties for suicide deaths, community lack of trust in the data collection institutions, stigma, lack of standardization and uniformity across counties, and lack of a central reporting system with standardized measures. These factors affect timeliness of data entry, analysis, and reporting of suicide and suicidal behaviors. Accurate analysis of the data is further complicated by the fact that there are no baselines available, for example the US Census does not ask about gender identity or sexual orientation and this information is often not entered into death records, so there is no county level baseline to which metrics can be compared.

Inaccurate third-party reporting: Suicide surveillance based on death certificates runs the risk of under-reporting certain demographics if the individual recording the cause of death does not know or agree with the deceased individual's identity (e.g. families of transgender individuals). Additionally, the ethnicities of Hispanics, Native Americans and Asian/Pacific Islanders are sometimes misreported death certificates (Arias, Heron, & Hakes, 2016), resulting in a possible underestimation of suicides.

Lack of trust in governments or institutions, particularly for immigrant and Native American communities, can make individuals reluctant to divulge personal or family information (or even to seek care) due to concern that such information might be used against them. A California county administrator described a sense of "historical trauma" for local Native American community members because of past cases of "data being

collected to benefit the government but not the people served” (Personal communication, 2019).

Stigma related to mental health and suicide can negatively impact the reporting and recording of suicidal outcomes (WHO, 2018). For example, a family member may choose to report a different cause of death.

Lack of central source of data on suicide and suicidal behaviors was mentioned as a barrier to proper suicide surveillance in a 2018 Fresno County report on their suicide prevention strategic plan (Lezine & Whitaker, 2018). Their data workgroup highlighted this lack as one of the barriers to suicide surveillance and suicide prevention efforts in their county, and has identified goals and objectives to improve data-collect capabilities by obtaining legal interpretation of data-sharing capabilities as it pertains to HIPAA, FERPA, etc. and creating a system that allows data sharing to improve suicide care and outcomes. Additionally, many counties still use paper death records and information must be entered manually into state databases, delaying accurate and timely reporting of suicide rates (Ashley Mills, personal communication).

Opportunities to Link Suicide Related Data with Other Data Sources

Other findings from this project suggest that suicide prevention efforts for particular populations could be better informed by linking data from suicide deaths with data from other departments, in order to gain a better understanding of training needs and inform better suicide prevention and care efforts. For example, individual death records could be linked to behavioral health care information, academic records, or unemployment records.

Linking suicide to behavioral health care: Individual death records could be linked to records from state hospitals, ER visits, and mental health clinics - efforts similar to what Ohio, Kentucky and Montana have accomplished.

Linking suicide to school context: Another opportunity to link data would involve connecting student deaths records with school records to better understand the academic context of these suicidal behavior in students. Additional circumstantial data regarding events such as visits to the school nurse or counselor, absences from school, behavioral problems and suspension or expulsions, academic achievement, etc. could better inform suicide prevention programs at the school level.

Linking suicides to unemployment context: Similarly, death records could be linked to employment and unemployment records to better understand any employment-related or unemployment-related outcomes such as unemployment rates or data

regarding discouraged workers. This data could be obtained from the Bureau of Labor Statistics and the Current Population Survey (CPS) (Liu, 2017).

[place holder to add any other opportunities to link suicide data]

Data Source Evaluation Summary

This section provides a summary of data sources evaluated for outcomes on suicide rates and suicidal behaviors. As discussed in more detail in the methods section, each data source was scored and evaluated on eight criteria. The first three 1) Accessibility, 2) Geographic Level, and 3) Data Updates are grouped together and have a combined score range of 0-4); the last five criteria are scored individually and have different score ranges: 4) Number of Outcome Indicators (score range for suicide rates 0-1) and for suicidal behaviors (0-4), 5) Demographics (score range 0-2), 6) Vulnerable Populations (score range 0-18), 7) Clinical Circumstances (score range 0-4), and 8) Social Circumstances (score range 0-4). Overall score range for suicide rates is 0-33 and for suicidal behaviors 0-36.

Suicide Rates

Of the six data sources identified for suicide rates, National Vital Statistics System, CDC National Center for Health Statistics Compressed Mortality File (CMF) through CDC Wonder, CDC National Violent Death Reporting System (NVDRS), the California Department of Public Health Office of Vital Statistics, the California Injury Data Online EpiCenter, and the California Pregnancy-Associated Mortality Review, the overall criteria scores ranged from 1.5 to 8 with an average score of 5.75 (See Table X). The CDC National Violent Death Reporting System had the highest overall score (8), followed by the California Injury Data Online EpiCenter (7.25), and the CDC Wonder (6.5), National Vital Statistics System (6.25), CADPH Office of Vital Statistics (5), and California Pregnancy-Associated Mortality Review (1.5).

Of the data sources that scored 2.25 or higher on accessibility, geographic-level and data updates, the EpiCenter had the highest overall criteria score (7.25), CDC Wonder and NVSS had similar scores, 6.5 and 6, respectively. To download data through the EpiCenter, multiple queries have to be made in order to download suicide rates by various indicators such as education, age group, gender, veteran status, and race and ethnicity. The CDC Wonder has a much easier system to download, however, CDC wonder also suppresses numbers for counties with less than 10 cases whereas the EpiCenter does not. As such, the CA EpiCenter is a more comprehensive county-level data source for suicide rates.

Suicidal Behaviors

Of the four data source identified for suicidal behavior, NSDUH, YRBS, OSHPD, and CHIS, the overall criteria score ranged from 9.4 to 23.3 with an average score of 22.45 (see Table Y). CHIS had the highest overall score (23.3 and 21.55 via AskCHIS), followed by NSDUH (17.6 and 16.6 via restricted use data system), and OSHPD (9.4).

Even though NSDUH had more comprehensive indicators (suicide ideation, plans, and attempts), CHIS had more comprehensive indicators for vulnerable populations, clinical and social circumstances. In addition, state and county indicators are not available in NSDUH public use files or in their restricted use data analysis system whereas CHIS does provide estimates at these geographic levels.

CHIS data provide two of the three suicidal behavior indicators in NSDUH, suicide ideation and suicide attempts. However, neither of these indicators are available in the downloadable public use files. To obtain estimates on suicide ideation, AskCHIS, a query tool for CHIS, is available. To obtain statistically stable estimates, multiple years will need to be pooled. To obtain estimates on suicide attempts, a data estimate request may be an avenue to use.

For publicly available free data that are accessible without a data request or data agreement, AskCHIS may be the best mode for obtaining data on suicide ideation. The query tool provides downloadable Excel files. However, a query and download must be conducted for each year and each cross-tab with another indicator. Also, good to note, cross-tabs with other indicators may not produce reliable estimates at the county-level for smaller counties. These may be only reliable for larger counties and at the state-level.

While NSDUH and CHIS provide aggregate data on household populations, OSHPD provides aggregate client-level data on hospitalizations and ER visits due to intentional self-inflicted injury. As such, OSHPD captures a particular vulnerable high-risk population and this data source needs to be considered separately from household-level data sources.

Recommendations

The following are three sets of recommendations. Each category is determined by the accessibility of the data from a particular data source. The ideal, pie in the sky, accessibility would be one in which current data can be accessed or shared immediately to display in a future dashboard and in a format that would help streamline the process for updating this dashboard. For the scope of this project, the UCLA team will provide MHSOAC with a data library that consists of three years of data for each indicator in each of the 7 MHSA outcomes – suicide, unemployment, homelessness, incarceration, removal from home, school failure or dropout, and prolonged suffering. As such, the

ideal accessibility would be to have publicly available data in which a complete data set with multiple indicators for a particular outcome or multiple outcomes can be downloaded at one time without a data request or data use agreement.

Category 1 describes recommended data sources that have current data that are publicly available, easily accessible, and can be downloaded without a data request or data use agreement.

Category 2 describes recommended data sources that may be more comprehensive in scope but need a data request or data use agreement in order to obtain the data in a timely manner. For instance, some data sources are publicly available but may require a data request to obtain a complete data set that could take 6 to 12 months, if not longer, to receive and there are some data that are part of a restricted data set with geocodes that would require a more extensive data request or a data use agreement where applicable.

Category 3 describes data capturing an outcome identified as important by stakeholders but data or a data source for this outcome does not currently exist.

Category 1 Recommendations

a) For Suicide Rates

Based on the overall criteria previously discussed and the ability to provide 3 years of data for the MHSOAC Data Library, the **California Injury Data Online (EpiCenter)** is the recommended data source to provide estimates on **suicide rates** for California and for each county.

b) For Suicide Behaviors

For suicide behaviors, the **California Health Interview Survey (CHIS) via AskCHIS** is in the recommended data source to provide estimates on suicidal ideation in the past year for California and for counties where reliable estimates are provided.

Category 2 Recommendations

a) For Suicide Rates

For Category 2 recommendations on suicide rates, we recommend that MHSOAC establish a data use agreement with the **California Department of Public Health (CDPH)** to share vital statistics data in real time. A data use agreement between these two entities would greatly streamline the process to access the data and update the dashboard. In addition, we recommend a data use/share agreement between MHSOAC and the **California Pregnancy-Associated Mortality Review (CA-PAMR)** as this data would get at a highly vulnerable population and could be used to tailor outreach and services to this population.

b) For Suicide Behaviors

For Category 2 recommendations on suicide behaviors, we recommend MHSOAC establish a data use/share agreement with the **California Office of Statewide Health Planning and Development (OSHPD)** to provide administrative data on a particularly high-risk population which includes those who have been hospitalized or had an ER visit due to a non-fatal self-inflicted injury.

For more comprehensive indicators on suicide ideation, plans, and attempts, we recommend data from the **National Survey on Drug Use and Health (NSDUH)**. To obtain data from NSDUH, a data request must be submitted and there may be applicable fees.

Category 3 Recommendations

Of all the data sources identified on suicide rates, the CDC National Violent Death Reporting System (NVDRS) and/or California Violent Death Reporting System were found to be the most comprehensive data sets as these provide more contextual information about those who have died by suicide. In alignment with the MHSOAC Suicide Prevention plan, we recommend that more efforts be made to extend the CVDRS to all 58 counties in California.

In addition to OSHPD data, we recommend that OSPHD data be linked with data from CA Department of Behavioral Health in order to ascertain the extent to which clients in the public mental health system are or are not being seen in hospital and ER settings for self-inflicted injuries.

Based on preliminary analysis of county and local ethnographic observations (including attending MHSA events and conducting focus groups and interviews), these are some suggestions for other metrics which would be relevant in understanding the “health” of a county with regards to suicide prevention.

1. Measurement of general population awareness and understanding

Public awareness and education are keys components in local, county and state level suicide prevention campaigns which focus on breaking the taboo against talking about suicide and increasing understanding of its causes, warning signs, and available resources.

Metrics that could serve as indicators for a county’s overall health in this domain might include the proportion of the general population who report:

- confidence in being able to recognize warning signs of suicidality (or other risk factors such as depression)
- comfortability with talking about suicide to someone who may be exhibiting warning signs

- knowledge of how to obtain help for themselves or a loved one
- awareness of any public education program (i.e. noticing billboards, having a presenter come to their school, etc.)

Such metrics could be further broken down by sub-population including:

- Populations who are known to be at higher risk, for example, Native Americans, White males, LGBTQ youth, veterans.
- Groups who would be in close contact with high-risk individuals and are not mental health professionals: for example, high-school and college students, teachers, social workers.

2. Measuring suicide's interconnection with the other negative outcomes

Suicides, suicide attempts, and suicidal ideation are extreme outcomes of un/under treated mental illness, which is known to be exacerbated by other factors including homelessness, unemployment, incarceration, child removal from home, and other forms of prolonged suffering. Additionally, suicidal thoughts and behaviors are of growing concern among children and youth and may occur in tandem with school failure. Finally, the degree to which mental illness is stigmatized (versus normalized) in a community strongly impacts both the likelihood that at-risk individuals will seek professional help and the ability of peers and family to recognize early warning signs, which is why many suicide prevention programs have a strong public outreach component.

Improvements (or worsening) in one domain can be expected to have a delayed downstream effect on the others and should be monitored accordingly. For example, greater involvement in the juvenile justice system is known to be associated with increased suicide ideation and behavior (Stokes et al., 2015). Therefore countywide programs that redirect youth with mental health issues into treatment rather than convictions would also contribute to a reduction in youth suicides.

Tables

Table 1: Selection Criteria for National and California Data Sources for Suicide Rates

Data Sources/Resources	Environmental Scan	Lit Review	Survey	Stakeholders
CDC National Vital Statistics/Compressed Mortality File	√	√		
CDC National Violent Death Reporting System	√	√		
California's Electronic Violent Death Reporting System	√	√		
EpiCenter – California Injury Data Online	√		√	
Kids Data	√		√	
California Pregnancy-Associated Mortality Review (CA-PAMR)			√	
National Institute of Mental Health			√	
California Department of Public Health	√			

Table 2: Selection Criteria for National and California Data Sources for Suicidal Behavior

Data Sources/Resources	Environmental Scan	Lit Review	Survey	Stakeholders
California Health Interview Survey	√	√	√	
California Health Kids Survey	√	√	√	
National Survey on Drug Use and Health by SAMHSA	√	√		
Youth Risk Behavior Survey	√	√		
Kids Data	√		√	
California Office of Statewide Health Planning and Development	√		√	

Table 3: National and California Data Sources for Suicide or Suicidal Behavior

Data source	Level of Detail	Age range	Age group	Race/ethnicity	Hispanic origin	Gender	SES	Immigrant status	LGBTQ identity	Justice-related	MH need/svs use	Subs. use	Other variables
National Violent Death Reporting System	Nat'l, State (27 states)	Lifespan	✓	✓	✓	✓			✓	✓	✓	✓	Foster care, homelessness, unemployment
Compressed Mortality File	Nat'l, State, County	Lifespan	✓	✓	✓	✓				✓			
National Survey on Drug Use and Health	Nat'l, Sub-state ¹	Lifespan (12yo+)	✓	✓	?	?	✓	✓	✓		✓	✓	
Youth Risk Behavior Surveillance System	Nat'l, State, school ²	Middle/high school	✓	✓		✓			✓			✓	
CA Health Interview Survey	County; SPA	Lifespan	✓	✓	✓	✓	✓	✓	✓		✓	✓	
CA Healthy Kids Survey	School	Grade 5, 7-11	✓	✓		✓	✓	✓	✓		✓	✓	Parent education; school connectedness
CA Electronic Violent Death Reporting System	14 counties	Lifespan	✓	✓		✓							Veterans, marital status
CA Injury Data Online (CDPH, EpiCenter)	County	Lifespan	✓	✓	?	✓							Injury cause
CA Pregnancy-Associated Mortality Review	State only	15-49		✓									
Kidsdata.org	County	0-17	✓	✓		✓	✓	✓	✓				Urban/rural, Special health care needs

¹ Does not include state-level data for confidentiality reasons. Uses Small Area Estimates for state and substate statistics.

² Data are organized by individual school, not by county. Has capacity to oversample in specific geographic areas.

Table 4: Examples of National Dashboards

Dashboard	Level of Detail	Age range	Can disaggregate by...					Immigrant status	LGBTQ identity	Justice-related	Related MH need/svs use	Substance use	Other variables
			Age group	Race/ethnicity	Hispanic origin	Gender	SES						
CARES Engagement Network	Nat'l; State County	Lifespan	✓	✓	✓	✓	✓				✓	✓	Urban/rural; Physical disability; English proficiency; unemployment
Live Stories: Statistics	Nat'l; State County	Lifespan	✓	✓		✓							
Kids Count Data Center	Nat'l; State	Lifespan	✓	✓	✓	✓	✓	✓					

Table 5: Suicide Related Data from County Reports or Dashboards

Data tracked	# Counties Yes	No or not listed	Yes % (out of 36 ^a)
Suicide death rates ^b	32	4	88.89%
Suicide attempts	9	27	25.00%
Suicidal thoughts	10	26	27.78%
Self-injury ^c	14	22	38.89%
Disparities (for any metrics):			
by age	24	12	66.67%
mentioned separate metrics for youth:	11		
by gender	11	25	30.56%
by race/ethnicity	9	27	25.00%
by zip code	3	33	8.33%
veterans	2	34	5.56%
Other info (for any metric):			
method	5	31	13.89%
calls to suicide hotline	2	34	5.56%
ER calls ^d	10	26	27.78%
Hospitalizations ^e	7	29	19.44%

Disparities listed by only one county: families coping with issues related to teen suicide; incarcerated/detained youth; marital status; Spanish speakers; subgroups with high levels of ED visits for self-injury; and suicide risk by education level.

^a Dashboards or county reports were found for 36 of the 58 counties. ^b Includes completed suicides, deaths due to self-inflicted injury, and counties that track leading causes of death. ^c Includes cases that were not suicide attempts or where motivation was not listed. ^d Includes suicide attempts, self-harm, or ER calls for mental health reasons. ^e Includes hospitalizations for suicide attempts or other self-harm.

Table 6: California County Dashboards with Data Related to Suicide

County	Dashboard Name & Link
Alameda	Healthy Alameda County: Community Dashboard
El Dorado	WELL Dorado: Wellness Happens Here
Fresno	Healthy Fresno County Community Dashboard
Kern	Healthy Kern County
King	Kings Partnership for Prevention
Los Angeles	Think Health LA
Marin	Healthy Marin
Mendocino	Healthy Mendocino: Connecting People and Information for Better Health
Orange	Orange County's Healthier Together: Improving Health Through Planning and Partnership
Placer	Be Well Placer
Riverside	SHAPE Riverside County (Strategic Health Alliance Pursuing Equity)
San Luis Obispo	SLO Health Counts
Sacramento	Be Healthy Sacramento
Solano	Solano Public Health: Healthy People 2020 Indicators
Ventura	Health Matters in Ventura County

Table 7: Continuum of Suicide Indicators by California Counties, 2019

County ^a	Suicide Ideation	ER visit due to suicide or intentional self-injury	Hospitalization due to suicide or intentional self-injury	Death Due to Suicide
Alameda				✓
El Dorado	✓	✓		✓
Fresno	✓			✓
Kern				✓
King ^b	✓	✓	✓	✓
Los Angeles				✓
Marin				✓
Mendocino				✓
Orange ^c	✓	✓	✓	✓
Placer	✓	✓	✓	✓
Riverside	✓	✓		✓
San Luis Obispo	✓			✓
Sacramento				✓
Solano ^d				✓
Ventura ^e		✓✓	✓✓	✓

^a All dashboards provide suicide data by gender, age, race and ethnicity, and for multiple years. ^b King County uses data from Center for Disease Control and Prevention, all other counties use data from the California Department of Public Health. ^c Orange County also provides suicide rates for females. ^d Solano Public Health Department manages their own dashboard, all other dashboards except one are maintained by Conduent Health Communities Institute. ^e Ventura's dashboard provides rates for ER visits and hospitalization for child/teen (under age 18) separate from adults (age 18 and over); all other counties provide these rates either for all ages or only for adults age 18 and over.

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DRAFT



DRAFT:
**Data Sources for Measuring
and Monitoring Removal from
Home**
Deliverable 2E.

Prepared for:
The Mental Health Services Oversight and Accountability Commission
Community Wellness and Outcomes Project

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Preface

This chapter on ***Data Sources for Measuring and Monitoring Removal from Home*** is part of a larger report for The Mental Health Services Oversight and Accountability Commission (MHSOAC) from the Community Wellness and Outcomes Project, comprised of researchers from the UCLA Center for Health Services and Society. The central objective for the Community Wellness and Outcomes Project is to identify data sources that will allow MHSOAC to develop a statewide dashboard to track county-level estimates on the 7 negative outcomes outlined in the Mental Health Services Act (MHSA) of California. This dashboard is envisioned as an early step in building capacity to improve the measurement and reporting of mental health care needs, the services delivered to meet those needs, and the outcomes of those services.

To identify metrics that are best suited to assess the seven negative outcomes, MHSOAC has contracted UCLA to make recommendations of key indicators and data sources to be included in the dashboard by using data from a statewide survey of county administrators, focus groups of stakeholders, and literature reviews of each outcome.

Products of the Community Wellness and Outcomes Project will include:

- Outcomes Report
- Data library, data management plan, and suggested data visualizations
- Data fact sheets and briefs

The **Outcomes Report** is designed to be the technical reference for the dashboard and will describe the methods and findings of the project. The primary audience for the report will be county administrators, mental health researchers, and others interested in the methodology and reasoning behind the dashboard indicator and data source selections.

The **data library, management plan, and visualizations** of the recommended indicators and data sources will assist MHSOAC in creating, maintaining, and updating the dashboard.

The **data fact sheets and briefs** will inform the general public about population-level outcomes associated with mental health challenges and unmet needs. These documents serve as the public-facing references and will explain why the recommended measures are critical to addressing the seven negative outcomes.

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Introduction

The goal of this chapter is to provide a brief overview of the importance of measuring **removal from home** as part of a surveillance effort for each county population. We briefly define removal from home and then provide ways that removal from home has been measured in counties and states, as well as at the federal and international levels. In defining this outcome, we examine ways of measuring risk for removal as well as removal from home itself. It is beyond the scope of this project to include surveillance of children once they have been removed from home. This chapter concludes with recommendations for state- and county-level surveillance of removal from home in the general population, including recommendations for publicly available data sources and key data elements. This chapter presents the preliminary findings of a mixed methods study of removal from home measurement in California. Data consist of a literature review, observations of mental wellness events in six California counties, a survey of county administrators, and an environmental scan of surveillance of removal from home at the global, national, state, and local levels.

Importance of Collecting and Tracking Data on Removal from Home

Population surveillance data are critical for informing evidence-based policies and program planning. Reliable and accurate data over multiple time periods provide stakeholders the opportunity to track and monitor changes in response to policy initiatives and program efforts. The CDC highlights that **surveillance should also include “data that are uniform and consistent across systems**. Consistent data allow public health and other entities to better gauge the scope of the problem, identify high-risk groups, and monitor the effects of prevention programs and policies” (Stone et al., 2017).

A statewide standardized system of measurement that can be compared across communities and over time will improve the state and local leaders’ ability to pinpoint areas of need, stimulate specific programs and services, and address inequities. In addition to providing a complete and accurate understanding of child welfare outcomes by county and state, such data would offer important insights into the intersection of child welfare and mental health outcomes.

Why Measure Removal From Home?

Removal from home is a key outcome that signals likely need for more prevention and early intervention as well as treatment services. Removal from home occurs when there is substantial risks for child maltreatment and/or neglect. Some of the common reasons for removal from home include physical and/or sexual abuse, and neglect. In 2017, 7 children per 1000 were reported to be victims of neglect, 2 for physical abuse, 1 for sexual abuse, and 1 for psychological or emotional abuse (US DHHS, 2002-2019). Of the 3.5 million children who were the subject of an investigation regarding allegations of maltreatment, approximately 674,000 were substantiated to be victims of maltreatment

(19%) (US DHS, ACF, Children's Bureau, 2019). About 270,000 children are removed from their homes every year (Children's Bureau, 2018). The World Health Organization (WHO) defines child maltreatment to include all forms of physical and emotional maltreatment, sexual abuse, neglect, and exploitation that results in potential or actual harm to the child's health, dignity, or development (2019). Maltreatment includes physical abuse, sexual abuse, emotional abuse, exploitation, and neglect and negligent treatment. Certain characteristics of maltreatment (type, severity, and frequency) can significantly influence rates of mental and behavioral disorders (Cantos, Gries, & Slis, 1996; Gabrielli, Jackson, & Brown, 2016; Maaskant, van Rooij, & Hermanns, 2014; Shin, 2005; Steele & Buchi, 2008).

According to the Centers for Disease Control (CDC), there are a number of risk factors for child abuse and neglect that span individual, family, and system/community level factors.

At the **individual level**, child characteristics such as age and having a special health care need (physical, mental, developmental) can place children at increased risk for abuse and neglect.

- Younger children are most vulnerable to maltreatment: children aged 0-3 had the highest rate of substantiated victimization at 15 per 1000 children of the same age in the general population, followed by each older age group; children age 4-7 (10 per 1000) and age 8-11 (8 per 1000).
- Children with emotional problems can be at increased risk for victimization. In one nationally representative study, children with internalizing disorders (Depression, Anxiety, PTSD) were found to experience greater sexual victimization from non-caregivers and maltreatment (caregiver physical, emotional, and sexual abuse and neglect), controlling for sociodemographic factors and parental substance use and mental illness (Turner et al, 2011). Similar results were not found for children with ADHD and developmental disorders.

Several **parent and family level characteristics** have also been found to predict maltreatment, when controlling for other variables (Turner et al 2011), including:

- Children living with a biological mother who has a diagnosis of a mental or substance use disorder
- Children living with a single parent or a stepparent or partner

In addition, the CDC has listed social isolation, family disorganization, and parenting stress as key family risk factors for victimization due to child maltreatment. Community risk factors include high rates of community violence and concentrated neighborhood disadvantage.

Although race/ethnicity does not predict maltreatment by parent (Turner et al 2011), it has been well-documented that certain racial and ethnic children and families are disproportionately represented in the rates of removal from home, due in part to their disproportionate exposure to adversity as well as the role of bias. African American and American Indian/Alaska Native children are removed from their homes and placed into the child welfare system at nearly twice the rate of White children (US DHHS, ACF, Children's Bureau, 2019). The literature suggests that the disproportionate representation of ethnic minorities in the foster care system is due to geographic location, high rates of concentrated poverty, racial biases, the biases of individual workers, and embedded discrimination in the child welfare and judicial systems (Johnson, Antle, & Barbee, 2009; Shaw et al., 2008). Visibility biases has also been suggested as a factor in the overrepresentation of African American and Native American children respectively, as well as that of high poverty families in general (Drake et al., 2009; Sinha et al., 2013). Visibility bias is the theory that, because certain populations (e.g. poor families on welfare) have more frequent contact with and scrutiny from institutional authorities, these groups are more likely to be reported and will therefore appear at higher rates than other, less scrutinized populations. When scanning for existing data systems and literature that measure child welfare outcomes, it was important to us to assess their ability to measure inequities among disproportionately impacted populations in child welfare. In this chapter, we present indicators that were identified in the literature, statewide survey, and qualitative data to be linked to need for mental health services and data sources that measure these indicators.

Indicators for Removal from Home

In order to prevent removal from home and support the mental health of families and children at risk for removal from home, it is imperative to measure and understand the breadth of factors that lead to removal. As such, we used the following research question to help guide the selection of indicators of risk that precede removal from home, examine surveillance and monitoring efforts, and identify data sources that can be used to measure the indicators.

What are the indicators that should be measured to help service providers identify and assist families and children at risk for out of home placement?

Although the child welfare system measures a whole host of indicators once a child is in the foster care system, we are focusing for this evaluation on those indicators that assess being at risk for removal from home with the ultimate indicator being entry into the foster care system:

- Allegations

- Repeat referrals due to recurrence of maltreatment
- Substantiations
- Entry into the foster care system

In FY 2017, the national rate of screened-in allegations was 31.8 per 1000 children (US DHHS, ACF, Children's Bureau, 2019). These rates are indicative of the need for support services such as parenting skills needed.

A national Child Family and Services Review (CFSR) indicator, **repeat referrals** occur when children are referred to child protective services (CPS) on multiple occasions. Specifically, the Administration for Children and Families seek to reduce "the percentage of children with substantiated or indicated reports of maltreatment who have a repeated substantiated or indicated report of maltreatment within six months" (US DHHS, ACF, Children's Bureau, 2019). Possible repeated victimization is associated with a wide range of short- and long-term negative outcomes, such as delayed cognitive development and mental illnesses that could extend into adulthood (Thompson & Wiley, 2009).

Substantiated allegations of maltreatment are also a risk factor for removal from home, during which CPS has determined that an incident of child abuse or neglect has occurred. Once allegations have been substantiated and a case has been opened, the agency will determine the safest course of action for the child.

If the child is at high risk of serious harm or has been seriously harmed, the child will be **removed from the home** by court order. Removal of the child from their home may include legal termination of the parent(s)'s rights to the control, custody, and care of the child (Child Welfare Information Gateway [CWIG], 2019). The child may be placed into a continuum of foster care placements, group homes, or kinship care (CWIG, 2019). Removal is often a culmination of a series of stressors for a child and the family, and entry into the foster care system is preceded by uncertainty and loss (Forkey & Szilagyi, 2014). When maltreatment is followed by removal from home, higher rates of behavioral health issues can occur. (Hambrick, Oppenheim-Weller, N'zi, & Taussig, 2016; Ryan & Testa, 2005).

In light of these findings, we have examined data sources that can be used for surveillance efforts early in the course of concerns of child maltreatment.

Data Sources for Child Welfare Outcomes

From this study, we found several national and state-level data sources on child welfare outcomes. The ones highlighted in this report are those that we found to

have 1) ongoing and reliable data collection, 2) recent data, and 3) estimates at the state-level and, in some cases, at the county-level or smaller geographic levels like city, census, congressional districts, etc. (see Table 1). These data sources were further examined by whether or not they could be disaggregated by demographic characteristics to identify vulnerable populations (e.g. age groups, race and ethnicity, poverty-level, etc.) Please see Table 2 and Table 3 for more detailed information.

National Data Sources on Child Welfare Outcomes

National Data Archive on Child Abuse and Neglect (NDACAN)

<https://www.ndacan.acf.hhs.gov/>

Data, codebooks, and additional information for the following national data sources are available in the National Data Archive on Child Abuse and Neglect (NDACAN), a data archive of child abuse data in the United States. Data is distributed to researchers free of charge. Datasets include the Adoption and Foster Care Analysis and Reporting System (AFCARS), the National Child Abuse and Neglect Data System (NCANDS), and the National Youth in Transition Database (NYTD), all of which are described below.

Adoption and Foster Care Analysis and Reporting System (AFCARS)

<https://www.acf.hhs.gov/cb/research-data-technology/reporting-systems/afcars>

AFCARS is a mandatory reporting system that contains data on the characteristics and circumstances associated with removal from home. State, county, and tribal Title IV-E agencies are required to submit case-level information twice a year on all children for whom they provide placement, care, or supervision through child welfare agencies.

- **Geographic level:** National, State, and Child welfare agency
- **Frequency of data collection:** Annually
- **Data availability:** publicly available upon request; distributed by NDACAN
 - <https://www.ndacan.acf.hhs.gov/datasets/datasets-list.cfm>
- **Removal from home indicators:**
 - Removal from home
 - Total number of removals from home
- **Removal reasons** (sexual, physical, emotional abuse, neglect, parent with drug or alcohol abuse, etc)
- **Sociodemographic variables:**
 - Age, race/ethnicity, gender
 - Child welfare and justice involvement
 - Homelessness
- **Child characteristics:**
 - Child emotionally disturbed (includes emotional and behavioral problems)
 - Mental retardation
 - Other medically diagnosed condition (includes Autistic Spectrum Disorder)

National Child Abuse and Neglect Data System (NCANDS)

<https://www.acf.hhs.gov/cb/research-data-technology/reporting-systems/ncands>

NCANDS is a voluntary data collection system that annually collects case-level data on child maltreatment known to Child Protective Services agencies in all 50 states, DC, and Puerto Rico. The case-level Child File is supplemented by an agency-level data submission called the Agency File. NCANDS data is used for the annual Child Maltreatment reports, which summarize the major national and state-by-state findings in child welfare outcomes.

- **Geographic level:** National, State, and Child welfare agency
- **Frequency:** Annually
- **Data availability:** publicly available upon request, but only by researchers who have IRB approval, distributed by NDACAN
 - <https://www.acf.hhs.gov/cb/research-data-technology/reporting-systems/ncands>
- **Removal from home indicators:**
 - Referrals
 - Repeat referrals
 - Substantiated allegations
 - Removal from home
- **Maltreatment type:** (abuse, neglect, etc)
- **Sociodemographic variables:**
 - Age, race/ethnicity, gender
 - Child welfare and justice involvement
 - Homelessness
- **Child characteristics:**
 - Emotional disturbance (DSM diagnosis)
 - Behavior problem (at school or community, includes running away)
- **Family characteristics:**
 - Single parent household, etc
 - Caregiver characteristics (drug or alcohol abuse, intellectual disability, emotional disturbance)
 - Financial problems
- **Service use**

California Data Sources on Identified Child Welfare Outcomes

California Child Welfare Indicators Project (CCWIP)

<https://www.hwcws.cahwnet.gov> and http://cssr.berkeley.edu/ucb_childwelfare/

The CCWIP provides measures of California child welfare outcomes by county and topic as a collaboration between the California Department of Social Services and the University of California, Berkeley.

Data comes from the Child Welfare Services/Case Management System (CWS/CMS). Each state is mandated to have a Statewide Automated Child Welfare Information System (SACWIS) to support case management and data collection of child welfare case management practices. As California's model of the SACWIS, CWS/CMS provides policymakers with the necessary information to manage child welfare services. CWS/CMS will soon be replaced by CWS-CARES, the California Automated Response and Engagement System.

CCWIP configures CWS/CMS information longitudinally and produces publicly available outcome reports and data visualizations.

- **Geographic level:** State and county
- **Frequency:** Quarterly, from the CWS/CMS
- **Data availability:** publicly available via a query tool
 - http://cssr.berkeley.edu/ucb_childwelfare/
- **Removal from home indicators:**
 - Allegations
 - Substantiations
 - Entries
- **Maltreatment type:** (abuse, neglect, etc)
- **Sociodemographic variables:**
 - Age, race/ethnicity, gender

Surveillance and Monitoring for Child Welfare Outcomes

Global and International Example

World Health Organization: Child Maltreatment

https://www.who.int/violence_injury_prevention/violence/child/en/

The World Health Organization monitors child maltreatment worldwide. Their site on violence prevention offers key publications and resources, advocacy materials, data briefs and reports, and prevention and response strategies. By working with government and community partners, their efforts form interventions that promote non-violent norms

and values, support parents and caregivers, create and sustain safe environments for children, and offer response and support services. Please refer to their ‘Partners’ section for more information on international efforts.

National Examples

The Children’s Bureau

<https://www.all4kids.org/>

The Children’s Bureau monitors State child welfare services through:

- The Adoption and Foster Care Analysis and Reporting System (AFCARS)
- Title IV-E Foster Care Eligibility Reviews
- Child and Family Services Reviews (CFSRs)
- The State Automated Child Welfare Information System (SACWIS) Assessment reviews

These efforts help the nation and States continuously improve practices to achieve the core set of national goals for child welfare: safety, permanency, and well-being. Systematic data gathering describes the achievement of these outcomes, identifies the gaps in performance, and enables agencies to address the gaps and other needs. The Children’s Bureau also conducts the [AFCARS Assessment Review](#), which is technical assistance process to understand the accuracy and reliability of the States’ foster care and adoption data, and the effective of the States’ data collection and reporting processes.

Child and Family Services Review (CFSR)

CFSRs are periodic reviews of state child welfare systems to 1) ensure conformity with federal child welfare policies and requirements, 2) identify what is actually happening to children and families when they are involved in the system, and 3) help states with supporting children and families to achieve positive outcomes. California’s CFSR is described in a later section of the chapter.

Reports from rounds 1 and 2 of the review are available at

https://library.childwelfare.gov/cwig/ws/cwmd/docs/cb_web/SearchForm

<https://www.acf.hhs.gov/cb/monitoring/child-family-services-reviews>

<https://www.acf.hhs.gov/cb/research-data-technology/reporting-systems/nytd>

Several reports from round 3 are available at:

<https://www.acf.hhs.gov/cb/monitoring/child-family-services-reviews/round3>

National Dashboard Examples

Dashboards eliminate the need for agencies to search for reliable, relevant, and up-to-date data. Dashboards enhance systems-level understanding of an outcome by comparing measures across populations and help promote awareness of an issue by

offering a usable, interactive interface. National dashboards can be important resources for child welfare surveillance and monitoring across states and within states.

Casey Family Programs

<https://www.casey.org/state-data/>

Utilizes data from AFCARS and NCANDS to display estimates state-by-state and nationally. Indicators include rate of kids in care, number of children involved in investigations versus number who enter foster care and why, and rate of repeat maltreatment.

Child Welfare Outcomes Report Data Dashboard

<https://cwoutcomes.acf.hhs.gov/cwodatasite/>

The Children's Bureau provides state-level performance data in seven categories of outcomes that are primary objectives for child welfare practice. The dashboard utilizes AFCARS and NCANDS data, which must be reviewed and approved by each state before inclusion. The site also provides contextual data regarding child maltreatment, caseworker visits, and race and ethnicity breakdowns. Data are available for download in multiple formats.

A full list and breakdown of each outcome and its measures is available at:

<https://cwoutcomes.acf.hhs.gov/cwodatasite/pdf/Outcomes%20and%20Measures.pdf>

Live Stories: Statistics

<https://www.livestories.com/statistics/us-children>

Collects and analyzes data from trusted and reliable sources such as the U.S. Census, the CDC, and the Bureau of Labor Statistics and provides an interactive dashboard to examine age-adjusted rates across years, by age, gender, and race and ethnicity. In child outcomes, household data, such as relationship to head of household or household type, are provided.

Kids Count Data Center

<https://datacenter.kidscount.org/topics>

A project of the Annie E. Casey Foundation, this site uses data from multiple data source to provide estimates on various outcomes for children and families by state and county. The following indicators and data source for child abuse and neglect and out of home placement are:

- National and State data for 7 child abuse and neglect indicators from NCANDS include:
 - Children who are subject to investigated report
 - Children who are confirmed by child protective services as victims of maltreatment

- By age group
 - By gender
 - By maltreatment type
 - By race and Latino ethnicity
- Children who are confirmed by child protective services as victims of maltreatment who receive post-investigation services
- Customized reports can be created that have California county data for 2 indicators on child abuse and neglect and 4 indicators on out of home placement from CCWIP include:
 - Rate of substantiated child abuse (per 1,000)
 - Percent of young children, ages 0-3, who do not experience recurring neglect or abuse
 - By race and Latino ethnicity

Non-California State Examples of Dashboard

Wake County Child Maltreatment Surveillance System (North Carolina)

Wake County, North Carolina, piloted a surveillance system that linked individual child records from Child Protective Services, the Raleigh Police Department, and the Office of the Chief Medical Examiner. While the pilot did identify more cases than CPS alone, the increase was not substantial (about 1.8 per 10,000 children, or less than 20%). However, the combined system also identified over twice as many possible child maltreatment cases that had not been substantiated by CPS. Shanahan et al argue that because a high burden of proof is needed to substantiate a case with CPS, these possible cases also indicate high family and child need and should be taken into account when making decisions about programs and policy.

California Examples of Dashboards

The California Child Welfare Indicators Project (CCWIP) Dashboard

<http://cssr.berkeley.edu/CWSCMSReports/Dashboard/>

The CCWIP dashboard provides county-level data on child population, allegations, substantiations, entries, exits, and count of children in care and in probation. Data tools allow users to examine measures by topic and has the option to stratify according to age, race, and gender.

The CCWIP Dashboard contains a wide range of measures on child welfare, including maltreatment in foster care, recurrence of maltreatment, permanency, placement stability, and re-entry into foster care. Data is available for each county in California. Using the data analysis tool, variables can be stratified by age, race, or gender and compared among counties or the State. Below, placement stability among ethnic groups

is compared between California and Los Angeles from 2018 to 2019 (Webster et al., 2019).

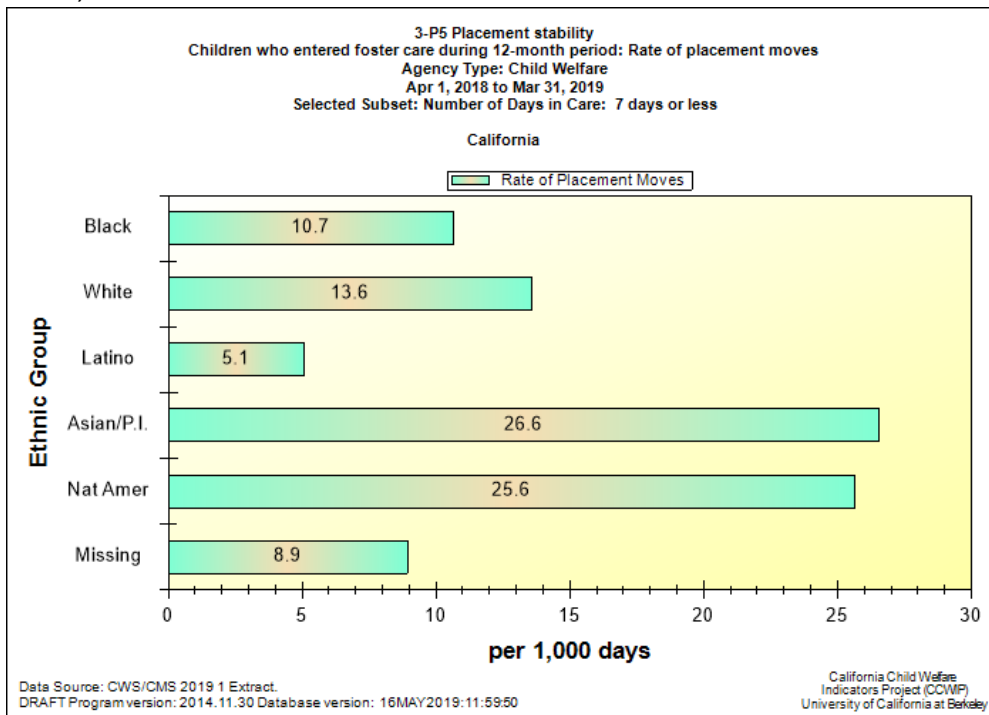


Figure 1 Children who entered foster care during 12-month period: California

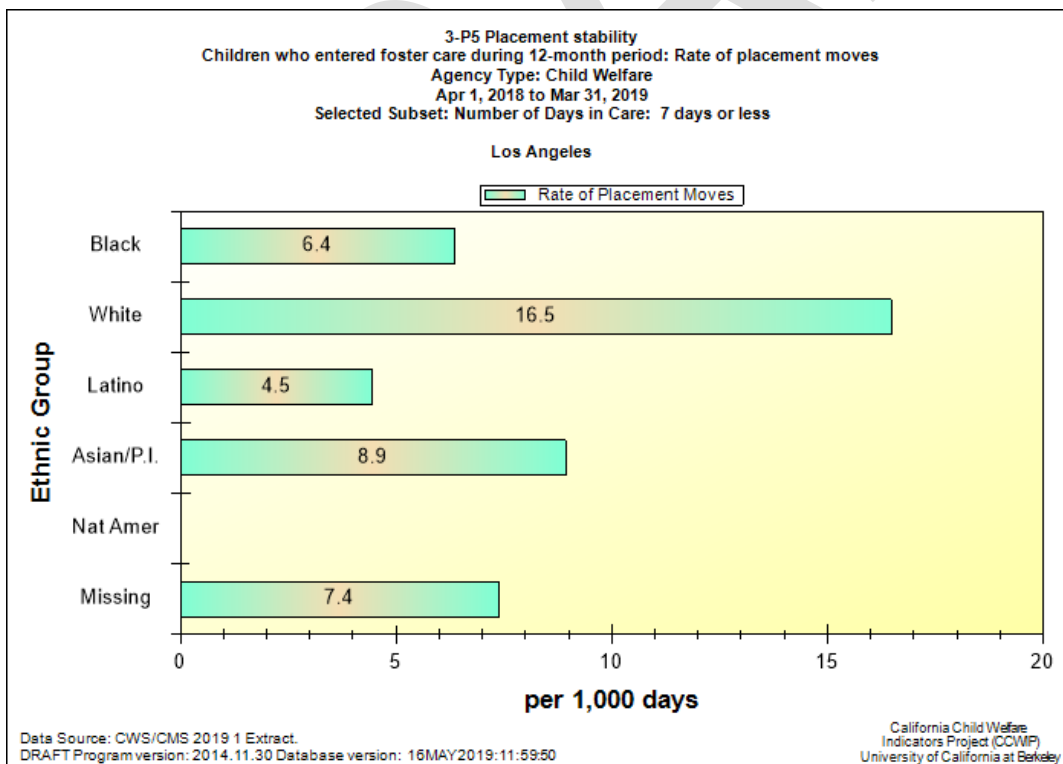


Figure 2 Children who entered foster care during 12-month period: Los Angeles

California Child and Family Services Review (C-CFSR)

<https://www.cdss.ca.gov/inforesources/Child-Welfare-Program-Improvement/Federal-Child-and-Family-Services-Review>

The C-CFSR improves child welfare outcomes by holding county and state agencies accountable for the outcomes achieved. This statewide accountability system includes the completion of a County Self-Assessment (CSA) which includes a peer review, development of a five year System Improvement Plan (SIP), the submission of annual SIP Progress Reports, and quarterly monitoring of SIP strategies and the effects on child welfare outcomes.

The Children's Movement of California

<https://www.childrennow.org/thechildrensmovement/>

Children Now, an advocacy, research, and policy development organization, leads the Children's Movement of California effort to advocate on behalf of children, which includes producing the [2018 California Children's Report Card](#). This report grades the state's ability to invest in issues affecting children and describes the state's progress. Child welfare outcomes include child abuse and neglect prevention, placement stability, and permanent connections.

County Prevention Data Dashboard – CA Department of Social Services

<https://www.cdss.ca.gov/inforesources/OCAP/Data-Dashboards>

The Child Welfare data dashboard provides annual county-level information on child welfare indicators. The latest data points are from 2017. Indicators include: number of children with child welfare involvement; disposition types of children with the first allegation; child welfare outcomes per 1000 children for allegation, substantiation, and entry rates; outcomes among children with a prior stage of involvement; and children with allegations in 12 months following the first allegation. Other domains include health, violence, service access, and racial disproportionality.

Kidsdata.org

<https://www.kidsdata.org/>

Kidsdata.org is a California based database that compiles data from trusted public sources such as the California Child Welfare Indicators Project, CA Departments of Education, Justice, and Health Care Services, Centers for Medicare and Medicaid Services, U.S. Census Bureau and more. Data is also drawn from a number of surveys such as the California Health Interview Survey, California Healthy Kids Survey, and the

American Community Survey. Data usage and reproduction of data visualizations are free of charge.

Outcomes include:

- Reports of child abuse and neglect
- Substantiated cases of child abuse and neglect
- Adverse childhood experiences, such as parental substance abuse
- Foster care entry

Project: State Medicaid and Child Welfare Data Linkages for Outcomes Research, 2019-2021

<https://www.acf.hhs.gov/opre/resource/state-medicaid-and-child-welfare-data-linkages-for-outcomes-research-2019-2021-overview>

Two offices from the Administration for Children and Families, the Office of Planning, Research, and Evaluation (OPRE) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), are partnering to develop state-level capacity to examine outcomes for children and parents in the child welfare system who may have behavioral health issues, especially for families experiencing substance use disorders. By developing new linked data infrastructure, leveraging existing data, and promoting the use of data to the larger research community, the project aims to become a model of data sharing and linking within and across states while minimizing burden to state agencies. This is an in-development project, a contract is scheduled to be awarded in September 2019.

Summary of California County Reports and Dashboards

The ability to disaggregate data by socioeconomic and demographic characteristics is important for understanding inequities in child welfare related outcomes. Many of these national and state dashboards provide the opportunity to understand these inequities – See Table 4 for more information.

This study found that 30 out of the 58 counties were monitoring child welfare related indicators in either county reports or county dashboards, many of which were through the county departments of public health. Of these 38 counties, 40% were tracking foster care related indicators and 60% were tracking indicators related to child abuse and neglect. About half of these indicators could be examined by age groups, gender, race and ethnicity. See Table 5 for more information.

Twenty out of the 58 CA counties have at least one dashboard tracking at least one child welfare-related indicator. Nine counties (Alameda, El Dorado, Kern, Napa, Placer, Sacramento, San Francisco, Santa Clara, and Yolo) have dashboard specifically for “Child Adversity and Well-Being”. These dashboards are a product of the Shared Data and Outcomes Workgroup of the California Essentials for Childhood (EfC) Initiative, a CDC-funded child maltreatment prevention project hosted by the California

Departments of Public Health and Social Services. All 24 county dashboards use data from the California Child Welfare Dynamic Report System (CCWIP). See Table 6 for more information on which child-welfare related indicators being tracked in each dashboard.

Discussion

In addition to measuring risk factors that predict vulnerability, it is also important to assess factors that predict resilience in families, such as:

- Concrete support for parents (basic resources; services for family-specific needs; and social services, such as for mental health and substance abuse treatment)
- Social connections
- Knowledge of parenting and child development
- Social and emotional competence of children
- Nurturing and attachment

Opportunities to Link Child Welfare Related Data with Other Data Sources

- In 2019, the Administration for Children and Families initiated a new project called the **Child Maltreatment Incidence Data Linkages** ([CMI Data Linkages](#)), which will identify and enhance existing administrative data linkages to more accurately survey incidence of child abuse and neglect.
- **Medicaid Analytic eXtract (MAX) files** (maintained by CMS): Medicaid eligibility files list the reason for eligibility, one of which is foster care. Examining this data source and linking it with a national dataset could allow closer study of foster populations, such as children with disabilities (Cidav et al., 2018; Leckman-Westin et al., 2018).
- **The Client & Service Information (CSI) and the Data Collection Reporting (DCR) Systems** collect client-level service utilization data from California's county mental health programs. This data has been linked to foster care data from kidsdata.org to improve FSP programming (Cordell et al., 2017). Future linkages could yield exploration of crisis service use and mental health service use in foster care youth.
- **The CCWIP** collaborates with the Children's Data Network (CDN, University of Southern California) to link CCWIP data to population-based data sources, such as birth or death records.

Limitations in tracking data removal from home

- Data sources that count the number of abuse reports (e.g. ED visits [Shanahan et al., 2018]) do not give an accurate picture of the number of individual affected children.
- Difficulty of tracking success of in-home preventative services (i.e. cases in which service receipt successfully prevented the need for removing the child from the home). In contrast, failure of such programs is easier to track by linking history of services received with history of out of home placement. (Courtney et al., 1994)
- Substantiated child maltreatment or child removal from home are the more extreme cases in the child welfare spectrum. Focusing on these metrics runs the risk of overlooking many high-need families who have not yet reached that point or who could be successfully assisted before removal from home becomes necessary. (Shanahan et al., 2018)

Limitations on data collection for American Indian / Alaska Native populations:

While indigenous children for a small proportion of the national population in the US, Canada and Australia, they are over-represented in the reporting and investigation stages of the child welfare process (Sinha et al., 2013). Some researchers have argued that this may be due to institutionalized historic racial bias in access to other services that would have replaced the need for child welfare (Roberts, 2002), as well as visibility bias (see below). Data collected on these populations are limited for the following reasons:

- The Native American status of children are inconsistently reported in child welfare databases (Magruder & Shaw, 2008).
- Native Americans comprise a smaller proportion of the national population. Therefore, nationally representative data sets have small sample sizes that are not sufficient enough to properly look at inequities.(Sinha et al., 2013)
- National data collection efforts such as NCANDS and AFCARS focus primarily on state-run child welfare agencies and have limited inclusion of data from independent tribal-run agencies (Sinha et al., 2013)

Recommendations

Recommendations of data sources and their related data elements are organized into three categories:

Category 1 describes recommended data sources that are publicly accessible and ready to use by MHSOAC.

Category 2 describes recommended data sources that require funds, resources, and time to access and utilize.

Category 3 describes data elements that are not currently being measured in a standardized setting, but may be of interest and useful to collect. The recommendations in this section have been identified through our environmental scans, literature reviews, and qualitative investigation from counties in California.

Category 1 Recommendations

None. Of the three data sources publicly available, none are available for download without a data request or other permissions.

Category 2 Recommendations

- **Category 2, #1 Recommendation:** NCANDS is the most complete data source, including a wide range of removal from home indicators and a broad number of child and family variables. This data source not only allows for surveillance of more proximal outcomes, but also has important variables to monitor high risk populations such as those children with emotional disturbance and behavioral problems, and parent and family factors.
- **Category 2, #2 Recommendation:** AFCARS is the second best data source but for only the one removal from home outcome of entry into the system. This data source similarly to NCANDS has variables that include child and parent factors.
- **Category 2, #3 Recommendation:** CCWIP is the third best data source. It has the advantage of having the broad number of removal from home indicators and sociodemographic variables, but it lacks information about child and parent characteristics.

Category 3 Recommendations

Based on preliminary analysis of county and local ethnographic observations (including attending MHSA events and conducting focus groups and interviews), these are some suggestions for other metrics which would be relevant in understanding the “health” of a county with regards to reducing children’s removal from their homes due to parents SMI or other unmet mental health need.

1. Disconnecting parent neglect/abuse from poverty, racism and economic precarity

A topic of high concern with community members we talked to is the fact that minority and low income families are disproportionately vulnerable to child abuse allegations and possible child removal from home. Cited reasons include racism, cultural differences in child rearing, poverty, and parents’ lack of access to or knowledge about institutional sources of support that could help them. This concern is also supported by our literature review which revealed that ethnic minority children are not at increased risk for experiencing maltreatment when all other pertinent factors are controlled, yet it is well-documented that ethnic minority children are at increased risk for removal from home.

Greater specificity of ethnic subgroups would be helpful to add to future surveillance questionnaires.

In addition, asking parents about the number of Adverse Childhood Experiences that their child has experienced could be important surveillance in identifying populations at risk for removal from home and who would benefit from prevention and early intervention (PEI) services.

2. Measuring the success of family maintenance programs (prevented potential removals)

A child's removal from home is an end outcome after the failure of several preventive steps (i.e. parent mental health treatment, parenting education, and family maintenance services). For this reason, it is important to not only measure a decrease in actual removals but also an increase in the success of these intermediate stages that prevented the need for such a removal.

Metrics that could serve as county-level indicators would have to track family progress over time. Some examples include:

- Proportion of substantiated allegations that led to families receiving various types of services (family therapy, parenting education, etc.)
- Proportion of families who received such services and did not result in a repeated allegation within the next year.
- Number of one-time allegations versus repeated allegations in a county's child welfare system.

3. Measuring removal from home's interconnection with the other negative outcomes

Removal from home, and the investigations leading up to it, are known to be impacted by a variety of factors including: parent mental illness, poverty, unemployment and homelessness. Children who are placed in foster care are also more likely to have mental health problems, **school failure**, adult **homelessness**, and **suicide**. The degree to which mental illness is **stigmatized** (versus normalized) in the local community affects parents' access to and acceptance of mental health resources. Finally, **culture**, **class**, and **ethnicity** will impact whether a parent's behavior is seen as out of line, or even the likelihood that abuse or neglect are noticed by institutional authorities.

Because these domains are interconnected, improvements (or worsening) in one domain can be expected to have a delayed downstream effect on the others, and should be monitored accordingly. For example, there is a known connection between youth experiences in foster care and a number of adult negative outcomes -- therefore, family maintenance programs that reduce the need for child removal from home may also contribute to reduced homelessness, unemployment, and even suicide years or decades later.

Conclusions

Removal from home occurs when there are safety concerns for the child and substantial risk of maltreatment or abuse that cannot be addressed within the family. About 270,000

children are removed from their homes every year and CPS has reported a 12% increase in suspected child maltreatment referrals since 2013, indicating a strong need for mental and behavioral health support for both the adults and the children involved. Ethnic minorities and low-income families are at increased risk of being targeted for allegations due to a variety of systemic factors including geographic location, concentrated poverty, racial bias, visibility bias due to already being under scrutiny by government institutions, and even discrimination embedded within the child welfare and juvenile justice systems.

Child maltreatment can impair cognitive development and mental and behavioral health and put children at high risk for lifelong mental illness. Subsequent removal from home causes stress and uncertainty for children and puts them at further risk for mental or behavioral health problems. For this reason, a statewide data tracking system should include not only actual rates of children removed from their homes, but also monitor indicators of risk or service need at earlier stages in order to prevent the family situation from escalating to the point where removal is necessary.

In this report we recommend tracking the following indicators at all stages of the process: referrals/allegations, substantiation, receipt of family maintenance services and the ultimate removal from home if those services fail, as well as tracking repeated patterns of maltreatment or neglect (repeat referrals or repeat removals). Indicators of removal prevention (e.g. cases where family maintenance services were successful) would also be of high value but may be more complicated to collect.

This report examined the currently available data sources on child maltreatment and removal from home internationally, within the U.S. and within California, as well as presenting some examples of existing county-level prevention and outreach efforts.

National Data Sources:

AFCARS and NCANDS are the main national-level data sources. They provide family level data on all cases in the United States, including not only removals from home but also risk factors and whether family maintenance service was provided.

They are both accessible through the NDACAN website.

Three of the example national dashboards we presented in this chapter (Casey Family Project Child Welfare Outcomes Report Data Dashboard and the Kids Count Data Center) both draw from these data sources.

NDACAN includes a third data source, NYTD, which is a survey of foster youth. This survey also collects data on other MHSA-targeted outcomes (homelessness and unemployment). However, it is more limited and only conducted every three fiscal years.

Statewide and California Data Sources:

Quarterly county level child welfare outcomes data for all of California are available through CCWIP, which tracks most of the indicators of interest to this report: allegations, substantiations, entries, receipt of maintenance services, and reentry following reunification. The County Prevention Data Dashboard (CA Department of Social

Services) also provides information on child welfare outcomes for allegation, substantiation and entry as well as repeat allegations.

Statewide accountability systems in California: C-CFSR and the Children's Movement of California statewide report card both assess provide metrics of how California is making progress on improving child welfare outcomes and on areas that need to be further addressed. Both report cards look at prevention of child abuse or neglect as well as placement stability and permanency of family connection. The Children's Bureau also conducts state-level assessment of child welfare services as well as monitoring the accuracy of AFCARS data.

Other California dashboards: As noted above, KidsData is a dashboard including multiple data sources that have previously been examined (CCWIP, CHIS, and CHKS) as well as additional data from state level departments and the U.S. Census Bureau.

Data Linkage Projects:

An in-proposal California project to develop state level capacity to track child welfare status and outcomes for children and parents with behavioral and substance abuse health issues by linking state Medicaid data with child welfare records.

Outside of California, the Wake County, North Carolina implemented a pilot program to merge CPS, Police, and Office of the Chief Medical Examiner data in order to create individual family records of both substantiated and alleged child maltreatment cases. Both of these programs indicate future directions for other project development to better link and centralize data on key indicators.

DRAFT

Tables

Table 1: Selection Criteria for National & California Data Sources for Child Welfare Outcomes

Data Sources/Resources	Environmental Scan	Lit Review	Survey	Stakeholders
Adoption and Foster Care Analysis and Reporting System	✓	✓		
California Child Welfare Indicators Project	✓	✓	✓	
Child Welfare Services/Case Management System				
Kidsdata.org	✓		✓	
National Data Archive on Child Abuse and Neglect	✓	✓		
National Child Abuse and Neglect Data System	✓	✓		
National Youth in Transition Database		✓		

Table 2: National Data Sources for Child Welfare and Removal from Home

Data source	Level of Detail	Maltreatment ¹	Foster care ²	Age group	Child v. adolescent	Race/ ethnicity	Gender	SES/ poverty	Phys. health /disability	MH need/ service use	Other variables
Adoption and Foster Care Analysis and Reporting System	Nat'l; State; County	✓	✓	C ³ A		C A	C A	A	C A	C	Immigrant status; substance use; prior relationship with adoptive parents; urban/rural
National Child Abuse and Neglect Data System	Nat'l; State	✓	✓	C A		C A	C A		C A	C A	Substance use; military family member
National Youth in Transition Database	Nat'l; State		✓	✓		✓	✓				Incarceration; substance abuse; employment status; education level; health insurance; homelessness
Child and Family Services Review	Nat'l	✓	✓	✓	✓	✓			✓	✓	

¹ Abuse, maltreatment or neglect; may include substantiated or investigated cases.

² May include entrance, exit, type of placement, time to permanency, or placement stability.

³ C = Child data; A = adult (parent/guardian) data.

Table 3: California Data Sources for Child Welfare and Removal from Home

Data source	Level of Detail	Maltreatment ³	Foster care ⁴	Age group	Child v. adolescent	R/E	Gender	SES/ poverty	Phys. health /disability	MH need/ svcs use	Other variables
California Child Welfare Indicators Project (CCWIP)	CA; County	✓	✓	✓	✓	✓					
Kidsdata.org	CA; County	✓	✓	✓	✓	✓	✓	✓	✓		Urban/rural; Immigrant status; LGBTQ identity
The California Child Welfare Indicators Project (CCWIP)	<i>(see under “California – Child Welfare Data Sources”)</i>										
County Prevention Dashboards (CA Dept of Social Services)	CA, County	✓	✓			✓		✓	✓		
State Medicaid and Child Welfare Data Linkages	Nat'l; State	<i>In development</i>									link parent Medicaid records with child welfare system records; substance use; foster care
Let's Get Healthy California	CA	✓				✓					

³ Abuse, maltreatment or neglect; may include substantiated or investigated cases.

⁴ May include entrance, exit, type of placement, time to permanency, or placement stability.

Table 4: Examples of National and California Dashboards

Dashboards	Level of Detail	Abuse, mal-treatment, neglect ⁵	Foster care ⁶	Age group	Child v. adolescent	Race/ethnicity	Gender	SES	Other variables
Casey Family Programs	Nat'l, States,	✓	✓	✓					
Child Welfare Report Outcomes Dashboard									
Kids Count Data Center	Nat'l, States	✓	✓	✓	✓	✓		✓	
Live Stories: Statistics	Nat'l; State		✓	✓		✓	✓	✓	
California Child Welfare Indicators Project (CCWIP)	State, Counties	✓	✓	✓		✓	✓		
County Prevention Data Dashboard	Counties	✓	✓			✓		✓	

⁵ May include substantiated or investigated cases.

⁶ May include entrance, exit, type of placement, time to permanency, or placement stability.

Table 5: Removal from Home Related Data from County Reports or Dashboards

Data tracked	# Counties	% Yes (out of 30 ^a)
DOMAINS:		
Foster care	12	40.00%
<i>entering/placements</i>	5	16.67%
<i>exiting</i>	1	3.33%
<i>length of stay</i>	2	6.67%
Out of home placements	4	13.33%
<i>type of placement</i>	3	10.00%
Homeless/unsheltered	8	26.67%
<i>history of foster care for homeless adults</i>	3	10.00%
Child welfare system	3	10.00%
Abuse/neglect	18	60.00%
INEQUITIES (for any metrics):		
for children/minors	23	76.67%
for youth/TAY	8	26.67%
by age	14	46.67%
by race/ethnicity	14	46.67%
by gender	13	43.33%
by household type	1	3.33%
foster youth who received specialty mental health services	1	3.33%

^a Dashboards or county reports were found for 30 of the 58 counties.

Table 6: California County Dashboards with Data Related to Removal from Home

County	Dashboard Name	Dashboard URL	Measure of Indicator	Data Source
Alameda	Healthy Alameda County: Custom Dashboard	http://www.healthyalamedacounty.org/indicators/index/indicatorsearch?doSearch=1&showComparisons=1&I%5B0%5D=132158	Substantiated Child Abuse Rates by Age, Gender, Race and Ethnicity	Child Welfare Dynamic Report System http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx
Alameda	Alameda County Data Dashboard: Child Adversity and Well-Being	https://www.acesconnection.com/g/alameda-county-aces/blog/alameda-county-data-dashboard-child-adversity-and-well-being	Reports of Child Abuse and Neglect	via kidsdata.org California Child Welfare Indicators Project http://cssr.berkeley.edu/ucb_childwelfare/
El Dorado	WELL Dorado: Wellness Happens Here	http://www.welldorado.org/	Substantiated Child Abuse Rates by Age, Gender, Race and Ethnicity	Child Welfare Dynamic Report System http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx
El Dorado	Health Happens Here: California ACEs Action	https://www.acesconnection.com/g/california-aces-action/blog/community-data-dashboards-for-ca	Reports of Child Abuse and Neglect	via kidsdata.org California Child Welfare Indicators Project http://cssr.berkeley.edu/ucb_childwelfare/
Kern	Health Happens Here: California ACEs Action	https://www.acesconnection.com/g/california-aces-action/blog/community-data-dashboards-for-ca	Reports of Child Abuse and Neglect	via kidsdata.org California Child Welfare Indicators Project http://cssr.berkeley.edu/ucb_childwelfare/
Napa	Health Happens Here: California ACEs Action	https://www.acesconnection.com/g/california-aces-	Reports of Child Abuse and Neglect	via kidsdata.org California Child Welfare Indicators Project

County	Dashboard Name	Dashboard URL	Measure of Indicator	Data Source
Placer	Health Happens Here: California ACEs Action	https://www.acesconnection.com/g/california-aces-action/blog/community-data-dashboards-for-ca	Reports of Child Abuse and Neglect	http://cssr.berkeley.edu/ucb_childwelfare/ via kidsdata.org California Child Welfare Indicators Project
Sacramento	Health Happens Here: California ACEs Action	https://www.acesconnection.com/g/california-aces-action/blog/community-data-dashboards-for-ca	Reports of Child Abuse and Neglect	http://cssr.berkeley.edu/ucb_childwelfare/ via kidsdata.org California Child Welfare Indicators Project
San Francisco	Health Happens Here: California ACEs Action	https://www.acesconnection.com/g/california-aces-action/blog/community-data-dashboards-for-ca	Reports of Child Abuse and Neglect	http://cssr.berkeley.edu/ucb_childwelfare/ via kidsdata.org California Child Welfare Indicators Project
Santa Clara	Health Happens Here: California ACEs Action	https://www.acesconnection.com/g/california-aces-action/blog/community-data-dashboards-for-ca	Reports of Child Abuse and Neglect	http://cssr.berkeley.edu/ucb_childwelfare/ via kidsdata.org California Child Welfare Indicators Project
Yolo	Health Happens Here: California ACEs Action	https://www.acesconnection.com/g/california-aces-action/blog/community-data-dashboards-for-ca	Reports of Child Abuse and Neglect	http://cssr.berkeley.edu/ucb_childwelfare/ via kidsdata.org California Child Welfare Indicators Project
Fresno	Healthy Fresno County Community Dashboard	http://www.healthyfresnocountydata.org/indicat	Substantiated Child Abuse Rates by Age,	Child Welfare Dynamic Report System http://cssr.berkeley.edu/

County	Dashboard Name	Dashboard URL	Measure of Indicator	Data Source
		ors/index/dashboard?alias=indicatorlist	Gender, Race and Ethnicity	ucb_childwelfare/RefRates.aspx
Kern	Healthy Kern County	http://www.healthykern.org/index.php?module=indicators&controller=index&action=dashboard&alias=indicatorlist	Substantiated Child Abuse Rates by Age, Gender, Race and Ethnicity	Child Welfare Dynamic Report System http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx
King	Kings Partnership for Prevention	http://www.kpfp.org/indicators/index/dashboard?alias=mentalandemotional	Substantiated Child Abuse Rates by Age, Gender, Race and Ethnicity	Child Welfare Dynamic Report System http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx
Los Angeles	Think Health LA	https://www.thinkhealthla.org/indicators	Substantiated Child Abuse Rates by Age, Gender, Race and Ethnicity	Child Welfare Dynamic Report System http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx
Mendocino	Healthy Mendocino: Connecting People and Information for Better Health	http://www.healthymendocino.org/index.php?module=indicators&controller=index&action=index	Substantiated Child Abuse Rates by Age, Gender, Race and Ethnicity	Child Welfare Dynamic Report System http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx
Orange	Orange County's Healthier Together: Improving Health Through Planning and Partnership	http://www.ochealthier.together.org/index.php?module=indicators&controller=index&action=index	Substantiated Child Abuse Rates by Age, Gender, Race and Ethnicity	Child Welfare Dynamic Report System http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx
Placer	Be Well Placer	http://www.placerdashboard.org/indicators/index/dashboard?alias=indicatorlist	Substantiated Child Abuse Rates by Age, Gender, Race and Ethnicity	Child Welfare Dynamic Report System http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx
Riverside	SHAPE Riverside County (Strategic	http://www.shaperivco.org/indicators/index/dashboard?alias=indicatorlist	Substantiated Child Abuse Rates by Age,	Child Welfare Dynamic Report System http://cssr.berkeley.edu/

County	Dashboard Name	Dashboard URL	Measure of Indicator	Data Source
	Health Alliance (Pursuing Equity)		Gender, Race and Ethnicity	ucb_childwelfare/RefRates.aspx
San Luis Obispo	SLO Health Counts	http://www.slohealthcounts.org/indicators/index/dashboard?alias=indicatorlist	Substantiated Child Abuse Rates by Age, Gender, Race and Ethnicity	Child Welfare Dynamic Report System http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx
Sacramento	Be Healthy Sacramento	http://www.behealthysacramento.org/indicators/index/dashboard?alias=indicatorlist	Substantiated Child Abuse Rates by Age, Gender, Race and Ethnicity	Child Welfare Dynamic Report System http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx
Solano	Solano Public Health: Healthy People 2020 Indicators	http://solano.networkofcare.org/ph/HealthIndicatorsDashboard.aspx	Substantiated Child Abuse Rates	Child Welfare Dynamic Report System
Ventura	Health Matters in Ventura County	http://www.healthmattersinc.org/indicators/index/dashboard?alias=indicatorlist	Substantiated Child Abuse Rates by Age, Gender, Race and Ethnicity	Child Welfare Dynamic Report System http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx
Yolo	Yolo County Community Indicator Dashboard	https://www.yolocounty.org/general-government/general-government-departments/county-administrator/community-indicator-dashboard-3354	Substantiated Child Abuse Rates by Age, Gender, Race and Ethnicity	Child Welfare Dynamic Report System http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx

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DRAFT:

**Data Sources for Measuring
and Monitoring
Unemployment**

Deliverable 2E.

Prepared for:

The Mental Health Services Oversight and Accountability Commission
Community Wellness and Outcomes Project

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Preface

This chapter on ***Data Sources for Measuring and Monitoring Unemployment*** is part of a larger report for the Mental Health Services Oversight and Accountability Commission (MHSOAC) from the Community Wellness and Outcomes Project, comprised of researchers from the UCLA Center for Health Services and Society. The central objective for the Community Wellness and Outcomes Project is to identify data sources that will allow MHSOAC to develop a statewide dashboard to track county-level estimates on the 7 negative outcomes outlined in the Mental Health Services Act (MHSA) of California. This dashboard is envisioned as an early step in building capacity to improve the measurement and reporting of mental health care needs, the services delivered to meet those needs, and the outcomes of those services.

To identify metrics that are best suited to assess the seven negative outcomes, MHSOAC has contracted UCLA to make recommendations of key indicators and data sources to be included in the dashboard by using data from a statewide survey of county administrators, focus groups of stakeholders, and literature reviews of each outcome.

Products of the Community Wellness and Outcomes Project will include:

- Outcomes Report
- Data library, data management plan, and suggested data visualizations
- Data fact sheets and briefs

The **Outcomes Report** is designed to be the technical reference for the dashboard and will describe the methods and findings of the project. The primary audience for the report will be county administrators, mental health researchers, and others interested in the methodology and reasoning behind the dashboard indicator and data source selections.

The **data library, management plan, and visualizations** of the recommended indicators and data sources will assist MHSOAC in creating, maintaining, and updating the dashboard.

The **data fact sheets and briefs** will inform the general public about population-level outcomes associated with mental health challenges and unmet needs. These documents serve as the public-facing references and will explain why the recommended measures are critical to addressing the seven negative outcomes.

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Introduction

Project Overview

This is the third chapter in a series aimed at exploring the data measurement for the 7 negative outcomes of unmet mental health need targeted by the California Mental Health Services Act: suicide, incarceration, school failure/dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes.

The goal of this chapter is to provide a brief overview of **unemployment** as well as to explore the different ways that this outcome has been measured at county, state, federal, and international levels. The chapter concludes with recommendations for state-level and county level surveillance of this outcome, including recommendations for publicly available data sources and key data elements. The results of this chapter will inform the development of a statewide data dashboard to track county-level estimates on the MHSA targeted outcomes and ultimately build capacity to improve the measurement and reporting of mental health care needs, the services delivered to meet those needs, and the outcomes of those services.

Importance of Collecting and Tracking Data on Unemployment

Population surveillance data is critical for informing evidence-based policies and program planning. Reliable and accurate data over multiple time periods provides stakeholders the opportunity to track and monitor changes in response to policy initiatives and program efforts. The Center for Disease Control (CDC) highlights the need for surveillance systems to include “data that are uniform and consistent across systems”. Consistent data allow public health and other entities “to better gauge the scope of the problem, identify high-risk groups, and monitor the effects of prevention programs and policies” (Stone et al., 2017). Collecting and tracking population-level data on outcomes of unemployment and mental health is imperative to addressing mental health as a major public health issue. A statewide standardized system of measurement, one that can be compared across communities and over time, will improve the state and local leaders’ ability to pinpoint areas of need, stimulate specific programs and services, and address disparities. In addition to providing a complete and accurate understanding of unemployment outcomes by county and state, such data would offer important insights into best practices detect population-level mental health risk factors that can lead to unemployment, mitigate the negative mental health impact of unemployment itself, and prevent cycles of repeated or chronic unemployment that can lead to ongoing mental health issues and suffering for individuals and families.

Unemployment and Mental Health

Unemployment is both an outcome of and a risk factor for mental health issues: those with serious mental illnesses are disproportionately unemployed, and prolonged unemployment itself has been correlated with stress, depression, social isolation and substance abuse.

In our examination of available data sources on unemployment, we also discovered a strong concern with mental health in the workplace (see e.g. CDC 2018), including prevention, accommodation, and reducing missed work days due to mental health concerns. Data on the effectiveness of such accommodations in preventing mental health related unemployment are worth examining.

Unemployment as an Outcome of Mental Illness

Untreated or inadequately treated mental health issues can impact an individual's ability to find and hold down a job and can lead to chronic or periodic cycles of unemployment or under-employment. According to a Substance Abuse and Mental Health Services Administration (SAMHSA) report, only 21.6% of State Mental Health Agency (SMHA) clients were employed in 2015 (Knettlar et al., 2016). Yet 6 out of 10 individuals with severe mental illness are capable of employment if given adequate support and most of them want and are willing to work (Diehal et al., 2014). Data from a national survey showed unemployment rates increase with increases in mental illness severity and that people with a serious mental illness are less likely to be employed after age 49 compared to people with no, mild, or moderate mental illness (Luciano & Meara, 2014).

A Note on Unemployment as a Risk Factor of Mental Illness

This chapter primarily focuses on unemployment as an *outcome* of unmet mental health need, rather than as a cause. However, unemployment is also cyclical: like homelessness or incarceration (which we discuss in other chapters), impacted individuals are at risk for entering into repeated cycles of chronic or periodic unemployment if they are not able to access adequate resources. In such cases, the outcome (being unemployed, homeless, or in prison) itself becomes a source of emotional distress that can increase the risk of future cycles occurring. For this reason, it is worth also looking at the effects of past or current unemployment on current mental health.

Involuntary unemployment can worsen mental health and wellbeing, leading to a sense of helplessness, low self-esteem, anxiety (including financial anxiety) and depression (Eisenberg & Lazarsfield, 1938; Goldsmith & Diette, 2012). This vulnerability increases with prolonged unemployment.

Understanding the link between unemployment and mental health at the population level is complicated by the fact that point-in-time surveys do not reveal whether mental

health issues are the cause of unemployment or its result. For example, a 2014 Gallup poll showed that individuals who had been unemployed for more than 27 weeks (a group classified as “long term unemployed” by the Bureau of Labor Statistics) were nearly twice as likely to suffer from depression as the general population (19% versus 10%) (Crabtree, 2014), but these statistics do not explain whether individuals developed depression as a result of their inability to find work or whether their depression had prevented them from successfully being hired in the first place.

Definitions

For national metrics, the term “unemployment” only includes individuals who are actively seeking jobs and excludes those who are unable or choose not to seek employment for a variety of reasons (e.g. in order to raise children full-time or due to serious mental or physical health issues).

The three categories standardized by the Bureau of Labor Statistics (BLS) for their monthly Current Population Survey (US Census Bureau, 2006 pp 5-1 to 5-6) are:

- **Employed:** at least 1 hour of paid work within the past week, on temporary leave from such work (e.g. maternity), or working at least 15 hours/week in a family business.
 - **Full-time:** more than 35 hours/week
 - **Part-time for economic reasons (involuntary):** available for full-time work, but currently working under 35 hours/week (due to inability to find a job, seasonal demand, etc.)
 - **Part-time for non-economic reasons (voluntary):** not available for full-time work for any other reason (e.g. medical limitations, childcare, school) or personal preference.
- **Unemployed:** actively seeking work within the past 4 weeks, or waiting to be recalled to a previous job.¹
- **Not in the labor force:** not employed and have not sought work in the past 4 weeks.

BLS also include metrics for two types of individuals who are not in the labor force but have searched for jobs within the past 12 months:

- **Discouraged workers:** those who stopped job-seeking due to lack of success or because they feel there are no jobs they qualify for

¹ For example, furloughed government employees may be eligible to apply for unemployment benefits during a shutdown (Weichart, 2019).

- **Marginally attached:** workers who have stopped job-seeking for other reasons (e.g. illness, family responsibility, school).

Mental Health-Related Risk Factors for Unemployment

In order to narrow the focus to unemployment that is caused by unmet mental health need, we recommend examining the following metrics:

- Employed individuals who are receiving or have expressed need for either mental health care or workplace accommodations
- Individuals with mental illness (or mental health need) who are unemployed and seeking work
- Individuals who are not in the labor force due to mental illness or emotional distress

The latter two categories would include both individuals who are diagnosed with mental illness and those with unmet and undiagnosed mental health need or emotional distress. While diagnosed individuals can be tracked through clinical records, those who are not formally diagnosed would require population level surveys that ask questions about both employment history and emotional distress (e.g. CHIS).

Additional indicators that will help to illuminate changes in county-level unemployment resulting from program implementation are:

- Statewide or countywide (un)employment rates by general population to serve as a baseline
 - Disaggregation by vulnerable populations (e.g. individuals with diagnosed SMI)
- Employee absenteeism (e.g. number of days in the past year missed work) due to mental illness or emotional distress
- Level of psychological distress among the employed, unemployed and not in the labor force populations

Workplace Risk Factors for Mental Health Need Potentially Leading to Unemployment

Work Stress

In the continuum of employment, those at risk of needing mental health services include employed individuals experiencing high levels of stress, signaling a critical stage at which to provide services that prevent unemployment. Approximately one-third of workers in the United States report high levels of stress, putting them at high risk for psychological disorders, maladaptive behaviors, and cognitive behaviors which may

cause them to miss more days at work, experience burnout, or perform poorly at work (Sauter, 2007).

Employee Absenteeism

Experiences of personal or work-related stress can often lead to mental health problems which can then lead to employee absenteeism. In a longitudinal study, having a history of or having current anxiety and/or depressive disorders was associated with increasing work disability and absenteeism compared to those without a history of these disorders (Hendriks et al., 2015). Targeted efforts to promote and enhance Employee Assistance Programs (EAP) can reduce the number of days away from work due to mental health-related problems (Nunes et al., 2018). As such, it is potentially important to measure and track data on the number of work days missed due to mental health problems to monitor efforts in programs such as EAP.

Economic Insecurity

Individuals who are employed but cannot afford their most basic needs represent a hidden at-risk segment of the employed population, often composed of workers in lower socioeconomic positions, racial and ethnic minorities, and immigrants (Landsbergis, Grzywacz, & LaMontagne, 2014). The stress and frustration of economic insecurity, puts such individuals at higher risk for unemployment and need for mental health services (Dooley, Prause, & Ham-Rowbottom, 2000; Friedland & Price, 2003).

Limitations when Examining Unemployment Data

Looking solely at the “unemployment” statistics runs the risk of underestimating the impact of mental or physical health issues on employment status.

For instance, individuals with serious or untreated mental health issues who are not job-seeking because they cannot work at all would be classified as “not in the labor force” while those who can only work reduced hours would be classified as “voluntary part-time.” Both of these categories also include individuals whose work status is by choice (e.g. staying home to raise children or quitting work to go back to school).

Additionally, part-time employees who are unable to find full-time work are vulnerable to the same mental health issues as those who are unemployed – particularly depression (Dooley et al., 2000) – as well as anxiety and helplessness if they are unable to cover their family’s financial needs.

Finally, it is especially important to track individuals who have recently changed employment-seeking habits (the “discouraged” or “marginally” attached workers who stopped job-seeking within the past year) as these may be indicators of new or worsening mental health issues caused by prolonged unemployment.

It is important to examine connections between unemployment and unmet mental health need in both directions in order to reduce the prolonged suffering (mental, emotional and economic) of individuals and families due to prolonged or periodic unemployment and to support individuals with existing mental health needs in obtaining financially sustainable and fulfilling jobs.

Data Sources for Unemployment and Mental Health-Related Outcomes

From this study, we found several national and state-level data sources for unemployment and the intersection of unemployment and mental health as well as employment and risk for mental health problems. The ones highlighted in this report are those that we found to have 1) ongoing and reliable data collection, 2) recent data, and 3) estimates at the state-level and, in some cases, at the county-level or smaller geographic levels like city, census, congressional districts, etc.(see Table 1).

For each data source, Table 1 also provides indicators for socioeconomic and demographic characteristics in which inequities in mental health related unemployment can be measured to identify vulnerable populations such as by gender, race and ethnicity, sexual orientation, veteran status, etc.

National Data Sources

Behavioral Risk Factor Surveillance System (BRFSS)

<https://www.cdc.gov/brfss/index.html>

The BRFSS assesses health risk behaviors of the noninstitutionalized US adult population via a repeated cross-sectional telephone survey conducted annually and stratified to provide state- and nationally representative samples. BRFSS data have been used by the CDC to study the relationship between depression and unemployment in emerging adults. In the past, BRFSS has administered the Veterans Health Module (VHM, 2010-2012) across 10 states to study risk factors in veterans.

- Geographic level: National, state, county and city
- Frequency: Annual
- Data are available: Yes, up to 2018
- Unemployment- and mental health-related outcomes measured:
 - Unemployment rate
 - Employment status (employed, self-employed, unemployed, unable to work, or retired/homemaker/student)
 - Days per month of self-rated good mental health
 - Lifetime diagnoses of mental illnesses

- Past 12-month suicidal ideation and/or attempt

National Health Interview Survey (NHIS)

<https://www.cdc.gov/nchs/nhis/index.htm>

The NHIS is a nationally representative, cross-sectional survey conducted annual by the National Center for Health Statistics.

- Geographic level: National
- Frequency: Annual
- Data are available: Yes. Survey data are de-identified and available through the CDC NCHS website.
- Unemployment- and mental health-related outcomes measured:
 - Employment status (employed, not in labor force, or unemployed)
 - BLS and the Current Population Survey define labor force as all persons classified as employed or unemployed. Those who are unemployed and are not looking for a job are counted as NOT in the labor force.
 - Ongoing chronic presence of depression, anxiety, or emotional problem severe enough to generate activity limitation(s) in a respondent
 - Ability to afford mental health counseling in the past year
 - Seeing a mental health professional in the past 12 months

National Survey on Drug Use and Health (NSDUH)

<https://nsduhweb.rti.org/respweb/homepage.cfm> and <https://pdas.samhsa.gov/#/>

The NSDUH is an ongoing annual national survey that assesses tobacco use, alcohol use and disorders, illicit drug use and disorders, and mental health symptoms in the United States. Respondents are a nationally representative sample of the noninstitutionalized citizen population age 12 and older.

- Geographic level: National and state estimates
- Frequency: annual
- Data are available: Yes, through the Public-use Data Analysis System (PDAS) on the SAMHSA website.
- Unemployment- and mental health-related outcomes measured:
 - Respondent without a job
 - Respondent actively looking for a job in the past 4 weeks
 - Respondent available for work at the time of interview
 - Full-time worker
 - Part-time worker

Data from NSDUH have previously been used to describe rates of employment by severity of mental illness. Results showed employment rates decrease with increasing severity of mental illness (Luciano & Maeda, 2014). These findings suggest that efforts to decrease the severity of mental illnesses can lead to higher rates of employment or said another way, lower rates of unemployment. Thus, measuring data on severity of mental illness in conjunction with employment status could be used to track improvements in reducing the severity of mental illness and ensure these improvements are leading to lower rates of unemployment.

Medical Expenditure Panel Survey (MEPS)

<https://www.meeps.ahrq.gov/meepsweb/>

The MEPS has two major components: the Household and Insurance Components. Respondents for the household component are drawn from a nationally representative subsample of households that participated in the prior year's **National Health Interview Survey**. Data from this survey includes U.S. non-institutionalized civilian population health outcomes, health insurance coverage, and health utilization. MEPS utilizes a complex national probability sampling methodology which includes stratification, clustering, and oversampling of certain population subgroups such as African Americans, Hispanics, Asians, and policy-relevant subgroups such as low-income respondents.

- Geographic level: National and state
- Frequency: Annual
- Data are available: Yes, up to 2018
- Unemployment- and mental health-related outcomes measured:
 - Employment status (FT, PT, self-employment, or unemployment)
 - Involuntary job loss (job ended; business dissolved or sold, or laid-off)
 - Perceived mental health

National Data Sources on Employee Absenteeism

Bureau of Labor Statistics (BLS)

As the nation's primary source of data on unemployment, BLS also collects information on employment and employment projections, pay and benefits, productivity, occupational requirements, regional resources, and workplace injuries. One of the ways BLS data are available is through Local Area Unemployment Statistics (LAUS), which provides monthly and annual unemployment, employment, and labor force data for Census regions and divisions, States, counties, metropolitan areas, and some cities. In the literature, BLS data has often been linked to other data sources to study the relationship between mental health and unemployment. For example, LAUS data are often linked to other data sources such as the National Survey of Substance Abuse

Treatment Services (N-SSATS) and the National Violent Death Reporting System (NVDRS). For example, Schiff et al found that rates of suicide were predicted by job and financial issues (2015), while Kerr et al assessed the independent effects of poverty and unemployment on suicide rates, finding that poverty was more indicative of suicide than unemployment (2017).

BLS publishes monthly unemployment estimates based on the Current Population Survey, a nationally representative sample of 60,000 households [Link: https://www.bls.gov/cps/cps_htgm.pdf] Data tools can help create State and County maps of unemployment rates, 12-month change in employment, 12-month change in average weekly wage, and 12-month percent change in average weekly wage. These data are able to be stratified by industry.

The BLS site includes a number of data tools that allow users to quickly find county-level data on unemployment. Data tools link: <https://www.bls.gov/data/> Data retrieval tools include a series report, a data finder, maps, and calculators, as well as top picks by the agency. These data also capture occupation, gender, race, age, industry, state, weekday, and time.

Data intersecting mental health and employment are available by State. For instance, one of the databases “Nonfatal cases involving days away from work: select characteristics (2011 forward) uses **data from the Survey of Occupational Injuries and Illnesses (SOII) program** to track nonfatal cases involving days away from work and their selected characteristics, including mental disorders and syndromes; anxiety, stress; post-traumatic stress disorder; adjustment disorder; anxiety or panic disorder; and depression or depressive episode.

According to 2017 national data from SOII, 70% of those who missed work due to unspecified mental disorders and syndromes missed 31 or more days – 6th in the top leading injury or illnesses leading to most missed days at work. (Calculations done with table R67 from <https://www.bls.gov/iif/soii-data.htm#dafw>) BLS tracks nonfatal cases involving days away from work and their selected characteristics, including mental disorders and syndromes; anxiety, stress; post-traumatic stress disorder; adjustment disorder; anxiety or panic disorder; and depression or depressive episode.

Below is one example of California data available for median number of days missed away from work due to different types of mental disorders and syndromes. In 2017, the highest median number of days missed from work (180) was due to unspecified mental disorders and syndromes (column B). This data also shows that the median number of days missed for those missing work due to post traumatic stress disorder (column E) has decreased over the past five years. However, caution is warranted with interpretation of this data as it is not clear whether this decrease is due to better treatment for those with PTSD or if those with more severe PTSD are no longer in the

work force and thus those with less severe forms miss fewer days decreasing the overall number of days missed.

Nonfatal cases involving days away from work: selected characteristics (2011 forward)

Series Id: CSU00X62XXXX3N006

Area: California

Ownership: All ownerships

Data Type: Median Days Lost

Case Type: Industry division or selected characteristic by detailed nature of condition

Category: All industry

Nature: Mental disorders and syndromes (A), Mental disorders and syndromes, unspecified (B), Anxiety, stress (C), Anxiety, stress (unspecified) (D), Post-traumatic stress disorder (E), Adjustment disorder (F), Anxiety or panic disorder (G), Anxiety, stress, n.e.c (H), Depression or depressive episode (I), Mental Disorders and syndromes, n.e.c. (J)

Figure 1: Mean Number of Days Away from Work by Type of Mental Disorder and Year, BLS

	A	B	C	D	E	F	G	H	I	J
2013	33	90	33	33	168	46	17	77	180	
2014	75	78	75	90	37		6	42		
2015	30	68	30	30	5		30	22		
2016	28	83	24	28	17		3	19		167
2017	39	180	39	39	55		8	30		

California Data Sources

California Health Interview Survey (CHIS)

<http://healthpolicy.ucla.edu/chis/Pages/default.aspx>

CHIS is the nation's largest state health survey, asking questions on a wide range of health topics in multiple languages. CHIS provides estimates at the state- and county-levels. More than 20,000 adults, teenagers, and children are interviewed via random-dial telephone surveys each year in all 58 counties. In addition to immigration health, health insurance coverage, and self-reported physical health status, CHIS covers:

- Serious Psychological Distress using the Kessler-6
- Self-reported perceived need for mental health services
- Self-reported used of mental health services

- Functional impairment due to mental health problems (including in the work place)
- Stigma
- Suicide ideation
- Suicide attempts

CHIS data also capture five indicators of employment status:

- Employed full-time
- Employed part-time
- Employed but missed the last week of work
- Unemployed and looking for work
- Unemployed and out of the work force

For data on the intersectionality of employment and mental health, CHIS includes

- Number of days unable to work due to mental health problems in the past year (asked of adults with serious psychological distress (Kessler 6 \geq 13) in the past year)

Data from 2017 shows that only about a quarter of adults with serious psychological distress were able to work all days in the past year; over half missed eight or more days.

Number of days unable to work due to mental problems
Source: UCLA Center for Health Policy Research

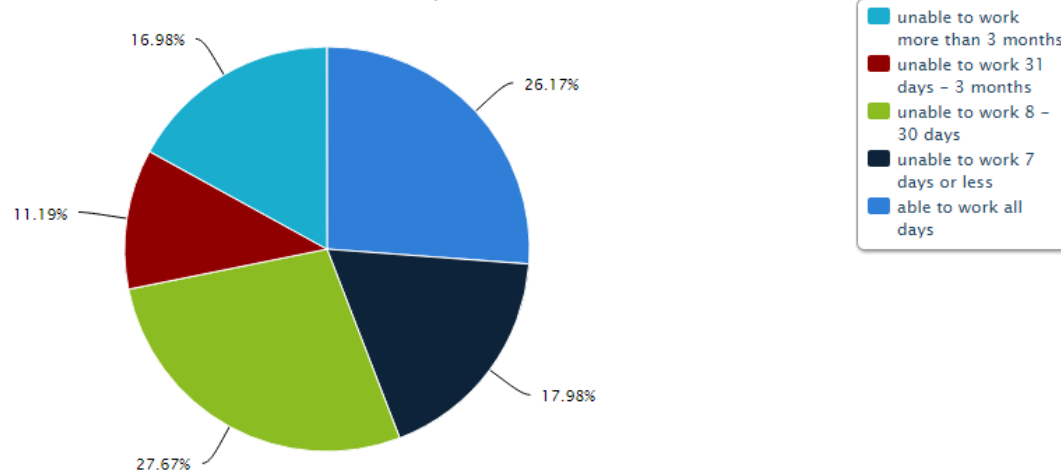


Figure 2 Number of Days Unable to Work due to Mental Problems

Source: CHIS, 2017

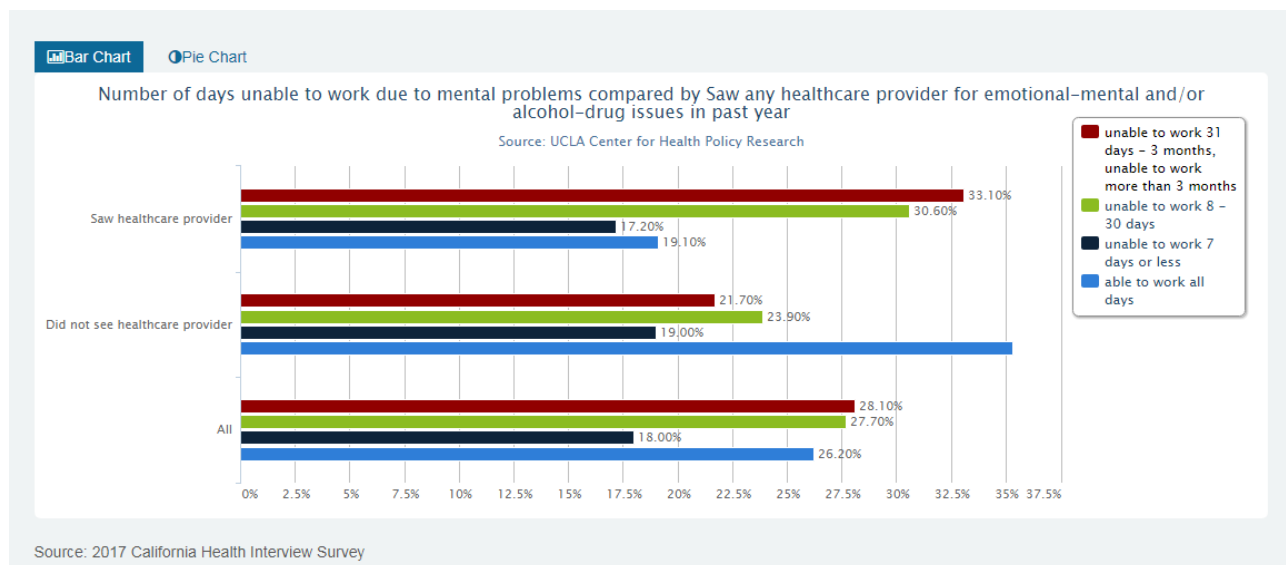


Figure 3 Number of days unable to work due to mental problems compared by health care provider visits in the past year

Source: CHIS, 2017

CHIS data and visualizations can be accessed free of charge through AskCHIS and AskCHIS Neighborhood Edition (AskCHIS-NE) by state, county, or service planning area (SPA). Public use data, confidential data, and technical assistance are also available.

CalWORKs

CalWORKs utilizes the Online CalWORKs Appraisal Tool (OCAT), a web-based statewide standardized appraisal tool, to form recommendations for services and assistance in employment by assessing barriers in employment, education, housing, transportation, general health, emotional and mental health, substance use, domestic abuse and safety, childcare and parenting, and relationships. Regarding employment, OCAT collects information on job history, skills, and work readiness to assess services needed to support the recipient. Regarding emotional and mental health, OCAT evaluates for mental health service need and related job readiness activities. OCAT is live in all counties and identifies strengths and barriers upon CalWORKS recipient entry into the welfare-to-work program. CalWORKS releases an annual summary that includes OCAT appraisals by month.

<https://www.cdss.ca.gov/inforesources/Research-and-Data/CalWORKs-Data-Tables>
<https://www.cdss.ca.gov/Portals/9/DSSDB/CalWORKsAnnualSummaryMarch2019.pdf?ver=2019-03-22-123821-433>

Unemployment Surveillance and Monitoring

Global and International Examples

Two United Nations agencies address the importance of vocational rehabilitation and employment for those with mental health problems and also address issues of mental health in the workplace.

World Health Organization (WHO) and International Labour Organization (ILO):

<http://www.ilo.org/global/lang--en/index.htm>

WHO primarily address issues related to mental health and ILO address issues related to employment. In a collaborative effort, WHO and ILO produced a book “Mental health and work: impact, issues and good practices” that address both of these issues. In this book they identify that the unemployment rate is almost double for people with a serious psychiatric background compared to those with physical or sensorial disabilities. In other words, these findings mean that only 10% of those with a serious mental illness who wish to work are able to work.

Canada’s Community Health Survey: Mental Health and Well-Being

Canada’s nationwide effort to research and educate the public on the relationship between unemployment and mental health is impressive. The [Canadian Mental Health Association](#) and Institute for Work & Health produce articles and briefs discussing the adverse impact of unemployment on mental health. In addition, the Institute for Work & Health has studied the management and programs for depression in the workplace, work injuries and poverty, and strategies for preventing mental health-related work disabilities. The Workforce Mental Health Collaborative, directed by the Canadian Mental Health Association, helps employers “address and improve psychological health and safety in the workplace.”

Surveys like the Canadian Community Health Survey: Mental Health and Well-being assess mental health, mental health service utilization, and employment variates, such as unemployment status and reason (emotional or mental health, physical health, or substance use), work pattern in the last 12 months, work stress, working conditions, hours of work, ability to work at a job, and whether they have a mental health condition that reduces the amount or kind of activity they can do at work. The survey also measures whether the respondent has sought mental health services to obtain help with employment status or work situation. Work stress is further analyzed by psychological job demand, job insecurity, social support at work, and job satisfaction.

- [Survey information](#)
- [Survey data document](#)

National Examples

United for ALICE (Asset Limited, Income Constrained, Employed)

<https://www.unitedforalice.org/home>

ALICE, which stands for Asset Limited, Income Constrained, Employed, represents individuals and families who are employed but unable to afford basic housing, child care, transportation, food, and health care. United for ALICE produces high quality reports on economic factors by state and nationally, including employment opportunities, housing affordability, and demographics. ALICE is used by numerous counties in California on their interactive dashboards to understand rates of employed individuals experiencing financial hardship. These data reflect a population of California who are facing financial stressors and who may be at risk for mental health problems and unemployment.

National Dashboard Examples

Dashboards eliminate the need for agencies to search for reliable, relevant, and up-to-date data. Dashboards enhance systems-level understanding of an outcome by comparing measures across populations and help promote awareness of an issue by offering a usable, interactive interface. National dashboards can be important resources for child welfare surveillance and monitoring across states and within states. In this study, several national dashboards were found that use the data sources identified to provide visualizations for unemployment related indicators. (See Table 2)

Table 2 also helps to identify dashboards that provide socioeconomic and demographic characteristics to help identify inequities in unemployment outcomes for vulnerable populations such as by age, gender, sexual orientation, veteran status, etc.

CARES Engagement Network is a national data and reporting platform. It uses data from the American Community Survey (ACS) to provide estimates on a number of unemployment-related indicators for communities, which includes California-wide and county-level data. In addition to monthly and annual unemployment rates for all states and counties, CARES provides customizable maps and reports. Data includes age-adjusted rates and comparisons provided by gender, race, ethnicity, and by years. Rates can be compared to State and national rates.

KIDS COUNT Data Center

<https://datacenter.kidscount.org/topics>

This dashboard tracks the well-being of children in the United States, drawing from more than 50 KIDS COUNT state organizations for state and local data. In addition to

outcomes related to economic well-being, KIDS COUNT provides estimates for outcomes related to Education, Family & Community, Health, Safety & Risky Behaviors, Race & Ethnicity, and Demographics.

Employment-related indicators include:

- Children under 6 with all available parents in the labor force
- Children ages 6 to 12 with all available parents in the labor force
- Unemployment rate of parents
- Children with at least one unemployed parent
- Children whose parents lack secure employment
- Children under age 6 with no parent in the labor force
- Children living in low-income households where no adults work
- Unemployed teens age 16 to 19

LiveStories: Statistics (LiveStats)

<https://www.livestories.com/statistics>

LiveStats collects and analyzes data from trusted and reliable sources such as the U.S. Census, the CDC, and the Bureau of Labor Statistics and provides an interactive dashboard to examine age-adjusted rates across years, by age, gender, and race and ethnicity. Live Stories: Statistics displays employment information but does not include any data on mental health.

Workplace Health in America 2017 Data Dashboard

<https://www.cdc.gov/workplacehealthpromotion/survey/index.html>

This dashboard utilizes CDC data to display information on a wide range of workplace health indicators at worksites. While it does not display data on mental health issues, indicators fall within range of stress management and substance use. For example, the dashboard provides the percentage of worksites that offer programs to address stress management or have manager-training on stress-related issues. The Workplace Health Promotion branch of the CDC also captures how many worksites offer depression counseling. Even though data in this dashboard are displayed by U.S. regions, this may be a good example to build upon to create state and county level data.

Report: <https://www.mhanational.org/sites/default/files/Mind%20the%20Workplace%20-%20MHA%20Workplace%20Health%20Survey%202017%20FINAL.pdf>

<https://www.cdc.gov/workplacehealthpromotion/pdf/CDC-Worksite-Health-ScoreCard-2017-Employer-Profile-508.pdf>

California Examples

The Employment Development Department (EDD) of California

<https://www.labormarketinfo.edd.ca.gov/data/unemployment-and-labor-force.html>

Each month, the EDD releases unemployment rates, industry employment, and preliminary civilian labor force data for metropolitan areas, counties, and sub-county areas in California. As of this document, the latest data release was July 2019. Data are displayed as interactive maps, interactive tables, and summaries. However, this system does not measure mental health outcomes. Further investigation is required to assess possibilities of data linkage to a system that contains mental health data.

MHSA County Performance Outcomes

Employment Outcomes for Full-Service Partnerships (FSP) Clients

As part of their MHSA performance outcomes, all counties collect data on employment outcomes for FSP clients - both adult and for transitional aged youth (TAY).

In addition to employment, other outcomes are measured for FSP clients: reduced incarceration/interactions with law enforcement, education for TAY, employment, housing, access to healthcare.

For a full list of county reports and page listing for their performance outcomes, please visit California Department of Health Care Service: [MHSA County Performance Outcomes](#).

California County Dashboards

In the environmental scan, twenty out of fifty-eight counties have community dashboards that use data from the U.S. Bureau of Labor statistics to provide state and county-level rates of unemployed workers in the civilian work force. This indicator describes civilians, age 16 and over, who are unemployed as a percent of the U.S. civilian work force. Fourteen of the twenty county dashboards also include the percentage of families who are Asset Limited, Income Constrained, and Employed (ALICE). See Table 3 for a list and link to county dashboards. See Table 4 for an overview of the unemployment, employment and ALICE indicators in each county dashboard.

Summary

[TBD]

Discussion

[Work In Progress]

The bidirectional nature of the relationship between unemployment and mental illness is important to understand and measure to develop effective supports. Collecting surveillance data simultaneously on both areas are crucial to understanding the well-being and needs of a community. Additionally, the methods of data collection are also relevant in order to account for and reduce under/mis-reporting for vulnerable populations.

Barriers to Surveillance

Although there are a number of data sources and surveillance systems that track unemployment and mental health independently, there are few that track rates of unemployment in all those who experience mental illness or mental illness in all those unemployed. Often, studies examining the relationship between mental illness and unemployment are only able to include those who are in the mental health care service system, which leaves out a population of individuals who may be even more vulnerable (Diehl et al., 2014).

Our ability to study the relationship between unemployment and mental health is further impeded by stigma toward mental health and seeking help. Working individuals experiencing mental illness may not request supports that would allow them to continue working safely and effectively in fear of stigma. Furthermore, the unemployed who are mentally ill are unlikely to seek mental health care services; common barriers are mental health literacy, stigma and discrimination, and the complicated structures of the health care system (Staiger et al., 2017).

Opportunities to Link Unemployment Related Data with Other Data Sources

Data linkages for tracking unemployment and unmet mental health need:

An ideal surveillance system for unemployment and mental health would link data from multiple sources to separate cause and outcome in order to track both un-/underemployment due to untreated mental illness as well as mental health issues (particularly depression and anxiety) caused by prolonged unemployment or inability to meet basic financial needs. Such a system would link across data sources to connect employment status and history, mental health status, and history of mental health care receipt prior to or just after becoming unemployed. Because financial insecurity is another risk factor leading to depression, data linkages between household income and individual un/under-employment status would also be useful.

- Data from the **Bureau of Labor Statistics** is often linked to national and state data sources, such as the National Survey of Substance Abuse Treatment Services (N-SSATS) and the National Violent Death Reporting System (NVDRS).

Recommendations

Recommendations of data sources and their related data elements are organized into three categories:

Category 1 describes recommended data sources that are publicly accessible and ready to use by MHSOAC.

Category 2 describes recommended data sources that require funds, resources, and time to access and utilize.

Category 3 describes data elements that are not currently being measured in a standardized setting, but may be of interest and useful to collect. The recommendations in this section have been identified through our environmental scans, literature reviews, and qualitative investigation from counties in California.

Category 1 Recommendations

- **Category 1, #1 Recommendation:** California Health Interview Survey (CHIS) is the best data source for this category and includes a range of unemployment indicators and demographic variables. Indicators include state and county unemployment rate, employee absenteeism due to mental illness or emotional distress, and the level of psychological distress among the employed, unemployed, and those not in the labor force. It is able to measure high risk populations and take into account clinical and social circumstances that are particularly important for the outcome.
- **Category 1, #2 Recommendation:** Bureau of Labor Statistics (BLS) is the second best data source. Data indicators include national, state, and county unemployment rates, and employee absenteeism due to mental or emotional distress.
- **Category 1, #3 Recommendation:** The Behavioral Risk Factor Surveillance System (BRFSS) is the third best data source in this category. There are a wide range of outcome-related and risk indicators, but data are publicly accessible only at the state level. The CDC analyzes BRFSS data at metropolitan and micropolitan statistical areas (MMSAs) but not all California counties are included.

Category 2 Recommendations

- **Category 2, #1 Recommendation:** NSDUH is the most complete data source and is able to measure 4 recommended data elements, the most out of all identified sources: 1) state and county level unemployment rates, 2) employee absenteeism due to mental illness or emotional distress, 3) level of psychological distress among employed, unemployed, and those not in the labor force, and 4) individuals with mental health need who are unemployed and seeking work. Data are measured for a wide range of target populations and clinical and social circumstances. Use of NSDUH would yield a comprehensive understanding of unemployment and mental health need as well as provide detailed analyses of disparities.
- **Category 2, #2 Recommendation:** NHIS is the second best data source. While a wide range of demographic populations and clinical and social circumstances are measured, only state and county level unemployment rates are measured.
- **Category 2, #3 Recommendation:** The Medical Expenditure Panel Survey (MEPS) is the third best data source. Outcome-related data and demographic data are similar to NHIS. However, the measurement of target populations and clinical and social circumstances are limited in range.

Category 3 Recommendations

Based on preliminary analysis of county and local ethnographic observations (including attending MHSA events and conducting focus groups and interviews), these are some suggestions for other metrics which would be relevant in understanding the “health” of a county with regards to reducing unemployment due to SMI or unmet mental health need.

1. Measurements of agency access to job networks

Individuals who are receiving proper mental health care and are able and willing to work may still have difficulty finding and applying to jobs. Particularly individuals whose SMI has kept them out of the workforce for some time may not have adequate networks or knowledge of how to find the types of jobs they are seeking.

Metrics that could serve as county-level indicators of strength in connecting individuals with mental health needs to employment resources include:

- For the population of individuals with SMI/at risk who are receiving mental health services:
 - Average number of jobs applied to before receiving an offer
 - Proportion who are aware of employment resources available through their mental health care
 - Proportion who made use of such resources (these data can be collected either as self-reports from clients or from the job assistance agencies or departments themselves)

- For the population of mental health service providers in the county:
 - Proportion who have job seeking or job application resources within their agency OR have an established way of referring clients to an outside agency
 - Rate of successful referrals
 - Employment success rate of clients who use those services

2. Measurements of general population (employer) stigma against mental illness

Individuals who are successfully receiving mental health services and are competent to work may still have trouble obtaining jobs due to stigma against their mental health condition, especially in cases where such a condition must be disclosed (for example, if the individual requires special accommodations or has been incarcerated). This may also be exacerbated by racism or other forms of discrimination.

There are a number of state, county and local mental health campaigns devoted to decreasing stigma against mental illness (including increasing the social acceptance of asking for help and normalizing individuals with MI in the eyes of the larger community). Measurements of the overall impact and success of such campaigns would also be relevant when examining county-level unemployment rates.

Separating mental illness stigma from other forms of discrimination by comparing overall rates of unemployment for marginalized populations (ethnicity, LGBT, etc) with rates for individuals in the same populations who have SMI.

Comparison of hiring, retention, and job accommodation rates in order to determine whether unemployment levels are due to un/under treated SMI (preventing an individual from being able to work) or mental illness stigma (preventing a capable individual from being hired).

- Low hiring rates may suggest that employers are negatively perceiving the job candidate in part due to their SMI.
- However, high hiring rates and low retention rates may suggest that the individuals' SMI (or their need for special accommodations) are preventing them from carrying out the job.

3. Measuring unemployment's interconnection with the other negative outcomes

Unemployment is known to be impacted by prior incarcerations and homelessness. It is also a risk factor that contributes to homelessness, further negative mental health outcomes, and – in extreme cases – suicidality. Finally, the degree to which mental illness is stigmatized (versus normalized) in a community affect both employer

perceptions and employee willingness to ask for needed accommodations, which can contribute to job hiring and job retention.

Improvements (or worsening) in one domain can be expected to have a delayed downstream effect on the others, and should be monitored accordingly. For example: a prior incarceration is a barrier to obtaining a job, therefore countywide programs that reduce mental health related convictions (for example by redirecting individuals into treatment) would also contribute to a delayed reduction in unemployment for the same population.

DRAFT

Tables

Table 1: National and Statewide Data Sources for Unemployment and Mental Health

Data Source	Level	Age Range	Gender	Race/ ethnicity	Sexual orientation	Education	SES	MH or MH svs need	Immigrant/ citizenship	Phys health/ Veteran/ military	Other
Behavioral Risk Factor Surveillance System	Nat'l; State	18yo+	✓	✓	✓			✓		✓	gender identity
Bureau of Labor Statistics / Current Population Survey	Nat'l	16yo+	✓	✓		✓			✓	✓	
Medical Expenditure Panel Survey	Nat'l	Household	✓	✓		✓		✓		✓	
National Health Interview Survey	Nat'l; State	Household	✓	✓	✓	✓	✓	✓	✓	✓	
National Survey on Drug Use and Health	Nat'l, Sub- state ^a	12yo+	✓	✓	✓		✓	✓	✓		
Survey of Income and Program Participation; US Census Bureau	Nat'l	Household	✓	✓	✓	✓	✓		✓	✓	Health insurance
CalWORKs	CA; County	Participants									
California Health Interview Survey	CA; County; SPA	Lifespan	✓	✓	✓	✓	✓	✓	✓	✓	

^a Does not include state-level data for confidentiality reasons. Uses Small Area Estimates for state and substate statistics.

Table 2: Examples of National Dashboards

Data source	Level of Detail	Age range	Can disaggregate by...					Related MH need/ svcs use	Subs. use	Other variables
			Age group	Race/ ethnicity	Hispanic origin	Gender	SES			
Workplace Health in America 2017 Data Dashboard	Nat'l;	Workplace ^a						✓	✓	Physical health
CARES Engagement Network	Nat'l	Work age	✓	✓	✓	✓				Educational attainment
Live Stories: Statistics	Nat'l; State County	Lifespan	✓	✓		✓				
Kids Count Data Center	Nat'l; State	Lifespan	✓	✓	✓	✓	✓			Immigrant status
Asset Limited, Income Constrained, Employed (ALICE)	Nat'l; State; County	Household								Families living below bare-minimum economic threshold

^a Provides data on workplaces, not individual employees

Table 3: California County Dashboards with Data on Unemployment and ALICE

County	Dashboard Name & Link
Alameda	Healthy Alameda County: Community Dashboard
El Dorado	WELL Dorado: Wellness Happens Here
Fresno	Healthy Fresno County Community Dashboard
Kern	Healthy Kern County
Los Angeles	Think Health LA
Marin	Healthy Marin
Mendocino	Healthy Mendocino: Connecting People and Information for Better Health
Orange	Orange County's Healthier Together: Improving Health Through Planning and Partnership
Placer	Be Well Placer
Riverside	SHAPE Riverside County (Strategic Health Alliance Pursuing Equity)
Sacramento	Be Healthy Sacramento
San Bernardino	Community Vital Signs
San Diego	Live Well San Diego
San Joaquin	Healthier San Joaquin
San Luis Obispo	SLO Health Counts
San Mateo	All Better Together
Santa Barbara	CottageData2Go
Santa Cruz	DataShare Santa Cruz County
Solano	Solano Public Health: Healthy People 2020 Indicators
Ventura	Health Matters in Ventura County
Yolo	Community Indicator Dashboard

Table 4: Continuum of Unemployment Indicators on California County Dashboards, 2019

County	Unemployed workers in civilian labor force	Households that are ALICE ^a	Households above the ALICE threshold	Employed Full-time (%)	Employed Part-time (%)	Labor force participation rate (%)
Alameda	✓	✓	✓	✓	✓	✓
El Dorado	✓					
Fresno	✓	✓	✓	✓	✓	✓
Kern	✓	✓	✓	✓	✓	✓
Los Angeles	✓					
Marin	✓	✓	✓	✓	✓	✓
Mendocino	✓	✓	✓	✓	✓	✓
Orange	✓	✓	✓	✓	✓	✓
Placer	✓	✓	✓	✓	✓	✓
Riverside	✓	✓	✓	✓	✓	✓
Sacramento	✓	✓	✓	✓	✓	✓
San Bernardino ^b	✓					
San Diego	✓					
San Luis Obispo	✓	✓	✓	✓	✓	✓
San Mateo	✓	✓	✓	✓	✓	✓
Santa Barbara ^c	✓			✓	✓	✓
Santa Cruz	✓	✓	✓			
Solano ^c	✓					
Ventura	✓	✓	✓	✓	✓	✓
Yolo ^c	✓	✓	✓	✓	✓	

^aALICE stands for Asset Limited, Income Constrained, Employed ^bThe San Bernardino County dashboard shows that it includes economic and employment indicators. However, their site is under construction. ^cSolano, Santa Barbara, and Yolo Counties manage their own dashboards; all other dashboards are maintained by Conduent Health Communities Institute.

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AGENDA ITEM 6

Action

November 21, 2019 Commission Meeting

MHSOAC Conflict of Interest Code

Summary: The Commission will consider adoption of the proposed amendments to the Commission's Conflict of Interest Code presented at the August 22, 2019 meeting.

Background: The proposed amendments to the Commission's Conflict of Interest Code were approved by the Commission at the August 22, 2019 meeting. The public was given 45-days to comment on the draft amendments.

State law requires the Commission to consider any comments received during the public comment period and decide whether to adopt the amendments that were initially proposed. The Commission received no comments during the 45-day public comment period and thus no changes were made to the proposed amendments presented at the August 22, 2019 meeting.

The amendments were needed because of statewide changes in the classification names of staff positions and new hires. The amendments change who must report the specified economic interests on the Statement of Economic Interest (Form 700) but do not change the economic interests that must be reported.

The enclosed amended code shows the new language in underline text and proposed deletions in strikethrough text.

Next Steps: If the Commission adopts the amended Conflict of Interest Code at the November 21, 2019 meeting, it will be filed with the California Fair Political Practices Commission for their approval.

Presenter:

- Filomena Yeroshek, Chief Counsel

Enclosures (2): (1) Proposed Amended MHSOAC Conflict of Interest Code; (2) Explanation of Changes.

Handouts: A PowerPoint presentation will be provided.

Proposed Motion: The Commission adopts the amendments to the Conflict of Interest Code and authorizes the Executive Director to submit the Code with the supporting documentation as required by law.

Mental Health Services Oversight and Accountability Commission

DRAFT AMENDED

CONFLICT-OF-INTEREST CODE

The Political Reform Act (Government Code Section 81000, et seq.) requires state and local government agencies to adopt and promulgate conflict-of-interest codes. The Fair Political Practices Commission has adopted a regulation, 2 California Code of Regulations Section 18730 that contains the terms of a standard conflict-of-interest code, in an agency's code. After public notice and hearing, the standard code may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act. Therefore, the terms of 2 California Code of Regulations Section 18730 and any amendments to it duly adopted by the Fair Political Practices Commission are hereby incorporated by reference. This regulation and the attached Appendices designating positions and establishing disclosure categories, shall constitute the conflict-of-interest code of the **Mental Health Services Oversight and Accountability Commission (MHSOAC)**.

~~Individuals holding designated positions shall file their statements of economic interests with the Mental Health Services Oversight and Accountability Commission, which will make the statements available for public inspection and reproduction. (Gov. Code Section 81008.) Upon receipt of the statement(s) of the Commission Members, and the Executive Director, the Mental Health Services Oversight and Accountability Commission shall make and retain copies and forward the original of the statement(s) to the Fair Political Practices Commission. All other statements will be retained by the Mental Health Services Oversight and Accountability Commission.~~

Commission members and the Executive Director shall file their statements of economic interests electronically with the Fair Political Practices Commission. All other individuals holding designated positions shall file their statements with the MHSOAC. All statements must be made available for public inspection and reproduction under Government Code Section 81008.

NOTE: authority cited: Sections 81008, 87300, 87306, Government Code. Reference: Section 87302, Government Code.

**Mental Health Services Oversight and Accountability Commission
Conflict of Interest Code, Form 700 Designation**

**APPENDIX A
Designated Positions**

Designated Positions	Disclosure Category
Commission Member	1, 2
Executive Director	1, 2
CEA (All levels)	1, 2
Staff Counsel (All levels)	1, 2
Consulting Psychologist	1, 2
Information Officer (All levels)	2
Research Scientist Supervisor (II)	2
Research Scientist (All levels)	2
Staff Services Manager (All levels)	1, 2
Mental Health Program Supervisor	1, 2
Health Program Manager (III)	1, 2
Research Program Specialist (All levels)	2
Research Data Specialist (All levels)	2
Health Program Specialist (All levels)	2
Staff Mental Health Specialist	2
Associate Governmental Program Analyst	2
Staff Information Systems Analyst	3
Information Technology Specialist (All levels)	3
Consultant and/or New Positions	*

*Consultants and/or New Positions shall be included in the list of designated employees and shall disclose pursuant to the broadest disclosure category in the code subject to the following limitations:

The Executive Director may determine in writing that a particular consultant and/or a New Position, although a “designated position,” is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant’s and/or New Position’s duties and, based upon that description, a statement of the extent of disclosure requirements. This determination is a public record and shall be retained for public inspection in the same manner and location as this conflict-of-interest code.

**Mental Health Services Oversight and Accountability Commission
Conflict of Interest Code, Form 700 Designation**

**APPENDIX B
Disclosure Categories**

Disclosure Category 1

A person holding a position designated in Disclosure Category 1 must report all investments and business positions in business entities, and all income (including gifts, loans, and travel payments) from sources, that operate a program of the type approved by the MHSOAC including any program of the type providing mental health services to a local agency such as voluntary and outpatient services under a plan approved by the MHSOAC.

Disclosure Category 2

A person holding a position designated in Disclosure Category 2 must report all investments, and business positions in business entities, and all income (including gifts, loans, and travel payments) from sources of the type that provide services, equipment, materials, vehicles, supplies, to the MHSOAC including but not limited to:

- Contracts to evaluate the outcomes and performance of the Mental Health Services Act and the community mental health system
- Contracts related to Commission and Committee meetings and community forums such as court reporters/transcribers, interpreters, leased facilities, and public relations
- Contracts related to training, consulting, or stakeholder involvement

Disclosure Category 3

A person holding a position designated in Disclosure Category 3 must report all investments and business positions in business entities and all income (including gifts, loans, and travel payments) from sources, of the type that engage in the information technology field services of the type utilized by the MHSOAC including training and consulting.

Conflict of Interest Code for MHSOAC
Explanation of Changes

Conflict-of-Interest Code, Page 1

Description of Changes
The second paragraph was rewritten to update the code to align with the Fair Political Practices Commission's new electronic filing system for filers of the Form 700

Conflict-of-Interest Code, Appendix A, Page 2

Position	Description of Changes
Commission Member	No Change
Executive Director	No Change
CEA (All levels)	No Change
Staff Counsel (All levels)	No Change
Consulting Psychologist	No Change
Information Officer (All levels)	No Change
Research Scientist Supervisor (II)	No Change
Research Scientist (All levels)	No Change
Staff Services Manager (All levels)	No Change
Mental Health Program Supervisor	DELETE position. Reclassified to Health Program Manager III to better align with the scope and duties of the position.
Health Program Manager III	ADD position. New position, formerly Mental Health Program Supervisor. Reclassification was necessary to reflect the expanded scope and duties of the position.
Research Program Specialist (All levels)	DELETE position. Abolished by CalHR's Research Data Series Consolidation Project, which was adopted by SPB on July 6, 2018 and effective August 1, 2018.

Position	Description of Changes
Research Data Specialist (All levels)	ADD position. Established by CalHR's Research Data Series Consolidation Project, which was adopted by SPB on July 6, 2018 and effective August 1, 2018. Formerly Research Program Specialist.
Staff Mental Health Specialist	No Change
Health Program Specialist (All Levels)	ADD position. New position. Health Program Specialist positions were first authorized for the MHSOAC in FY 2016-17 for the newly created Innovation Plan Review Unit.
Associate Governmental Program Analyst	No Change
Staff Information Systems Analyst	DELETE position. Abolished by CalHR's Information Technology Consolidation Project, which was adopted by SPB on January 11, 2018 and effective January 31, 2018.
Information Technology Specialist (All levels)	ADD position. Established by CalHR's Information Technology Consolidation Project, which was adopted by SPB on January 11, 2018 and effective January 31, 2018. Formerly Staff Information Systems Analyst.
Consultant and/or New Positions	No Change

Conflict-of-Interest Code, Appendix B, Page 3

Description of Changes
No Change

AGENDA ITEM 7

Information

November 21, 2019 Commission Meeting

Executive Director Report Out

Summary: Executive Director Ewing will report out on projects underway, on county Innovation plans approved through delegated authority and on other matters relating to the ongoing work of the Commission.

Presenter:

- Toby Ewing, Executive Director, MHSOAC

Enclosures(15): (1) Motions Summary from the September 26, 2019 Meeting; (2) Evaluation Dashboard; (3) Innovation Dashboard; (4) County Presentation Guidelines; (5) Staff Analysis - Glenn County Crisis Response and Community Connections (CRCC); (6) Glenn County CRCC Innovation Plan; (7) Staff Analysis - San Francisco Addressing the Needs of Socially Isolated Older Adults; (8) San Francisco Extension Request - Addressing the Needs of Socially Isolated Older Adults; (9) Staff Analysis - San Luis Obispo Holistic Adolescent Health; (10) Staff Analysis - San Luis Obispo Threat Assessment Program (SLOTAP); (11) San Luis Obispo Innovation Proposals; (12) Letter from County of San Luis Obispo Behavioral Health Department; (13) Calendar of Tentative Agenda Items; (14) Department of Health Care Services Revenue and Expenditure Reports Status Update; (15) Legislative Report to the Commission.

Handouts: None



Motions Summary

**Commission Meeting
September 26, 2019**

Motion #: 1

Date: September 26, 2019

Time: 9:35 AM

Motion:

The Commission approves the August 22, 2019 Meeting Minutes.

Commissioner making motion: Commissioner Danovitch

Commissioner seconding motion: Commissioner Alvarez

Motion carried 9 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Berrick	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Boyd	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Danovitch	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Gordon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Madrigal-Weiss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Mitchell	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vice-Chair Ashbeck	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
15. Chair Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Motions Summary

**Commission Meeting
September 26, 2019**

Motion #: 2

Date: September 26, 2019

Time: 10:41 AM

Motion:

The Commission approves the following item(s) on the Consent Calendar:

- *Sutter-Yuba County Innovation plan: Approve \$5,939,288 in Innovation funding to support the five-year project, “Sutter-Yuba Innovative and Consistent Application of Resources and Engagement (iCare) Innovation Plan.”*

Commissioner making motion: Vice-Chair Ashbeck

Commissioner seconding motion: Commissioner Madrigal-Weiss

Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Berrick	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Boyd	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Danovitch	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Gordon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Madrigal-Weiss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Mitchell	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vice-Chair Ashbeck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Chair Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Motions Summary

Commission Meeting September 26, 2019

Motion #: 3

Date: September 26, 2019

Time: 1:55 PM

Motion:

The Commission elects Vice-Chair Ashbeck as Chair for 2020.

Commissioner making motion: Chair Tamplen

Commissioner seconding motion: Commissioner Mitchell

Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Berrick	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Boyd	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Danovitch	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Gordon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Madrigal-Weiss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Mitchell	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vice-Chair Ashbeck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Chair Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Motions Summary

**Commission Meeting
September 26, 2019**

Motion #: 4

Date: September 26, 2019

Time: 1:58 PM

Motion:

The Commission elects Commissioner Madrigal-Weiss as Vice-Chair for 2020.

Commissioner making motion: Commissioner Alvarez

Commissioner seconding motion: Chair Tamplen

Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Berrick	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Boyd	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Danovitch	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Gordon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Madrigal-Weiss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Mitchell	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vice-Chair Ashbeck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Chair Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Summary of Updates

Contracts

New Contract: 19MHSOAC015

Total Contracts: **5**

Funds Spent Since the September Commission Meeting

Contract Number	Amount
17MHSOAC081	\$0
17MHSOAC085	\$33,469
18MHSOAC020	\$33,900
18MHSOAC040	\$145,126
19MHSOAC015	\$0
Total	\$212,494

Contracts with Deliverable Changes

[17MHSOAC081](#)

[17MHSOAC085](#)

[18MHSOAC040](#)

Regents of University of California, Los Angeles: Population Level Outcome Measures (17MHSOAC081)

MHSOAC Staff: Katherine Elliot

Active Dates: 7/1/2018-7/31/2020

Total Contract Amount: \$1,200,000

Total Spent: \$510,300

The purpose of this project is to develop, through an extensive public engagement effort and background research process, support for datasets of preferred (recommended) & feasible (delivered) measures relating to

- 1) negative outcomes of mental illness
- 2) prevalence rates of mental illness by major demographic categories suitable for supporting the evaluation of disparities in mental health service delivery & outcomes
- 3) the impact(s) of mental health & substance use disorder conditions (e.g., disease burden),
- 4) capacity of the service delivery system to provide treatment and support,
- 5) successful delivery of mental health services
- 6) population health measures for mental health program client populations.

Deliverable	Status	Due Date	Change
Work Plan	Complete	09/30/18	No
Survey Development Methodology/Survey	Complete	12/31/18	No
Survey Data Collection/Results/Analysis of Survey	In-Progress	3/30/20	No
Summary Report (3 Public Engagements)	Complete	3/30/19	No

Deliverable	Status	Due Date	Change
Summary Report (3 Public Engagements)	Complete	6/30/19	No
Outcomes Reporting Draft Report —3 Sections	In-Progress	9/31/19	No
Outcomes Reporting Draft Report – 4 Sections	In-Progress	12/31/19	Yes
Outcomes Reporting Final Report	Not Started	06/01/20	No
Outcomes Reporting Data Library & Data Management Plan	Not Started	06/01/20	No
Data Fact Sheets and Data Briefs	Not Started	06/01/20	No

Mental Health Data Alliance: FSP Pilot Classification & Analysis Project (17MHSOAC085)

MHSOAC Staff: Rachel Heffley

Active Dates: 07/01/18 - 3/31/19

Total Contract Amount: \$234,279

Total Spent: \$133,874

The intention of this pilot program is to work with a four-county sample (Amador, Fresno, Orange, & Ventura) to collect FSP program profile data, link program profiles to the FSP clients they serve, & model a key outcome (early exit from an FSP) as a function of program characteristics, service characteristics, & client characteristics

Deliverable	Status	Due Date	Change
Final Online Survey	Complete	02/04/19	No
FSP Program Data Sets	Complete	05/06/19	No
FSP Formatted Data Sets (Amador & Fresno)	Feedback Provided	09/07/19	Yes
FSP Formatted Data Sets (Orange & Ventura)	In-Progress	09/30/2019	No
FSP Draft Report	In-Progress	10/28/19	Yes
FSP Final Report	Not Started	12/31/19	No

The iFish Group: Hosting & Managed Services (18MHSOAC020)

MHSOAC Staff: Rachel Heffley

Active Dates: 01/01/19 - 12/31/19

Total Contract Amount: \$400,143

Total Spent: \$318,018

To provide hosting & managed services (HMS) such as Secure Data Management Platform (SDMP) & a Visualization Portal where software support will be provided for SAS Office Analytics, Microsoft SQL, Drupal CMS 7.0 Visualization Portal, & other software products. Support services & knowledge transfer will also be provided to assist MHSOAC staff in collection, exploration, & curation of data from external sources.

Deliverable	Status	Due Date	Change
Secure Data Management Platform	Complete	01/01/19	No
Data Management Support Services	In-Progress	12/31/19	No

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (18MHSOAC040)

MHSOAC Staff: Dawnte Early

Active Dates: 07/01/19 - 06/30/21

Total Contract Amount: \$1,161,008

Total Spent: \$145,126

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis activities.

Deliverable	Status	Due Date	Change
Quarterly Progress Report	Complete	09/30/19	Yes
Quarterly Progress Report	In-Progress	12/31/19	Yes
Quarterly Progress Report	Not Started	03/31/2020	No
Quarterly Progress Report	Not Started	06/30/2020	No
Quarterly Progress Report	Not Started	09/30/2020	No
Quarterly Progress Report	Not Started	12/31/2020	No
Quarterly Progress Report	Not Started	03/31/2021	No
Quarterly Progress Report	Not Started	06/30/2021	No

Mental Health Data Alliance: Knowledge Transfer Consulting Hours (19MHSOAC015)

MHSOAC Staff: Rachel Heffley

Active Dates: 10/22/19 - 12/31/20

Total Contract Amount: \$15,000

Total Spent: \$0

The goal of this project is to provide guidance and knowledge transfer to the MHSOAC regarding the California Department of Health Care Services' Client Services Information (CSI) and Data Collection Reporting (DCR) as well as the California Department of Justice's (DOJ) datasets.

Deliverable	Status	Due Date	Change
Consulting Hours	Not Started	12/31/2020	No

INNOVATION DASHBOARD NOVEMBER 2019



UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	2	10	12
Participating Counties (unduplicated)	2	4	6
Dollars Requested	\$722,904	\$15,515,331	\$16,238,235

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2014-2015	N/A	26	\$128,853,402	16 (27%)
FY 2015-2016	N/A	23	\$52,534,133	15 (25%)
FY 2016-2017	33	30	\$68,634,435	18 (31%)
FY 2017-2018	34	31	\$149,219,320	19 (32%)
FY 2018-2019	53	53	\$303,143,420	32 (54%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2019-2020	7	7	\$14,441,719	6 (10%)

Total number of counties that have presented an INN Project since 2013:	Average Time from Final Proposal Submission to Commission Deliberation [†] :	[†] This excludes extensions of previously approved projects, Tech Suite additions, and government holidays. FY: Fiscal Year (July 1st – June 30th)
56 (95%)	52 days	

INNOVATION PROJECT DETAILS

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Review	El Dorado	HUBS Project (extension)	\$2,158,704	1 Year	4/30/2019	Pending
Under Review	El Dorado	Senior Health and Nutrition	\$900,000	2 Years	4/30/2019	Pending
Under Review	Stanislaus	NAMI On Campus High School	\$923,259	5 Years	8/28/2019	Pending
Under Review	Stanislaus	Whole Health Approach to Improve Mental Health Outcomes	\$3,519,000	5 Years	8/28/2019	Pending
Under Review	San Mateo	Preventing Homelessness to Economic and Emotionally Stressed Older Adults	\$750,000	3.9 Years	9/30/2019	Pending
Under Review	San Mateo	Addiction medicine Fellowship in a Community Hospital	\$591,650	3.9 Years	10/2/2019	Pending
Under Review	San Mateo	Co-location of Prevention & Early Intervention Services in Low Income Housing	\$925,000	3.9 Years	10/2/2019	Pending
Under Review	San Mateo	PIONEERS (Pacific Islanders Organizing, Nurturing, and Empowering Everyone to Rise and Serve)	\$925,000	3.9 Years	10/2/2019	Pending
Under Review	San Mateo	Cultural Arts and Wellness Social Enterprise Café for Filipino/a/x Youth	\$2,625,000	5 Years	10/2/2019	Pending
Under Review	Mendocino	Healthy Living Community	2,197,718	5 Years	10/16/2019	Pending

FINAL PROPOSALS

Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Napa	Statewide Early Psychosis Learning Health Care Network	\$258,480	4.5 Years	4/30/2019	10/17/2019
Under Final Review	Butte	Physician Committed (extension)	\$464,424	3 Years	7/25/2019	10/9/2019

APPROVED PROJECTS (FY 19-20)

County	Project Name	Funding Amount	Approval Date
Siskiyou	Integrated Care Project (extension)	\$518,180	August 2019
Alameda	Supportive Housing Community Land Trust	\$6,171,599	August 2019
Sutter-Yuba	iCARE (Innovative & Consistent Application of Resources and Engagement)	\$5,228,688	September 2019
Glenn	Crisis Response and Community Connections	\$787,535	September 2019
San Francisco	Addressing Socially Isolated Older Adults-EXTENSION	\$195,787	October 2019
San Luis Obispo	Holistic Adolescent Health	\$660,000	October 2019
San Luis Obispo	San Luis Obispo-Threat Assessment Program	\$879,930.40	October 2019



COMMISSION MEETING PRESENTATION GUIDELINES

These recommendations for innovation plan presentations have been developed to support the dialogue between the Commission and the counties. Please note that the recommendations below regarding length, the county brief, PowerPoint presentation and presenter information are to ensure that counties and the Commission have ample opportunity to engage in a dialogue to gain a better understanding of the needs in the county, how the innovation plan meets those needs, why it is innovative and how will it be evaluated to support shared learning.

1. Length of Presentation

- a. County presentations should be no more than 10-15 minutes in length
- b. The Commission will have received the Innovation Project Plan as well as the Staff Analysis prior to the meeting
- c. The remaining time on the agenda is reserved for dialogue with the Commission and for public comment

2. County Brief

- a. Recommend 2-4 pages total and should include the following three (3) items:
 - i. Summary of Innovation Plan / Project
 - ii. Budget
 - iii. Address any areas indicated in the Staff summary

3. PowerPoint Presentation

- a. Recommend 5 slides and include the following five (5) items:
 - i. Presenting Problem / Need
 - ii. Proposed Innovation Project to address need
 - iii. What is innovative about the proposed Innovation Project? How will the proposed solution be evaluated (learning questions and outcomes)?
 - iv. Innovation Budget
 - v. If successful, how will Innovation Project be sustained?

4. Presenters and Biographies

- a. We request no more than a few (2-4) presenters per Innovation Project
 - i. If the county wishes to bring more presenters, support may be provided during the public comment period
- b. Recommend biography consisting of brief 1-2 sentences for individuals presenting in front of the Commission
 - i. Include specific names, titles, and areas of expertise in relation to Innovation Plan / Project

Note: Due dates will be provided by Innovation Team upon Commission calendaring for the following items: Presenter Names, Biographies, County Brief, and PowerPoint presentation.



STAFF ANALYSIS - GLENN COUNTY

Innovation (INN) Project Name:	Crisis Response and Community Connections (CRCC)
Total INN Funding Requested:	\$787,535
Duration of Innovative Project:	5 Years

Review History:

Approved by the County Board of Supervisors:	May 7, 2019
County submitted INN Project:	May 31, 2019
MHSOAC consideration of INN Project:	August 2019

Project Introduction:

Glenn County is seeking to use up to \$787,535 of Innovation spending authority over five (5) years to establish a community crisis response process.

This project proposes to explore and assess whether using a multi-disciplinary team (MDT) comprised of behavioral health clinicians, case managers and a Sheriff's Deputy, combined with prevention services to populations at higher risk for crisis, will work in a small rural county to reduce emergency department admissions, help stabilize a person earlier, and link clients to outpatient and follow-up services sooner.

The Need

In FY 2016/17, the County reports that it received 929 crisis calls. In FY 2017/18 they report that 1,730 calls were received on the crisis line, nearly a 200% increase in calls. The County attributes this to providing support to Butte County during and after the Camp Fire, continued support to Glenn and Butte County residents who are without permanent housing or any service infrastructure. Previously, Glenn County was providing support to its neighboring county, Shasta, during the CARR Fire and prior to either of these fires, The County reports that some of its own mental health staff are currently homeless due to the fires. Glenn County provided mental health support, housing and infrastructure services to the 200,000 residents who were evacuated due to the threatened flooding due to the structural problems with Oroville Dam.

In addition to the county experiencing increased crisis calls, the need for emergency room admissions and services are increasing. For a county with only 28,000 residents, this increased need for services requires new and innovative methods for managing them.

Currently, the County reports that most of the crises calls are handled in the emergency department (ED). In addition, they reported that there was an 86% increase in afterhours calls, that they hope this project will address by providing more prevention/wraparound type services during the day to reduce the number of crisis calls that occur after hours. In FY 2017/18, 90% (over 1,500) of the crisis line interventions were handled in the emergency room. Prior to transporting a person to the emergency department, the crisis line staff attempts to de-escalate the situation and if they are not able to, they have the person transported to Willows (the nearest emergency department) usually by the police department, where they will be met by the crisis line worker. A total of \$851,988 was spent in FY 2017/18 to manage these crisis line calls.

Additionally, due to all the logistical challenges, the county is experiencing as well as its proximity to counties with natural disasters the County reports that most of the individuals seen in the ED are not current clients of Glenn County Behavioral Health. Because of this, while the person may receive a referral for county behavioral health services, the crisis worker may not be able to follow up with the person to see if they attended services or have additional needs.

Commission staff found that in 2014 three small counties were awarded Triage funds; one county was about half the population of Glenn and then other two were about twice as large as Glenn County. Two of the originally awarded Counties have provided a report on the effectiveness of the programs they developed and have indicated that the addition of a law enforcement officer (Sheriff) contributed to both the success of the program as well as helped to reduce hospitalizations. Two additional small counties were awarded Triage funds during the second round of funding (Glenn County applied but was not awarded during this funding round). Glenn also reports that counties with triage or triage-like teams (specifically Nevada County) were studied by Glenn County and did not provide outcome information relevant to Glenn County's need, either in terms of staffing or success measures.

The County acknowledged these findings and will seek to incorporate lessons learned at the implementation stage.

Glenn County is currently completing a successful innovation pilot program (System Wide Mental Health Assessment Response Treatment Team-SMART) that responds, assesses and de-escalates crises, the majority of which are in the schools (page 5), according to the County. The County proposes to adapt the school innovation program and add elements (staffing protocols) of those triage programs identified in larger counties to determine if this is an appropriate model for small counties both in terms of treatment success and managing resources.

The Response

The County plans to utilize and adapt the learning from SMART program described above along with their research on crisis response teams throughout the state, and stakeholder input to try to expand crisis services throughout the county.

The County is proposing to test if using a multi-disciplinary team (MDT) to respond to crises in a rural community with limited resources will have similar results as those MDTs that are used in larger communities. Staff research and review of the program effectiveness reports provided by the initial counties receiving triage grants funds, indicates that this is accurate, along with the use of a law enforcement officer, and in this case, a half -time Sheriff. An important observation of MDTs is that the combined expertise of a range of mental health professionals, delivering comprehensive care to individuals is seen as the most effective way of delivering mental health services to people with mental health problems.

To prevent crises from re-occurring and recidivism, Glenn County's team will provide the following services and support the individuals who are vulnerable or at risk:

1. Conduct a Brief Wellness and Recovery Screening
2. Conduct a Strengths-Based Assessment
3. Develop a Wellness and Recovery Action Plan (WRAP)
4. Provide linkage to key services in the community

The team will work with law enforcement, hospitals, TAY Peer Mentors, LGBTQ service providers, child welfare, and other community networks to identify individuals at risk for crisis and engage them in services. This model of community collaboration to develop a “help first” system of supports is consistent with the philosophy of the MHSA.

The team will respond to a deputy call to a crisis after it has been determined safe for the team to participate in the process. The team will then provide help to the person and potentially de-escalate the situation or provide support to that person while they are being evaluated by the ED. Either after an ED admission or preparatory to an ED discharge, the MDT will provide follow up services (linkages to ongoing services and supports, family connection, housing, psychiatric medications) to the individual. If the individual is being released from jail, the MDT will provide connection services to that person so that the transition back into the community goes smoothly.

The Community Program Planning Process

The Community Program Planning (CPP) Process began in the Fall of 2018 with the County sending a survey (available in Spanish and English) out to stakeholders. Thirty-one (31) responses were received from that effort with 81% of the respondents indicating that they were interested in the County developing a crisis response and prevention service.

The County also conducted focus groups at the TAY Center and Harmony House, a drop-in center. Respondents from the TAY group indicated that they wanted “increases in preventative care before a crisis in the community, post crisis check-ins, and

partnerships with other agencies to increase TAY opportunities for housing support for TAY and their families.”

Harmony House respondents indicated similar priorities as the TAY group, and more outreach to meet the needs of ‘this time’ (post fire) and a homeless shelter (pg. 19). Additional community planning involved the Sheriff’s and Probation Departments, hospital Emergency Departments, the Behavioral Health Board, the System and Quality Improvement Committees, and the Cultural Competence Committee.

The proposed Innovation plan was posted for public comment March 26, 2019 through April 24, 2019 and a public hearing was conducted April 25, 2019. There were no comments in opposition to this plan. The County did receive compliments regarding their attention to the needs of the LGBTQ community.

The Commission shared this plan with its list serve and stakeholders along with the county public review process on March 28, 2019 and then in its final stage on June 5, 2019. One comment was received indicating that while this person was in support the “crisis response team model and follow up for the small Glenn County,” they felt that the “the only missing point not expressed in the proposal is upper management support.”

Learning Objectives and Evaluation

Glenn County seeks to develop a crisis response process that will meet the primary purpose of improving the quality of mental health services in the county, including measured outcomes. The County, with the use of a multi-disciplinary team (MDT), hopes to learn what types of coordinated strategies are helpful in responding to crises in a small rural county. The County will test adaptations to other models by utilizing wellness and strength-based prevention services. Glenn County will target individuals 14-years of age and older (potentially individuals 7-years of age and older), who are either in crisis and/or in out-of-home placement (**see pg. 11 of County plan**). It is estimated that 100 individuals will be served annually through the CRCC project.

To guide the evaluation of their project, the County has identified several learning questions and include:

1. The extent to which the CRCC Team can lead to improved client outcomes;
2. Identifying which response components are effective for crises situations;
3. Identifying which follow-up and community connections are effective in improving outcomes and reducing crises and impatient hospitalizations;
4. Determining if the implementation of the CRCC contributes to improved collaboration between MDT agencies;
5. Determining if WRAP Plans and Post Crisis Plans are effective in preventing crises; and
6. Determining if the program was implemented as planned (**see pgs. 19-20 of County plan**).

Quantitative and qualitative data will be collected to gather the information necessary for evaluation. Surveys will be developed and administered to clients, family members, staff

and partnering agencies. Service-level data will be collected from CRCC tracking forms, Anasazi, and Jail Census Reports to measure response times, client participation, calls to crises, time to service receipt, hospitalizations, etc. Additionally, collaboration will be evaluated using the Interagency Collaboration Activities Scale (IACAS). A full list of intended outcomes, measurements and data sources have been identified (**see pgs. 19-20 of County plan**). The evaluation will be contracted out and completed by IDEA Consulting.

While the evaluation plan is appropriate to meet the primary purpose and overall learning goals of the project, one key component that needs clarification is the way in which baseline data will be established to determine if outcomes have been met. Additionally, if successful, the County is encouraged to develop a broader dissemination plan to share lessons learned that goes beyond the local level.

The county may wish to review those evaluations prepared by small counties who were awarded Triage funds and determine if their learning questions are similar or may have already been answered.

The Budget

The total project cost for five years is estimated to be \$2,837,579.

The County is seeking authorization to spend up to \$787,535 (27.75% of the total cost) of its Innovation funds as follows:

\$596,502 for staff, a prorated share of 2.0 clinicians and 2.0 case managers,
\$ 96,576 for operating costs,
\$ 38,156 for contracts,
\$ 16,650 for evaluation, and
\$ 39,544 for administration

Additional costs for the program will be paid through other funding sources.

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations, California Code of Regulations (CCR) Section 3930.

References

<https://www.ruralhealthinfo.org/topics/mental-health#resources> retrieved June 18, 2019

<https://www.ruralhealthinfo.org/toolkits/mental-health/2/program-models> retrieved June 18, 2019

<https://www.yolocounty.org/home/showdocument?id=42674> retrieved June 18, 2019

Multidisciplinary Team Working: From Theory to Practice
<https://www.mhcirl.ie/File/discusspapmultiteam.pdf>

Innovation Project Overview

County Name: Glenn County

Date submitted: Proposed Plan submitted 05/31/2019
Proposed Plan revised 08/16/2019

Project Title: Crisis Response and Community Connections (CRCC)

Total amount requested: \$ 787,535

Duration of project: 5 Years

Innovative Project definition: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovative Project is defined as a project that “the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports.” As such, an Innovative Project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Section 1: Innovation Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

CHOOSE A PRIMARY PURPOSE:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- Increases access to mental health services to underserved groups
- Increases the quality of mental health services, including measured outcomes
- Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

- A. *What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.*

Glenn County is a small, rural county with a population of 28,094, which covers 1,327 square miles. Resources are limited for all partner agencies. As a result, it is imperative that all agencies collaborate to provide coordinated services for citizens and persons traveling through the county. The ability to respond to crisis situations in the county has many barriers, and it is the goal of Glenn County to learn and develop strategies and coordinate resources to resolve a crisis as quickly as possible. This Innovation Project would provide funding to learn ways to improve how agencies respond to each crisis situation; learn how to work together to meet the needs of each person and their family in the least-restrictive environment; and how to follow up with coordinated services to reduce future crises and psychiatric hospitalizations.

Resources are limited across all agencies involved in responding to a crisis. The Sheriff's department covers the entire county and has three (3) officers available for each shift, which includes three towns and a Native American tribal community. If one officer responds to a person with a mental health crisis, the officer may be involved with the crisis for several hours. The current crisis response includes responding in the community; ensuring the safety of the situation; assessing for 5150; providing transportation to the Emergency Department (ED), when needed; and providing the security supervision in the ED until the crisis is resolved. With one officer involved for several hours with a crisis situation, there are only two (2) officers available to cover the county and respond to all other community needs.

Currently, Glenn County Behavioral Health (GCBH) responds to crisis situations by having on-call crisis workers available 24/7. The crisis worker will speak with the person on the phone to try to de-escalate the crisis and/or respond to a crisis in the ED to assess the person and conduct a 5150 evaluation (danger to self, danger to others, gravely disabled). If the person requires a psychiatric hospitalization, the crisis worker remains at the hospital to find an available bed at a hospital in the region (which is often 60 or more miles away). Currently, the crisis worker does not accompany law enforcement into the community to help assess a crisis in the community.

There is one small hospital in Glenn County with an ED that has only three (3) beds. The ED is staffed with one medical doctor and one nurse. For any major health issue (e.g., trauma from car or race track accident; or heart attack), patients, once stabilized, are immediately transported to the Butte County Hospital in Chico, or to another location, using Life Flight or ambulance.

Each crisis situation can be very traumatic for the person in crisis and their family. It is the goal of GCBH to learn which strategies are most effective to improve crisis services for clients, while reducing the trauma. Some best practice strategies that will be implemented and evaluated

include coordinating services with partner agencies; de-escalating the crisis in the community, whenever possible; and providing follow-up support and services to each person with a crisis and/or ED visit and psychiatric hospitalization.

In FY 2017/18, there were 961 persons who received specialty mental health services from GCBH. Of these individuals, 324 (33.7%) were children; 225 (23.4%) were Transition Age Youth (TAY); 349 (36.3%) were adults; and 63 (6.6%) were older adults.

In FY 2016/17, GCBH received approximately 929 crisis contacts: 365 contacts during business hours and 564 contacts after hours. In FY 2017/18, this number almost doubled: there were approximately 1,730 crisis contacts, with 850 contacts during business hours and 880 contacts after hours (an 86% increase).

Of the 1,730 calls in FY 2017/18, 263 unique persons received 1,006 hours of mental health crisis intervention services, with a cost of \$339,827. Over 90% of these crisis intervention services were delivered in the local ED. There were also 63 unique individuals admitted to inpatient services, for a total of 647 bed days and a cost of \$512,161. The total cost of crisis intervention and psychiatric inpatient services was \$851,988 for the year.

Currently, the crisis intervention team is comprised of staff persons who are on-call during business hours, after hours, and during the weekends. The on-call crisis staff travel to the ED to respond to a crisis and they do not go out into the community to respond to a crisis. Law enforcement may go out into the community to address a crisis and transport the person to the ED. The on-call crisis worker will meet them in the ED to assess the person for lethality, possible 5150, and/or development of a safety plan. If the person in crisis is currently a GCBH client, the person is linked to their clinician, case manager, and/or psychiatrist as appropriate. Many of the individuals seen in the ED are not current clients. These individuals may be referred to the GCBH for ongoing assessment and specialty mental health services. Others are not linked to services and the crisis worker does not routinely follow-up with the individual in the next few days to determine if there are additional needs.

When individuals do not receive timely access to services, and/or do not receive follow-up services after a crisis, psychiatric inpatient stay, or are released from jail, they are more likely to have another crisis or hospitalization. In addition, if the individual does not receive follow-up support with a psychiatrist for a medication refill and/or to understand how to take the medication that was prescribed at the inpatient hospital, the person is more likely to go into crisis or be re-hospitalized after they are discharged from the hospital. Persons who are released from jail may not be given sufficient medications to last until the person is able to schedule an appointment with GCBH for medication management service. These are also situations that need to be addressed in this small, rural county with limited services and resources.

The most recent GCBH Innovation Project, which ends June 2019, developed a System Wide Mental Health Assessment Response Treatment (SMART) Team to respond to threats and crises in the schools. The SMART Team has been highly effective over the past five years in learning how to respond, assess, and de-escalate crisis situations in the schools. The SMART Team received 178 referrals across the project years; and served a total of 93 unique individuals, with

the majority served in the schools. Due to the success of the SMART Team, stakeholders suggested utilizing this model to develop strategies to learn how to respond to crisis situations in the community, and include persons of all ages, not just children and youth.

In addition, in the past two years, there have been several major fires that have greatly impacted people in this region, including Glenn County residents. Most significantly was the Camp Fire (November 8, 2018) in Paradise, Butte County, with 85 fatalities and 18,804 homes/structures destroyed (most within the first four hours), and the CARR fire (July 23, 2018) in Shasta County, with 38,000 evacuated, 8 fatalities, and over 1,000 homes destroyed by the fires. The ongoing stress from these fires has increased the number of crisis calls and crisis situations in the community. In response to the Camp Fire, Glenn County has offered several locations for the placement of both FEMA and private trailers and campers. Countywide, over 100 FEMA trailers are parked. These temporary living sites have increased the number of crisis calls and law enforcement visits. This situation adds to the importance and immediacy of the development of a project to help strengthen the crisis response practices of this small, rural county with limited resources.

Glenn County has worked with Butte County to provide assistance in the aftermath of these disasters. This support included providing shelter services for those individuals evacuated due to the Oroville Dam failure as well as for the Camp Fire. Mental Health staff provided immediate mental health crisis response to temporary shelters until the shelter was closed, and/or when the Red Cross took over. This aid included staffing the shelter from 8:00 am to 8:00 pm each day that the shelter was active. During the disaster, it became apparent that there many requirements and activities needed to be done in the area of response for all aspects of shelter duty.

These tragic fires, loss of homes, schools, churches, and business has created an ongoing stressful environment throughout the region. These fires impacted both the availability of homes, and the cost of renting and/or purchasing homes. With so many people in the region (including several Glenn County staff) who were suddenly homeless, with over 10,000 homes lost, real estate and rentals suddenly cost significantly more money. The cost of a single family home rose \$100,000 or more within a month of the fire. The cost of rental apartments/homes also rose dramatically. This situation created additional stress for persons with limited incomes and/or with Medi-Cal benefits who cannot afford to pay the increased cost of a small apartment.

Recent crisis data, the experience with the SMART Team, and the impact of the fires have led GCBH to identify the need to create an innovative model for helping individuals earlier in their crisis cycles, responding quickly to each crisis; de-escalating a crisis whenever possible; and creating community connections and supports for each person to link to ongoing services, with the goal of reducing new crisis events and psychiatric inpatient admissions.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project.

In the past several years, funding for triage services has been available through SB 82 Triage Grants. Glenn County applied for this grant; however, only two small, rural counties (Calaveras and Trinity) were awarded the Triage Grant funding. As a result, small counties were limited in their ability to learn how to respond to crisis situations in the community to reduce the need for an ED 5150 evaluation and psychiatric hospitalization.

Nevada County (population 99,814), while considered a small county, is three times larger than Glenn County. Nevada County received an SB 82 Triage grant in 2014. The grant supported the development of a Respite Center, which is a peer-operated center where individuals may stay for up to 28 days to help them stabilize and reduce the need for hospitalization. The grant also supported Nevada County to pay for additional clinical positions, so that the crisis workers who were on call could be co-located adjacent to the hospital ED to reduce the time needed to respond to a crisis in the ED. The crisis workers do not go out into the community to respond to the crisis in Nevada County.

The traditional on-call crisis response model is effective at responding to people who are in crisis in the ED and need to be evaluated for admission to a psychiatric hospital. However, several larger counties used the SB 82 funding to develop a Mobile Crisis Team (MCT). Many of these counties, such as Santa Clara and Placer, developed MCTs that respond to the crisis in the community, and/or ride along with law enforcement during the day from 8:00 a.m. to 5:00 p.m. (or 8:00 p.m. in some cases). Although no formal data or information has been released to the public by SB 82 counties, anecdotal data suggests that larger counties have found that having a Multi-Disciplinary Team (MDT) available to respond to a crisis in the community can greatly reduce the number of people who need to be transported to the ED. It has been found that immediate, community-based services can be effective at de-escalating the crisis and meet the person's needs in the community. These MCTs have also found that it is effective to provide follow-up support services after the crisis is resolved to help the individual remain stable in the community. However, one of the challenges that these MCTs have experienced is that local dispatch does not always call the MCT when a behavioral health crisis occurs.

The GCBH Innovation Pilot Project will take what was learned with SMART and from MCTs, and apply it to crisis situations across a small county, for persons of all ages. This pilot will provide the opportunity to evaluate if GCBH can improve the response to persons who are in crisis in the community.

This INN project would develop the Crisis Response and Communication Connections (CRCC) program that will utilize an MDT approach to identify situations when a person is likely to have a crisis and providing services whenever feasible. This approach will help de-escalate the crisis and help stabilize the person's symptoms early in the cycle; and it will help individuals stay in

the community, receive supportive services, and be linked to outpatient services, when needed. Providing support to people in crisis to those returning from a psychiatric inpatient treatment will support these individuals to return to the community more quickly and ensure that they receive ongoing mental health services to reduce recidivism.

The CRCC is designed for a small rural county with limited resources. The CRCC will utilize an MDT that is comprised of 2.0 FTE behavioral health clinicians, with a specialization of working with persons with a dual-diagnosis (mental health and substance use disorder); 2.0 FTE case managers, with a preference for hiring persons with lived experience, or family members with relatives with mental health problems; and a part-time (0.5 FTE) Sheriff's Deputy who will be available to accompany the CRCC in the community to respond to crisis situations. By actively involving law enforcement in the MDT, GCBH anticipates avoiding the challenge that other MCTs have experienced when dispatch fails to call the MCT for behavioral health crises. Whenever possible, persons who are bilingual, bicultural will be hired to these positions to be able to offer crisis services to persons in their primary language, either English or Spanish.

The development of the CRCC program that responds to a crisis situation in the community, when appropriate, in coordination with the Sheriff's Deputy, would help reduce the number of people who need to be assessed in the ED and help avoid hospitalization, whenever possible. Each shift, the CRCC will be comprised of a behavioral health clinician, a case manager, and a Sheriff's Deputy. The composition of the CRCC provides the expertise to initially assess the key indicators to determine the safety of the situation and determine which situations can be safely responded to in the community by the CRCC. The Sheriff's Deputy will always assess the crisis situation in the county to determine if it is safe for the clinician and/or case managers to enter the community setting. Once the Sheriff's Deputy assesses the situation and notifies the CRCC that it is clear to come into the home/community setting, the CRCC members will be nearby and able to help de-escalate the situation and begin establishing a therapeutic relationship with the individual and his/her family, as appropriate.

When the CRCC determines that the immediate crisis is resolved, the Sheriff's Deputy may return to routine duties. The CRCC will remain with the individual and family to continue to assess the situation and develop a safety plan, when appropriate. In situations when the crisis situation cannot be resolved, the Sheriff's Deputy will transport the individual to the ED for further evaluation, and 5150 hospitalization, when needed.

Helping individuals in crisis and supporting them after the crisis, and/or after a psychiatric hospitalization, is a high priority to reduce the trauma of multiple crisis and/or inpatient admissions and to wrap services around the person to achieve positive ongoing outcomes. In addition, persons who may be at risk for a crisis, such as persons being released from jail and/or families involved in Child Welfare Services (CWS) and are experiencing stress, may also be served by the CRCC. The CRCC will learn how to expand these support services to provide support and linkage to individuals with a mental illness who are released from the jail and need follow-up mental health treatment services in the community to help the individual to remain stable in the community.

The CRCC will work collaboratively to identify individuals who have a mental illness and are in crisis, providing a coordinated system of immediate response, as quickly as possible, and linkage

to ongoing services through GCBH. Individuals will be supported by the CRCC until the immediate issue is resolved, the individual is linked to ongoing services, and a family support network is in place, when appropriate. When the person has been hospitalized, the CRCC will provide ongoing support services to the person to help them transition back into the community. Similarly, persons who are being released from jail or involved in CWS will be linked to services to help prevent a crisis. This ongoing CRCC support may last several weeks to ensure the person is linked to psychiatric medications, and other ongoing services, as needed.

The CRCC will operate from 8:00 a.m. to 5:00 p.m., Monday through Friday, and will be available to respond to crisis situations in the community. In addition, the CRCC will proactively provide services to individuals across the county who are at-risk of a crisis as well as provide follow-up services to the individual and family.

The CRCC will be located in Willows and Orland and will respond county wide. The CRCC Sheriff's Deputy will be available to work with the CRCC. The CRCC will have morning check-ins to discuss any crisis situations that occurred the previous day, or overnight with the on-call crisis staff. The CRCC will also discuss each person who is being followed by the CRCC, including persons currently hospitalized, those who are in jail and ready to be released, and any persons identified as high-risk. The morning planning meeting will outline priorities for each CRCC staff member, including identifying people who need to be followed, and scheduling appointments and psychiatric services and identifying other needed supports.

Referral and Admission Processes

Each person who is evaluated for crisis services in the ED will be referred to the CRCC on the same day or the next business day. The crisis worker in the ED will talk with the individual about having the CRCC contact them the same or next day. While the CRCC services are voluntary, each person in crisis will be encouraged to participate with CRCC staff to help resolve the situation which preceded the crisis and receive ongoing support.

The CRCC will also be proactive in reaching out to high-risk and vulnerable persons before a crisis occurs, including individuals who are:

- Seen in the ED the previous evening, but were released back to the community (e.g., did not meet 5150 criteria)
- Admitted to a psychiatric hospital
- Ready to be discharged from a psychiatric hospital and need to be linked to ongoing outpatient services
- Ready to be released from jail
- CWS families in crisis
- Frequent users of crisis and inpatient services
- Homeless
- Frequent callers to the Welcoming Line
- Experiencing their first psychotic break
- Victims of trauma (e.g., students when a classmate's suicide happens; Camp/Carr Fire)
- Returning from SUD residential treatment
- Living in a Group Home or Board and Care

- Dual-diagnosed
- Youth with suicidal thoughts and behaviors
- LGBTQ
- Victims of threats and/or domestic violence

For persons who are newly identified and/or referred to the CRCC project, the CRCC will utilize evidence-based and promising practices to:

1. Conduct a threat assessment using the Mosaic Assessment Tool, when applicable.
2. Conduct a Brief Wellness and Recovery Screening which includes and identification of the person's strengths and needs, and other support persons.
3. Conduct a Strengths-Based Behavioral Health Assessment for persons needing ongoing support.
4. Help to develop a Wellness and Recovery Action Plan (WRAP), either in a group or individually.
5. Provide linkage to key outcomes/services, as needed:
 - Ongoing individual and group therapy
 - Assessment and/or adherence with psychiatric medications
 - Substance use disorder treatment, including residential treatment
 - Housing
 - Activities of Daily Living
 - Family support
 - Social support
 - Community peer support (e.g., Alcoholics Anonymous; Narcotics Anonymous; Cocaine Anonymous; Marijuana Anonymous: AA/NA/CA/MA)
 - Harmony House (an adult wellness and drop-in center)
 - Transitional Age Youth Wellness Center
 - Benefits, including Food Stamps, Medi-Cal and Social Security
 - Employment skills

The CRCC will coordinate discharge activities with the individual and psychiatric hospital staff during the psychiatric hospitalization to begin engaging them in ongoing services in preparation for their discharge. The CRCC will coordinate with the hospital discharge staff regarding the day and time of discharge. On the day of discharge, the CRCC will be available to provide and/or coordinate transportation back to Glenn County. The CRCC will coordinate appointments with the psychiatric hospital and outpatient staff to schedule a follow-up appointment as quickly as possible, to ensure individual's prescriptions are continuous. In the interim, the CRCC will meet with the individual as frequently as needed to provide support to both the individual and their family/significant support persons.

In addition, the CRCC will communicate with jail staff and Probation staff to identify persons with mental health and/or substance use disorders problems who are at an increased risk of crisis

when released from the jail. The jail staff will notify the CRCC the morning of a person's scheduled release and will coordinate with CRCC to arrange transportation to the GCBH office to help the person transition back into the community and be linked to needed services. The CRCC will ensure that if the individual is leaving the jail with psychiatric medications, that there are enough medications to last until the person has an appointment with the psychiatrist. Similarly, CRCC will coordinate services into the community to help the individual transition to a safe living situation and that family/support persons are prepared and ready to welcome the individual home.

For youth in crisis and/or leaving the psychiatric hospital, the CRCC will coordinate services with the Transition Age Youth (TAY) Peer Mentors who are located at the TAY Center, the youth wellness and drop in center in Orland. Together, the CRCC, Peer Mentors, and the treatment team from the youth and family component will coordinate services, including working closely with family and the youth's social support system to help them transition back to school and link to appropriate services in the community. Similarly, adults will be linked to Harmony House, the adult wellness center in Orland, and Coaches will coordinate services with CRCC to identify and address their needs and provide ongoing support. TAY Peer Mentors and HH Coaches are trained to help individuals develop a WRAP and a Post Crisis Plan. The WRAP and Post Crisis Plan is a self-designed prevention and wellness process to help individuals get well and stay well. Following a crisis, the Post Crisis Plan helps an individual identify what they need to do when they return home, what others can do for them, and what can wait until the person feels better. The development of these tools helps each person maintain control over their lives at a time when life feels out of control.

For youth and adults who are LGBTQ, CRCC will offer support and/or link them to LGBTQ services in the county or region, as appropriate. Persons who are LGBTQ are at higher risk of suicide, and it is a goal of the CRCC to ensure that individuals from the LGBTQ community create a safety net and offer a welcoming and supportive environment. Support services will also be available to the families of these individuals to help them create a safe environment when they return.

Persons who are experiencing their first psychotic break are also a high priority for the CRCC. While there are only a few persons each year in this small community, it is essential to provide an extensive support network to the individual and their family to help them understand the symptoms of mental illness as well as the importance of family support and compliance with medication(s) to help address the acuity of their symptoms. Supportive services to family members, and linkage to other families in the county who have a family member who has a serious mental illness, will be available for creating a positive, immediate support network.

Families who have youth or adult relatives who are in placement (juvenile hall; jail; residential treatment; CWS, etc.) also need a strong support network. Often, families are uncomfortable talking about their family member's situation and therefore feel isolated from other parents and family members. CRCC will reach out to these families and help them address current needs, link them to support groups, and help them to develop healthy strategies in preparation for when the family member returns home.

Achieving the vision of this Innovative Plan requires the development of strong interagency and community collaboration. Strategies will be developed to meet the needs of the community by implementing culturally-competent services and coordinating the CRCC with the support of a Sheriff's Deputy, to assess the safety of a crisis in the community, to help resolve the crisis, de-escalate the situation, and resolve the crisis in the community, whenever possible. This interagency collaboration is critical to the success of the project and provide valuable learning opportunities to all BH county systems, especially small, rural communities like Glenn County. This data will provide valuable information regarding key outcomes, as well as create the foundation for law enforcement and partner agencies to apply for other grants to sustain this program over time.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

The CRCC Innovative Project promotes interagency and community collaboration related to mental health and substance use treatment services, supports, and outcomes. The CRCC will enhance collaborative processes across several agencies, including Behavioral Health, the Sheriff, ED and hospital staff, Probation, the county jail, and child welfare in order improve the continuity of care for persons in crisis and/or utilizing intensive services.

CRCC will meet regularly with the Sheriff's Deputy, ED, hospital, and jail staff to discuss client progress toward goals, coordinate services, develop and implement culturally responsive services, and to increase positive outcomes. This MDT will involve other collaborative agencies, which will be determined on an individual basis to meet the needs and support the success of each client. The CRCC will increase interagency and community collaboration through its work with these agencies, by providing and coordinating services to ensure continuity of care for individuals in Glenn County.

While the CRCC will not provide long-term, ongoing treatment, it will provide intensive, timely assessment, treatment, and linkage to needed services to ensure immediate response and coordinated planning to meet the person's needs at a critical time and begin offering timely support.

C) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

This Innovative Project blends the success of the mobile crisis team model implemented in larger counties and what GCBH learned to be effective in responding to school crisis situations through the System Wide Mental Health Assessment Response Treatment (SMART) Team.

The GCBH SMART project paired a Sheriff's Deputy with a behavioral health clinician and case manager (person with lived experience) to respond to schools and the community when a child/youth was exhibiting threatening behavior and/or having a crisis at the schools. The SMART Team also enabled Glenn County staff to follow-up with individuals who may pose a threat to the community, and ensure they receive adequate support and linkage to services and

other community resources. The SMART Team has been highly effective over the past five years, but there is a need to expand services to include persons of all ages, have the ability to respond to crises in the community, and provide supportive services to other individuals who are at high-risk of experiencing a crisis (e.g., persons discharged from an inpatient psychiatric facility; persons with a mental illness who are released from jail; persons involved in the child welfare/child protective services system).

MCTs respond to a crisis in the community, meet with a law enforcement officer who responds to the crisis, and work together to de-escalate the situation. In many instances, the law enforcement officer may leave the scene and return to active duty, when the MCT arrives. MCTs have been found to be effective at improving access to mental health treatment for persons with a serious mental illness. They have also been found to be effective at reducing recidivism for high-risk individuals. However, the majority of MCTs have been implemented in larger counties where more resources are available, including staffing at all levels (law enforcement, behavioral health, local hospitals, etc.).

This small county's Innovative Project will combine these two models, adapt the principles found to be effective, and apply them across a small, rural county with limited resources. This new INN project utilizes practices developed by larger counties that have implemented MCTs and paired it with the GCBH success in working collaboratively with the Sheriff's Department to respond to crisis and threat situations in the schools. This INN project will help GCBH learn if it is effective to combine a program comprised of a Sheriff's Deputy, mental health clinician, and case manager/family advocate and have them go out into the community to work to resolve a crisis situation as quickly and effectively as possible. This project will be an opportunity to determine if this model is effective with persons of different ages, genders, race/ethnicity, and sexual orientation. In addition, the follow-up activities and community connections offered by the CRCC will help assess the effectiveness of providing follow-up services for several days or weeks, to help the person to continue to improve and access needed services in a timely manner.

Expanding the CRCC activities to include persons released from the hospital, persons with a mental illness and released from jail, and/or persons involved with child welfare/child protective services, will help utilize the expertise of the CRCC to help respond proactively to potential crisis situations.

Having a program that can respond to a crisis, or other at-risk situation, creates an opportunity to develop a program that helps divert individuals from crisis and inpatient services. It will also coordinate services to help link individuals ready for discharge from inpatient services, to be immediately linked to community services. These services are designed to be culturally-competent and meet the cultural needs of individuals and their families.

This project will utilize culturally-relevant, evidence-informed strategies to engage individuals in the program; utilize strength-based interventions to reduce stigma and create awareness of mental health and substance use issues; address public safety concerns and improve services to this vulnerable, high-need population. This Innovative project will create opportunities to identify additional strategies for improving outcomes for this high-risk population in a rural community, as well as help identify activities that are most effective for achieving positive

results with persons in crisis or at-risk of crisis. This project will also identify ways to include families throughout the program and promote strong cultural connections in the community.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

It is estimated that up to one hundred (100) unique individuals will be served each year. While there are approximately 1,600 calls to the crisis line and 260 receive behavioral health crisis intervention services in the ED each year, CRCC services are voluntary to the consumer, so not all people in crisis will be interested in receiving services. Also, some people in crisis are already receiving ongoing behavioral health services and do not need the enhanced support of the CRCC.

Across the five project years, it is estimated that the CRCC will serve at least three hundred (300) unique individuals, ages 7 and older. It is estimated that CRCC will be involved with each person an average of two (2) weeks, with some only receiving services for 1-2 days, and others receiving CRCC services for four (4) weeks or longer.

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).

The target population for the CRCC is primarily individuals ages 14 and older, but the program may serve children 7 to 13 who are in crisis and/or in out-of-home placement and who can benefit from CRCC collaborative services.

These individuals include, but are not limited to:

- Are ages 7 and older;
- Are current residents of Glenn County;
- May be experiencing mental health symptoms (including crisis, suicidal behavior);
- May have a pattern of substance use that impacts their daily functioning;
- May be dual-diagnosed with a mental illness and substance use disorder;
- May be experiencing their first psychotic break;
- May be of any race/ethnicity;
- May be LGBTQ;
- May be homeless;
- May be persons being released from psychiatric inpatient hospital facility;
- May be persons being released from jail and are at-risk;
- May be involved in the Child Welfare system;
- May be living at the tribal reservation, Grindstone Rancheria.

Services will be available to persons who meet the above criteria, regardless of gender, race, ethnicity, sexual orientation, and language. It is estimated that 30% of the persons served will be Hispanic.

The CRCC will respond to crisis situations and referrals during business hours, and follow up with the person the next business day when seen in the ED. The CRCC will meet with the individual and begin developing a relationship and assess needs for services. This approach will create the opportunity for the CRCC to develop a trusting relationship with the individuals; and will allow the CRCC time to plan and coordinate services in the community, including housing, coordinate prescription and medications between the hospital and behavioral health clinic and/or between the jail and behavioral health clinic, and appointments for other needed services, in a timely manner. This strategy promotes wellness and recovery and reduces recidivism.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

There were similar projects that were implemented in the past five years. Two small counties received SB 82 Triage grants to help improve their crisis programs. Calaveras County's (population 45,670) project was to provide a crisis support Sheriff Liaison position at the Sheriff's Department to provide immediate crisis stabilization to help individuals, and their families, during a mental health crisis. After searching for 18 months, a case manager was hired for the Sheriff Liaison position,. The Sheriff Liaison was housed at the Sheriff Department and responded to dispatcher's calls from officers throughout the county as well as referrals from National Alliance for the Mentally Ill (NAMI) and other community agencies. This person worked noon to 9 p.m., Tuesday through Saturday. The plan indicated that the Sheriff Liaison would respond with a Sheriff's officer when they receive a potential 5150 call and to help them to determine in the field if the person needs to be placed on a 5150 with the local hospital or to develop a safety plan.

Following a year of implementation, data showed that there were improved relationships between the Sheriff's Office, Police Department, and Highway Patrol, as well as community agencies. Unfortunately, after this one year of implementation, the Sheriff's Department did not routinely contact the Sheriff Liaison prior to transferring residents to the ED for 5150 evaluations. The Triage Program staff requested changes in the second year to contact the Sheriff's Liaison when responding to a potential 5150 crisis call.

Some of the recommendations included establishing and maintaining the confidence of law enforcement to build rapport; ensure case manager is available when calls are highest in frequency; and provide follow-up support services after the crisis. These recommendations have all been addressed in our Innovation project.

Trinity County (population 12,709) project was to assist five Access Point Agencies, which were identified by mental health crisis situations within the community. The goal of the project was to decrease the number of hours ED personnel spend on a mental health crisis as well as decrease the time law enforcement officers are taken out of the field for these situations. Satisfaction surveys, the number of hospital admissions and the number of bed days were reported across time. Satisfaction surveys of the five Access Point agencies found that community members found the Triage Work on-site helpful and that it helped to reduce the number of hospitalizations and bed days. Recommendations included developing a peer Respite Home to expand their

crisis triage program in this small, isolated county. In addition, it was recommended that the county offer a 24-hour wrap solution, to help reduce the need for 5150 placements and/or law enforcement intervention.

The recommendations and lessons learned from these two projects, as well as the success of the GCBH SMART Team and MCTs that have been implemented in other counties, helped to inform and design the CRCC Innovative Project. The CRCC includes a Sheriff's Deputy to respond consistently and as a multi-disciplinary team. MCTs are successful when they have mental health clinicians either travel with law enforcement to respond to a crisis or have law enforcement respond to the crisis and call the MCT when the situation involves a mental health crisis. Neither model work for a small, rural county, where the number of crisis situations are small, and the number of staff are limited. Having a clinician riding along with law enforcement would be inefficient and not utilize the mental health clinician's time in a productive manner. In FY 17/18, there were approximately 850 calls to the crisis line during business hours, and 880 calls to the crisis line after hours. Of these calls, 263 unique persons received GCBH mental health crisis services.

Similarly, there are only a few law enforcement officers in the county and their time is stretched too thin to attend routine meetings to discuss complex situations and plan strategies on an ongoing basis to support individuals before they have a crisis and/or following the crisis/hospitalization. The Sheriff's Deputy is dedicated to the CRCC Team each week. As an integrated member of the CRCC Team, the Deputy is well trained and knowledgeable about how the team works collaboratively with the behavioral health staff and case managers, as well as getting to know many of the most at-risk clients.

The CRCC Innovation Project will test the effectiveness of having an MDT that includes mental health staff, case management, and a part-time Sheriff's Deputy working together to respond to crisis situations during the day as well as provide support and follow-up after a crisis, psychiatric hospitalization, release from jail, and/or child welfare involvement. This timely response, as well as support services that may last up to a month, explores a different model from the traditional MCTs that only responds to the crisis and occasionally follows up on the individual with a phone call. Also, many MCTs do not pay for the law enforcement officer, only the mental health staff. Helping to pay for the salary of the Sheriff's Deputy greatly enhances the CRCC and ensures active participation by the Deputy, but also helps to support local law enforcement that has limited funding. The effectiveness of this model in a small, rural county will be a valuable learning opportunity that could easily be replicated in other small counties.

The CRCC will coordinate training for law enforcement and behavioral health staff to deliver evidence informed strategies, including Motivational Interviewing and Trauma-Informed CBT. Training will include delivering culturally-responsive services and to respect different cultures; to understand mental illness and substance use behaviors; to respect family diversity and facilitate family engagement. These activities will also create the opportunity to identify and document strategies for working with different age groups, to de-escalate the crisis, reduce recidivism, and enhanced strategies to involve families in supporting the person to achieve positive outcomes.

- B) *Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.*

The Crisis Intervention Teams model (CIT) was originally developed as an urban model for police officers responding to calls about persons experiencing a mental illness crisis. Skubby, Bonfine, Novisky, Munetz, and Ritter (2012) found that literature suggests that there are unique challenges to adapting this model in rural settings. This study identified the unique challenges through focus group interviews and found that there were both external and internal barriers to developing CIT in rural communities. These barriers were a result of working in small communities and working within small police departments. It was recommended that law enforcement and Behavioral Health working closely together could provide the best outcomes through collaboration and coordinated services. The CRCC is designed to develop and enhance the collaboration between the sheriff and the behavioral health crisis team to respond in one, coordinated and collaborative team to reduce barriers and improve outcomes in this rural community.

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

- A) *What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?*

The CRCC will learn the key strategies for coordinating services between behavioral health, the Sheriff's Deputy and partner agencies, including ED staff, hospital discharge staff, jail staff, and CWS. These partner agencies will screen, identify, and refer persons eligible for services. The key learning will be to identify how to respond to a crisis in the community in a timely manner, with a focus on utilizing wellness and strength-based prevention services to help de-escalate each crisis and reduce the need for repeat crisis services and/or hospitalization. The CRCC will provide each person with a wellness toolbox that will help support their recovery and resiliency prior to and during a crisis. This strategy will document how the CRCC can respond in a manner to support each person's recovery.

Learning goals include:

1. Can the Crisis Response and Community Connections (CRCC) multidisciplinary team, comprised of a Sheriff's Deputy, clinician, and a Peer/Family Advocate, respond to the crisis in the community, de-escalate the person in crisis, reduce the frequency of transporting people to the ED, as well as reduce the amount of time the officer needs to be at the scene?

2. Can the CRCC de-escalate the crisis in the community and therefore reduce the number of crisis evaluations in the ED, which will help keep the three (3) ED beds open for persons with injuries and other health concerns?
3. Can the CRCC respond to and de-escalate the crisis in the community, thereby reducing the amount of time law enforcement needs to remain at the scene of the crisis?
4. Can the CRCC help reduce the number of people with repeat crisis and psychiatric hospitalizations by providing follow-up services, including WRAP Plans, after the crisis? This would include working with psychiatric hospital staff to coordinate discharge planning, medications, and link to Mental Health and Substance Use Disorder (SUD) services and other community resources.
5. Can the CRCC help reduce the number of people who have repeat crisis and psychiatric hospitalizations, by providing support to the family and significant persons, during the crisis, and through follow-up and linkage to community resources?

Ultimately, this Innovation funding will provide the opportunity to learn how to create a CRCC that is effective at:

- de-escalating a crisis in the community;
- reducing the amount of time law enforcement needs to remain at the scene of the crisis;
- reducing the volume of persons in crisis in the ED; and
- providing support to the family members to help create a positive social support system.

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

These goals are consistent with the key elements outlined in this plan to develop and implement a culturally relevant CRCC Team that supports each individual to resolve their crisis in the least restrictive environment possible, and to develop skills to utilize wellness and strength-based prevention services to help decrease crisis calls, ED visits, and psychiatric hospitalizations.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

The successful implementation of this five-year Innovation Project will have a strong evaluation component to document the positive outcomes of this innovative program. This data will provide valuable information regarding key outcomes, as well as create the foundation for law enforcement and partner agencies to apply for other grants to sustain this program over time.

The evaluation will include several components:

- a) Individuals will be surveyed periodically to obtain their input to improving services. Staff and client perceptions of access to services, timeliness, and quality of services will be measured.
- b) Service-level data will be collected to measure the:
 - Number of crisis calls;
 - Timely response by the sheriff and/or CRCC Team;
 - Length of time for sheriff to stay at the crisis;
 - Number of persons linked to ongoing services;
 - Other referrals and linkages to services;
 - Number of contacts and duration of services;
 - Location of services;
 - Number of persons hospitalized;
 - Length of hospitalization;
 - Follow-up after hospitalization; and
 - Recidivism to hospitalization.

Services will be evaluated to assess the timeliness of services, duration of services, outcomes over time, and community connections. A brief screening tool to assess the individual's level of risk and needs, as well as provide a risk assessment for identifying the goals for services, will be developed and utilized.

- c) Client and family perception of services and outcomes will be measured at least annually to determine if services are helping to improve outcomes. These outcomes will include mental health, substance use, wellness, and other key elements.
- d) Periodic surveys of staff, clients, and partner agency staff will help to inform the progress of the Innovative Project on collaboration, communication, successes, and barriers to services. Review of these surveys will help continually inform staff from each organization, as well as stakeholders, of the success of the project.

- e) A Collaboration survey will be collected at least annually across partner agency staff to help identify levels of collaboration, and improvement in collaboration across the five years of this project.
- f) A Participant Survey and a Family Survey will be collected at least every six months to identify level of involvement with family and other support persons in each aspect of service.

Please see the Evaluation Chart on the following pages for key learning questions, outcomes, measures, and data sources.

Glenn County Behavioral Health
 Innovation Plan – Crisis Response and Community Connections (CRCC)
 Evaluation Chart

Learning Question	Outcome(s)	Measurement Metric	Data Source(s)
1. To what extent does CRCC lead to improved outcomes?	<ul style="list-style-type: none"> - Increased utilization of mental health services - Culturally relevant, individualized services - Reduced crisis calls - Linkage to services - Reduced mental health symptoms - Reduced substance use - Reduced time spent in jail or diversion from jail - Reduced recidivism 	<ul style="list-style-type: none"> - Mental health service utilization - Case management - WRAP plan developed - Post Crisis Plan developed - Participation in CRCC - Participation in TAY or Harmony House Center - Adherence with prescribed medication(s) 	<ul style="list-style-type: none"> - Anasazi (Cerner) - CRCC Tracking Forms - Jail Census Report - Participant Perception of Care Survey
2. What are the key components of responding effectively to crises in the community for persons of all ages?	<ul style="list-style-type: none"> - Timeliness of CRCC responding to crisis in the community - Timeliness of Sheriff Deputy responding to crisis in the community - CRCC working with individual in community - CRCC working with family in community - CRCC follow-up services after crisis - CRCC Coordination with inpatient staff on release date - CRCC Coordination with jail staff on release date 	<ul style="list-style-type: none"> - Time between crisis call and Sheriff response - Time between crisis call and CRCC response - Follow-up services after crisis - Calls to Crisis after CRCC - Hospitalizations after CRCC - Timely services following inpatient discharge - Timely services following jail release 	<ul style="list-style-type: none"> - Anasazi (Cerner) - CRCC Tracking Forms - Participant Perception of Care Survey - Family member questionnaire
3. What follow-up services and supports are most effective at improving outcomes and reducing crisis and hospitalizations in the future?	<ul style="list-style-type: none"> - Increased utilization of mental health services - Culturally relevant, individualized services - Reduced crisis calls - Linkage to services - Reduced mental health symptoms - Reduced substance use - Reduced time spent in jail or diversion from jail - Reduced recidivism 	<ul style="list-style-type: none"> - Mental health service utilization - Case management - WRAP plan developed - Post Crisis Plan developed - Participation in CRCC - Participation in TAY or Harmony House Center - Adherence with prescribed medication(s) 	<ul style="list-style-type: none"> - Anasazi (Cerner) - CRCC Tracking Forms - Jail Census Report - Participant Perception of Care Survey - Family member questionnaire

Learning Question	Outcome(s)	Measurement Metric	Data Source(s)
4. To what extent does implementation of the CRCC contribute to improved collaboration between a.) GCBH, the Sheriff, Courts, ED, and Probation; and b.) consumers and their families?	<ul style="list-style-type: none"> -Improved coordination and communication among GCBH, the Sherriff, ED and hospital staff, and jail -Timely response to crisis calls in community -Timely follow-up services and community connections -Reduced recidivism, crisis, and hospitalizations -Shared reports to track outcomes and improve services over time -Family members are involved in support services 	<ul style="list-style-type: none"> -Interagency Collaboration Activities Scale (IACAS) -Length of time at crisis; in ED 	<ul style="list-style-type: none"> -Anasazi (Cerner) -IACAS Collaboration Survey -Participant Perception of Care Survey -Family member questionnaire
5. How effective are WRAP and Post Crisis Plans in helping prevent a crisis in the future?	<ul style="list-style-type: none"> -Improved communication between individual; staff; family regarding crisis -Reduced calls to crisis line -Reduced visits to ED -Reduced hospitalizations -Improved communication with family/support persons -Family members are involved in support services 	<ul style="list-style-type: none"> - Participation in mental health services - Participation in case management services - WRAP plan developed - Post Crisis Plan developed -Participation in TAY or Harmony House Center -Adherence with prescribed medication(s) 	<ul style="list-style-type: none"> -Anasazi (Cerner) -CRCC Tracking Forms -Participant Perception of Care Survey -Family member questionnaire
6. To what extent was the program implemented as planned?	<ul style="list-style-type: none"> -Program implemented -Eligible participants referred / receive CRCC Services -Strengthened and increased support for individuals who have a mental illness -Reduced use of crisis line; crisis services; hospitalizations 	<ul style="list-style-type: none"> -Staff hired or designated to the CRCC program -Number of individuals referred to the CRCC -Number of individuals enrolled in the CRCC -Number of crisis calls -Number of ED visits -Number of hospitalizations 	<ul style="list-style-type: none"> -Anasazi (Cerner) -CRCC Tracking Forms -IACAS Collaboration Survey -Participant Perception of Care Surveys -Family member questionnaire

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

This project will be an GCBH program with a MOU with the Sheriff's Department. The evaluation component of this Innovative Plan will be contracted out to IDEA Consulting. IDEA Consulting has been providing exemplary consultation and evaluation services to GCBH for the past 29 years, and works closely with the Behavioral Health Director, Deputy Director, and management team. This established relationship ensures quality and compliance with regulations.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

Stakeholders have been and will continue to be actively involved in all components of the CRCC Innovative Project. For the planning process, GCBH obtained input from several different stakeholder groups, including clients; Adults; Older Adults; TAY; consumers who utilize the TAY Center and Harmony House; Probation; Glenn County Office of Education, Sheriff's Office and ED staff. With input and planning meetings with stakeholders, GCBH was able to identify the unique needs of its community and an Innovative Project that is well designed for the county.

There has been significant diversity in stakeholders involved in the development of the Innovative Project. A Stakeholder Mental Health Services Act (MHSA) Innovative Project Survey was distributed in Fall 2018. There were 31 respondents to the survey. Results fully supported the development of the CRCC. For the question: Please choose the services that you think may be helpful to the community (check all that apply). The percent of persons selecting each response is shown below:

Service	Percent of Respondents
Crisis Response and Prevention Services	81%
Inpatient Discharge Support	55%
Jail Discharge Support	58%
Crisis Support for CPS Families	52%
Bridge Medications between hospital/jail and Outpatient	58%
Expanded post-crisis services	52%
Safety Check ins	65%
Services for families with youth in placement	65%
Community connections for at-risk populations	58%

Of the 31 persons responding to this survey, 45% were Hispanic, 35% Caucasian, 10% Native American; 3% were Asian; and 7% were more than one race. There were 14% that reported Spanish as their primary language, 4% reported Lao; and 82% reported English. Of the 28 persons responding to age, 7% were 16-25; 61% were 26-45; 25% were 46-59; and 7% were 60+. There were 45% who reported having a disability.

In addition to the survey, focus groups were held at the TAY center and Harmony House drop-in center in the Fall 2018, in preparation for planning for the Innovative Project. At the TAY center, youth recommended that there was 1) an increase in preventive care before a crisis in the community; 2) an increase in check-ins post crisis; 3) an increased partnerships with other agencies to increase TAY opportunities; 4) increased housing support for TAY and families. Persons attending the consumer Voice Stakeholders meeting at Harmony House recommended: 1) more support before going / prevention services to a high level of care with immediate support; 2) increased linkage and follow-up that supports with daily life needs; 3) more outreach to meet the needs of this time: post CAMP Fire; 4) a local homeless shelter; 5) support to individual with post-crisis with access to services immediately; and 6) support to individuals with follow-up after crisis.

Stakeholder diversity is always valued and includes participants of various ages (16 and older), gender, LGBTQ, veteran status, and consumer status. This broad diversity in stakeholders provides important input and feedback throughout the planning and evaluation activities. The proposed Innovative Plan integrated stakeholder input, results from a community survey, and input from planning meetings with the Sheriff's Office, Probation, and ED staff to identify needs and develop a CRCC that will be successful in this small county. The planning process also involved discussions at the Behavioral Health Board; System Improvement Committee; Quality Improvement Committee; Cultural Competence Committee meetings; and at staff meetings, to obtain input and strategies for designing a CRCC process that will be successful in this small community. All stakeholder groups and boards are in full support of this MHSA Innovative Plan. These stakeholders provided meaningful involvement in the areas of mental health policy; program planning; implementation; monitoring; quality Improvement; evaluation; and budget. Note: Interpreters are always available during stakeholder events to provide translation services for mono-lingual Spanish speaking clients. Surveys were available in English and Spanish.

In addition to the comprehensive planning process and developing the CRCC model to meet the needs of this county, stakeholders will continue to be involved by providing ongoing input into planning and design of the program; prioritizing services for those in crisis and at-risk of crisis; developing creative methods for engaging, assessing, and meeting the needs of these high-risk individuals; designing the implementation; and participating in evaluation design and review of outcomes.

The MHSA Innovative Plan Stakeholder planning process included a wide representation from the community, social service agencies, law enforcement, probation, education, and persons with lived experience and family members. Interpreters were available to provide translation services for mono-lingual Spanish speaking clients. GCBH conducted focus groups and stakeholder meetings at both the adult wellness center (Harmony House) and the Transition Age Youth

(TAY) Center. In addition to the focus groups, GCBH incorporated surveys during drop-in center events and stakeholder meetings for those who could not attend the focus groups.

Consumers comprised the majority of the focus group participants. These discussions centered on housing and homeless support for youth, families and adults; living skills group ideas for both the drop-in centers; increased immediate support for individuals to prevent higher levels of care (psychiatric inpatient services; crisis services); increase support for individuals following crisis services and hospitalization; assistance in navigating through system hoops; increased coordination with partner agencies to increase TAY opportunities, and overall satisfaction with the current MHSA services. The ideas presented by consumers will be used to enhance MHSA services in the coming year.

PUBLIC REVIEW AND COMMENT PERIOD

This proposed INN project was posted for a 30-day public review and comment period from March 26, 2019 through April 24, 2019. An electronic copy was also posted on the County website, with an announcement of the public review and comment period, as well as the public hearing information. The posting provided contact information to allow input on the proposed project in person, by phone, written and sent by mail, or through e-mail. A hard copy of the proposed project was distributed to all members of the Mental Health, Alcohol and Drug Commission; System Improvement Committee; consumer groups; and staff. Copies of the proposed project were available at the clinics in Willows and Orland; at Harmony House (the Adult Wellness Center); at the TAY Center (the youth wellness center); with partner agencies; and at the local libraries. The proposed project was also available to clients and family members at all of these sites, on the County website, and upon request.

A public hearing was held on Thursday, April 25, 2019, at 9:00 am, at the Community Recovery and Wellness Center (CRWC) Annex Conference Room, 1167 Road 200, Orland, CA 95963. 11 individuals participated in the public hearing, including Glenn County Health and Human Services staff, individuals with lived experience, and community stakeholders. Participants included TAY, Adults, and Older Adults; and LGBTQ individuals. The race/ethnicity of the participants included Asian, Hispanic, Native American, and Caucasian. The majority of the participants were female.

Public discussion included clarification on the CRCC Team's coordination with CWS and group homes; and about the state review and approval process. Comments included an appreciation for the LGBTQ elements throughout the proposed plan. There were no substantive recommendations for changes from stakeholders.

The proposed INN CRCC plan was submitted to the County Board of Supervisors for approval during the May 7, 2019 meeting. The County Board of Supervisors approved the proposed plan unanimously.

Upon BOS approval, the proposed plan was submitted to the California Mental Health Services Oversight and Accountability Commission (MHSOAC) for review. Edits to the plan were made

under the guidance of MHSOAC staff, and the document has been submitted to the MHSOAC for approval.

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

- a) *Community Collaboration*
- b) *Cultural Competency*
- c) *Client-Driven*
- d) *Family-Driven*
- e) *Wellness, Recovery, and Resilience-Focused*
- f) *Integrated Service Experience for Clients and Families*

The CRCC services will reflect and be consistent with all the MHSA General Standards. Enhanced community collaboration and coordination of culturally-competent services across county agency partners is one of the primary goals of this Innovative Project. These activities closely align with the General Standards. The CRCC will be multi-disciplinary and foster collaboration and communication across the several agencies involved in this Innovative Project. As a component of the evaluation, a Collaboration Survey will be utilized to demonstrate improvements in communication and collaboration across the various agencies involved in the project.

All services will be culturally and linguistically competent. It is the goal of GCBH to hire bilingual, bicultural clinicians and case managers, whenever possible, to meet the needs of all persons who are in crisis. In addition, GCBH will strive to provide culturally-responsive services to the various cultural groups served, including but not limited to persons who are Hispanic, the LGBTQ community, TAY, adults and older adults, consumers, and family members, to support optimal outcomes. Wellness, recovery, and resilience will be the foundation for all services to deliver culturally responsive services. Beginning with the Brief Wellness and Recovery Screening and Assessment, each person will help identify their strengths and needs, and identify other support persons who can support them during and after a crisis. This process helps each person, and family, to identify goals and strategies to support wellness and recovery. Each person will also be supported in developing a Wellness and Recovery Action Plan (WRAP) to help support their individual resiliency skills to achieve positive outcomes. A Post Crisis Plan will also be utilized to help the individual document key strategies and support persons who can help the individual during and after the crisis.

Families, and other support persons, will also be integrated into all components of the program to provide encouragement, strengthen relationships, and support the individual's goals. Services will be client and family driven, and follow the principles of recovery, wellness, and resilience. The CRCC will strive to provide appropriate, individualized services to each unique person promoting hope, empowerment, and recovery. Through collaboration across agencies, the CRCC will provide an integrated service experience for individuals and their families. The

CRCC will collaborate and communicate across the several agencies involved in this Innovative Project, facilitating community connections to the continuum of care for the individual and their family.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

It is the goal of GCBH to hire bilingual, bicultural clinicians and case managers, whenever possible, to meet the needs of all persons who are in crisis. GCBH will strive to provide culturally-sensitive services to the LGBTQ community, TAY, adults and older adults, consumers, and family members, to support optimal outcomes. The CRCC will facilitate training for law enforcement and behavioral health staff to deliver culturally-relevant services and to respect different cultures; to understand mental illness and substance use behaviors; to learn de-escalation strategies; and to respect family diversity and facilitate family engagement.

Stakeholders have been and will continue to be actively involved in all components of the CRCC Innovative Project. This involvement includes ongoing input into planning; prioritizing services for those in crisis or just released from the ED/hospital/jail; developing creative methods for engaging, assessing, and meeting the needs of these high-risk individuals; designing the implementation and evaluation activities; and through ongoing funding. Meetings will be held at least quarterly with stakeholders and organizations to discuss implementation strategies, identify opportunities to strengthen services, and celebrate CRCC Team successes. Data on timely response to crisis events, linkages to services, service utilization, and client outcomes will also be reviewed with stakeholders to provide input on the success of the project and the sustainability and/or expansion of services throughout the five years and beyond.

The successful implementation of the CRCC will be self-sustaining. If all components of the CRCC are successful, clients will receive services in a timely manner, at the most appropriate level of care. Key outcomes will show improvement over time and services will be accessible to at-risk individuals in crisis.

INNOVATIVE PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety or keep particular elements of the INN project without utilizing INN Funds following project completion. Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

The CRCC will create the opportunity to develop and strengthen services to individuals who are in crisis or pre-crisis and have a mental health and/or substance use issue. The CRCC will assess each person's health, mental health, and/or substance use needs. Promoting mental health and recovery will be a high priority, as well as the ongoing support necessary to help the individual to resolve the crisis and remain stable in their mental wellness and recovery over time. The

opportunity to learn how to address and reduce crisis situations as well as link individuals to services will also help to identify how to sustain these services after the five-year funding cycle for this project. Services will continue to be available through MHSA funds, county realignment and Medi-Cal funding, so that high-risk individuals in crisis will continue to receive services to meet their needs.

This project will also identify and highlight key components of the program that were effective at meeting the needs of individuals and family members who are Hispanic and, potentially, monolingual Spanish speakers. Levels of engagement and services delivered, reduced recidivism to the ED and psychiatric hospital, coordination with law enforcement, engagement with families, and other elements will be analyzed to improve and sustain services over time.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

- A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?*

Meetings will be held at least quarterly with stakeholders and organizations to discuss implementation strategies, identify opportunities to strengthen services, and celebrate the CRCC Team's successes.

Data on access to services, service utilization, and client outcomes will also be reviewed with the CRCC and various stakeholders to provide input on the success of the project and the sustainability and/or expansion of services throughout the five years and beyond.

GCBH will share results, successful practices, and lessons learned to other counties, small and large, through county forums, such as CBHDA, small counties meetings, and NorQIC. GCBH will disseminate information to other counties on the crisis response of a CRCC in supporting persons to resolve their crisis in the community, whenever possible. In addition, GCBH will provide information on the effectiveness of early intervention on reducing the length of stay in the hospital. GCBH will also share concepts for reducing the amount of time law enforcement spends at the scene and in the ED, so that an officer is available to respond to other community emergencies.

GCBH is committed to disseminating lessons learned from the CRCC project to help increase the success of similar projects implemented in other counties in the future.

- B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.*

Crisis response; de-escalation; mental health; substance use; serious mental illness.

TIMELINE

A) Specify the expected start date and end date of your INN Project

GCBH anticipates that the CRCC will begin engaging eligible individuals by July 1, 2019. This date will allow time for MHSOAC approval; MOU development and execution; staff hiring and training; and collaborative implementation of the policies, forms, and protocols necessary to the project. Innovation funding for this project will end on June 30, 2024. (Dates may vary depending upon the date of MHSOAC approval.)

B) Specify the total timeframe (duration) of the INN Project

It is anticipated that the CRCC Team will be funded through MHSOAC Innovation funds for five (5) years to help us learn how to effectively deliver crisis response and community connects to improve outcomes for clients and family members.

C) Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

Please refer to the timeline, included on the next pages. Please note that the following timeline shows the order of the implementation of the various activities. The actual start date will be based upon the date the Innovative Plan is approved by the MHSOAC.

Bibliography

Skubby, D., Bonfine, N., Novisky, M. Munetz, MR; Ritter, C. Community Mental Health Journal (2013) 49: 756. <https://bit.ly/2HI5wFb>

Glenn County Community Response and Community Connections Team
 Timeline of Key Implementation Activities

KEY IMPLEMENTATION ACTIVITIES	YEAR 1				YEARS 2-5			
	2018-2019				2019-2023			
	1	2	3	4	1	2	3	4
Staffing and Pre-Implementation Activities								
Hire/identify CRCC Clinicians, Case Managers; MOU for Sheriff's Deputy	●							
Contract with Evaluator	●							
Purchase materials for selected evidence-based practice(s), if needed	●							
Meet with the CRCC Team to discuss step-by-step process	●							
Training and Supervision								
Train new CRCC members on recovery, wellness, crisis response, Motivational Interviewing, Trauma-Informed CBT, community resources, evidence-based practices (EBPs), de-escalation techniques, WRAP, Post Crisis Plans, documentation standards, and HIPAA regulations	●	●						
Train new CRCC members to implement the core elements of the CRCC mission and vision	●	●						
Provide ongoing supervision of the CRCC model (principles, techniques, outcomes)	●							→
The CRCC Team develops process for engaging, motivating, and implementing program	●							→
Engage Clients								
Identify individuals who are in crisis or in pre-crisis and have a mental health and/or co-occurring substance use issue that impacts their daily functioning	●							→
Hospital staff identify persons who are ready to be discharged from the psychiatric inpatient hospital and refer the person to the CRCC Team	●							→
Jail staff identify persons with a mental illness who are ready to be released from jail and refer the person to the CRCC Team	●							→

KEY IMPLEMENTATION ACTIVITIES	YEAR 1				YEARS 2-5			
	2018-2019				2019-2023			
	1	2	3	4	1	2	3	4
CWS staff identify persons who are in crisis and refer the person to the CRCC	●							▶
Enroll clients in the CRCC	●							▶
Assess each person’s mental health and substance use status	●							▶
Engage family members in program (as feasible)			●					▶
Deliver Services								
Deliver the CRCC person-centered behavioral health services, including co-occurring substance use services	●							▶
Deliver the CRCC services in the community to help de-escalate the crisis and reduce the need for ED and hospitalization	●							▶
The CRCC Team coordinates with hospital discharge staff and jail staff to coordinate services on the day of release into the community	●							▶
Collect baseline data on key indicators; periodically track progress	●							▶
Link clients to other community services, as needed	●							▶
Involve family members in services, when appropriate	●							▶
Provide service coordination and ensure continuity of care to improve outcomes	●							▶
Deliver culturally-appropriate services and services in the client’s preferred language, whenever feasible	●							▶
Offer trainings and workshops to clients and family members on health, wellness, and recovery	●							▶
Collaboration and Information-Sharing Between Agencies								
Develop an MOU between key agencies to provide coordinated, collaborative services to CRCC clients	●							

KEY IMPLEMENTATION ACTIVITIES	YEAR 1				YEARS 2-5			
	2018-2019				2019-2023			
	1	2	3	4	1	2	3	4
Develop Releases of Information and Consent for Treatment forms to share information between appropriate CRCC staff members, and implement procedures for collecting forms	●							→
Hold quarterly CRCC meetings, with key partners to identify and improve continuity of care	●							→
Create and maintain the capacity to coordinate services with community partners to improve outcomes	●							→
Data Collection, Evaluation, and Reporting								
Develop evaluation data collection forms to collect evaluation data	●							
Train the CRCC staff to reliably collect data and submit it in a timely manner	●	●						
Develop summary data reports on service delivery, recovery and wellness, and client outcomes to the CRCC and other stakeholder groups.		●						→
Share summary data reports with the CRCC consortium, county Quality Improvement Committee, clients, and family members		●						→
Submit required reports to MHSOAC		●		●		●		●

Section 4: INN Project Budget

Glenn County CRCC Project Budget

1. All Funding Sources – by Category and Fiscal Year

	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Total
	Year 1	Year 2	Year 3	Year 4	Year 5	
Personnel	389,053	423,330	436,478	450,347	450,347	2,149,556
Operating	69,500	69,500	69,500	69,500	70,023	348,023
Contracts	27,500	27,500	27,500	27,500	27,500	137,500
Evaluation	12,000	12,000	12,000	12,000	12,000	60,000
Administration	28,500	28,500	28,500	28,500	28,500	142,500
Total	526,553	560,830	573,978	587,847	588,370	2,837,579

2. Funding – by Funding Source and Fiscal Year

	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Total
	Year 1	Year 2	Year 3	Year 4	Year 5	
Medi-Cal	302,101	302,101	302,101	302,101	302,101	1,510,507
2011 Realignment	22,075	22,075	22,075	22,075	22,075	110,375
Other Revenues	57,500	57,500	57,500	57,500	57,500	287,500
Innovation	144,877	165,292	159,122	159,122	159,122	787,535
Rollover		13,862	33,179	47,049	47,572	141,662
Total	526,553	560,830	573,977	587,847	588,370	2,837,579

Budget Narrative

1. Personnel Costs – This line items includes salaries and benefits for the GCBH members of the project team, including clinicians (2.0 FTE) and case Managers (2.0 FTE). Staff are bilingual and bicultural, when available. Expenditures in this category are based on current County Personnel Salary tables.
2. Operating Costs – This category includes support staff time; project-related facility costs, such as rent; and other operating expenses including communications, office supplies, utilities, IT, and janitorial services. Expenditures are based on historical costs.
3. Consultant Costs/Contracts – This category covers the expenses associated with the Sheriff’s Deputy (0.5 FTE) assigned to the project.
4. Evaluation – This line items covers project evaluation, which will provide an assessment of project access and effectiveness as well as client-level outcomes achieved.
5. Administration – This category includes administration costs, including A-87, associated with the project.

providers, (6) The housing crisis in San Francisco yields already scarce housing alternatives.

San Francisco County received approval from the Commission on February 26, 2015, for two years and \$500,000.

The Commission approved an extension request of funding and time on July 28, 2016, for an additional \$635,000 and an additional two years.

The County underestimated the funding and time required to complete this project successfully with the following challenges:

- 1). The County found that an increase in homelessness and isolation amongst low-income seniors, aggregated the demand for and urgency of this project.
- 2.) The initial proposal shows a three-phase timeline: start up (six months); implementation (12 months); and a final phase for reflection, evaluation, and dissemination (six months). This timeline had a very small window for any unforeseen obstacles or barriers to the project.

The Commission approved a second extension of time and funding on June 5, 2018 for one year and \$170,250.

There were two main objectives for requesting a one-year and additional funding of \$170,250:

- 1). Add additional interventions to engage ethnically diverse populations and reach out to the hardest to reach isolated seniors, who have no connections to services.
- 2). To provide The Curry Senior Center Evaluation Team more time to implement assessment tools and evaluate the impact of the program.

The Need

San Francisco County, in numerous discussions with Commission staff, indicated that it has encountered several unanticipated challenges and delays in the project including difficulty in the outreach process to contact Socially Isolated Older Adults. The County made over 75 presentations to communities to cultivate referrals from those not connected but found most were connected. Though connected, there were huge gaps with loneliness and isolation, fear of losing their control and loss of independence. Additionally, San Francisco County completed presentations with six (6) peer staff. The number of peers to reach the communities, especially the Tenderloin district was insufficient to make the number of connections to meet the learning objectives. As a result, San Francisco County created four (4) social events to draw seniors out of their Single Room Occupancy (SRO), which proved more successful. The County also encountered problems with development, training, and administration of the “Peer Outreach Program – Baseline Questionnaire.” It was recently completed and only administered consistently to five (5) older adults and inconsistently to many older adults. In this population, many experience numerous health problems as well as death, rendering consistent information gathering difficult. The additional funding will allow the

County more time to administer the questionnaire to more older adults and assist with data collection, analysis, and distribution of learnings.

Due to the challenges described above, the County was not able to successfully provide the services needed by the Socially Isolated Older Adults and measure the outcomes of services that have proved efficacious.

The Response

In order to remedy the enduring challenges, the County proposes to utilize this third extension of time and money to hire additional Peer Staff and provide professional development trainings as well as specialized trainings in understanding the needs of older adults including Understanding Trauma for Aging Seniors, Dementia Signs and Symptoms, and the Grief and Loss Process.

San Francisco County intends on using the additional funding to meet the following needs:

- Increase the number of administrations and consistently administer every six (6) months, the *Peer Outreach Program-Baseline Questionnaire*.
- Create more events to draw out, motivate and encourage older adults to stay engaged in community activities as well as formulate relationships
- Peers will have more time to link services, including housing
- Allow more time for peers to establish relationships through rapport building and trust
- Foster the new relationships and referral sources, in order to strengthen learning about the effectiveness of a peer to peer system, for those who are not just socially isolated but also disconnected from services
- Allow for qualitative and quantitative data to be collected
- Identify what supportive services are needed for this population
- Provide professional development trainings for peer staff such as identifying signs of Dementia, Understanding Trauma, and dealing with Grief and Loss
- Hire additional peer staff who have skills in culturally and linguistic competency
- Increase social connectedness, strengthen support for recovery and wellness, and increase access to mental health services which supports utilizing a peer to peer model

The County's reviews of the project and lessons learned revealed that additional components were needed to make this project successful.

1. Participation in the programs offered by The Curry Senior Center, included development and administration of the Peer Outreach Questionnaire.
2. Hiring cultural and linguistically competent peers.
3. Training and professional development for peer staff.

4. Provide specific professional training for peers; content focused on older adults' issues such as Dementia, Understanding Trauma for Seniors Aging Process and dealing with Grief and Loss.
5. Creating events and presentations to draw out older adults to the programmatic opportunities The Curry Senior Center offers.
6. Difficulty with outreach in the Tenderloin District due to fear of being on the streets with the high rates of crime and drug use.
7. Single Room Occupancy (SRO) frequently had broken elevators, denying accessibility and limiting older adults' ability to get downstairs to events and services.
8. Collect more qualitative and quantitative data for learning purposes and transfer of this seemingly successful project to another funding source for continuation of services.
9. Hire a contractor to analyze data, interpret and generate a report.
10. Provide professional training to peers; content focused on older adults' issues such as Dementia, Understanding Trauma for Seniors Aging Process and Grief and Loss.

The Innovation project required development of the assessment tool known as The Peer Outreach Program – Baseline Questionnaire. The questionnaire went through several revisions, which took longer to complete. Since its' completion, the County consistently administered the questionnaire to only five (5) older adults. More data is required to properly answer the learning objectives and complete the evaluation report.

In addition, the County reflected that peers providing services to the older adults required more time to establish rapport and build trust before they could provide education and build relationships as well as offering linked services. Initially, peers were scheduled for one (1) hour visits due to limited staff and needed four to six (4-6) hours to begin building rapport with the older adults, to lay the foundation for a relationship. With limited peer staff, the County found it difficult to team the older adults up with a culturally and linguistically competent peer. Some older adults waited to be scheduled at time when they could be teamed up with a peer who could speak their language, as a result of limited peer staff. In addition, provide peer staff training and professional development including specific problematic issues of older adults such as Dementia, Understanding Trauma for Senior Aging Process and dealing with Grief and Loss. Training has taken longer, as peer staff transition in and out of the role over the past few years.

In an effort to draw the older adults out of their rooms, numerous presentations were conducted in various areas and yielded little results due to transportation problems, the inability to get out of their SRO's due to elevator problems, fear of the unknown, safety concerns from living in a high crime/drug area, and lack of skills to build relationships after periods of isolation.

Further, the County states that they need to collect more consistent qualitative and quantitative data as well as hire a contractor to analyze the data and formulate the

evaluation report. **If this extension is not approved, the County will not have enough data or be able to hire a contractor to analyze and formulate a final report.**

Learning Objectives and Evaluation

- Incorporate a culturally informed training curriculum, supervision/support plans, and engagement strategies and tools to improve San Francisco’s system of support for socially isolated older adults
- To build effective partnerships between individuals and organizations that promote mental health outcomes through peer support services and other programs for socially isolated older adults at risk of or with a mental illness.
- To develop a more coordinated system of care and support for socially isolated older adults

There is an expectation that this project will strengthen San Francisco’s network of peer support services, increase linkages among mental health providers, and older adults’ systems of care, enhance skills that foster the ability for older adults to develop and maintain relationships, and be active members of the community. The project will also increase a team of peer support staff that are focused on the needs of socially isolated older adults and thereby promote positive mental health outcomes. San Francisco’s peer-based model embodies principles of recovery and wellness by building strong relationships with peers, and by developing and providing a system of support for peer supporters.

In addition to the County’s system goals, the primary goal for this project is to increase social connectedness through peer support and relationship building, strengthen support for recovery and wellness, increase access to mental services and provide additional linked services. In addition, the project endeavors to support recovery and personal and professional development of peer staff.

The program will administer the Peer Outreach Program – Baseline Questionnaire to track perceived and actual isolation and connectedness. Peer staff will be trained to administer the Questionnaire at first point of contact and consistently, every six months thereafter. The program will also collect information about peer experiences and most helpful practices in their work with socially isolated older adults.

The new contractor will analyze the results of the qualitative evaluations and complete the final evaluation report. The County stated that they will also evaluate the community partnerships for increased value and collaboration. Currently, the County’s primary partnership is with The Curry Senior Center in San Francisco.

The Budget

The County is seeking to use the requested amount of \$195,787 of additional funding for hiring peer staff and increase the number of connections with older adults, while consistently administering the initial and subsequent timed interval administrations of the Peer Outreach Program – Baseline Questionnaire. The peer staff are trained in the administration of the questionnaire and need more older adults' consistent participation. The additional funding will also help with professional development for peers. Specifically, the funding will support older adults focused issues including Understanding Trauma for Aging Seniors, recognizing signs of Dementia, and dealing with Grief and Loss. In addition, the County will hire a contractor to assist with data analysis and completion of the Final Project Report.

Additional Regulatory Requirements

The proposed project extension appears to meet minimum requirements listed under the MHSA Innovation regulations.

Comments

Commission staff conducted a site visit of The Curry Senior Center on August 29, 2019, and met with staff from the County, The Curry Senior Center and currently engaged peers. The staff discussed problems that delayed project implementation such as questionnaire development, difficulty in hiring and training peers, and problems drawing out and connecting peer staff with the socially isolated older adults.

The Curry Senior Center and County staff articulated the concerns about completing the project including the dissemination of lessons learned, delays in project implementation and reaching those in need of the services. The Peer staff shared their need to connect with more socially isolated older adults to administer the questionnaire and more importantly, serve those in need.



City and County of San Francisco
London N. Breed
Mayor



San Francisco Health Network
Behavioral Health Services

Irene Sung, MD
Interim Director

April 5, 2019

Toby Ewing
Executive Director, Mental Health Services Oversight & Accountability Commission
(MHSOAC)
1325 J. Street, Suite 1700
Sacramento, CA 95814

Dear Toby Ewing:

We would like to submit this funding increase request for the following San Francisco Mental Health Services Act (MHSA) Innovation Project: *Addressing the Needs of Socially Isolated Older Adults*. The MHSOAC approved this program on June 5, 2018 for the *five (5)*-year term of July 1, 2015 to June 30, 2020. The *Addressing the Needs of Socially Isolated Older Adults* was approved for \$1,305,250 over the aforementioned five-year period.

We are requesting an increase of (*15% of the overall budget*): **\$195,787**.

Addressing the Needs of Socially Isolated Older Adults

Program Summary

The *Addressing the Needs of Socially Isolated Older Adults* provides peer-based outreach and engagement services to socially isolated older adults with mental health concerns living in the Central neighborhoods of San Francisco, including the Tenderloin. The primary purpose of the project is to increase social connectedness; strengthen support for recovery and wellness; and increase access to mental health services and support. The program achieves this by engaging and connecting socially isolated adults with social networks and behavioral health services through the use of the peer-to-peer model. Peer Outreach Specialists create linkages to community resources, treatment services, and social activities and provide services from strengths-based, wellness and recovery-oriented, and harm reduction-based approaches.

Clients are reached in the following settings: the streets, meal sites, drop-in centers, and Single Room Occupancy hotels. Programming includes regular monthly themed group events and special events, as well as one-on-one peer support.

Specifically, the project does the following:

- Provides a culturally-informed training curriculum, supervision/support plans, and engagement strategies and tools – which improve the system of support for socially isolated older adults.
- Builds effective partnerships between individuals and organizations that provide peer support services and programs for socially isolated older adults.
- Develops a more coordinated system of care for socially isolated older adults.

Original Learning Questions

Learning Question #1: Will using a peer-to-peer system effectively engage, empower, and instill protective factors for adverse mental health outcomes for socially isolated older adults living in the highly depressed neighborhood of the Tenderloin in San Francisco?

Learning Question #2: What kinds of support are most needed by peer supporters in their learning as mental health professionals, as well as in their recovery journey from mental health challenges?

Justification for Request

As Addressing the Needs of Socially Isolated Older Adults enters its final year of Innovations funding, the following objectives could serve to enhance the impact of the program:

1. **Program Evaluation:** Hire an independent Program Evaluator to continue to measure the impact the Peers have made on program participants at baseline, six months, and one year.
2. **Final Innovations Report:** Hire an independent contractor to analyze five years of program reporting and data collecting and help writing a Final Innovations Learning Report. This evaluator can also assist with crafting proposals for securing additional funding.
3. **Professional Development:** Support the current Peer staff in their professional development through trainings and conferences.
4. **Underserved Population:** Explore working with under-served populations in collaboration with the Transgender Pilot Project.

Objective 1 – Program Evaluation:

An Independent Program Evaluator would benefit the program by reducing the possible bias that can occur in assessing the clients for isolation and loneliness, through the use of validated measuring tools (mentioned more in detail in the paragraph below). Currently, Peer Outreach Specialists conduct these assessments concurrently while carrying client caseloads. An outside evaluator – trained in research and evaluation - not only would provide an unbiased assessment

of the clients enrolled in the program but would also be able to outreach to a larger population of seniors who are not involved directly in the program.

Objective 2 – Final Innovations Report:

A professional grant writer will be able to analyze data and lessons learned culminating in a Final Innovations Learning Report. The data currently collected uses the validated measuring tools of the Duke Isolation Scale, UCLA Loneliness Scale, and a 2Q Depression Questionnaire. Other data collected also includes barriers to socialization, programs frequented, medical and mental health challenges, along with MHSA demographics. The data would need to be analyzed and skillfully reported resulting in our final report. This report would also include a section on possible future funding opportunities.

Objective 3 – Professional Development:

Funding would go towards supporting the current staff in their professional development, and would include attending the Alternatives 2019 Conference, which includes as many diverse perspectives as possible in mental health recovery. This Alternatives Conference is the oldest and largest conference of its kind, organized and hosted for more than three decades by peers for peers. The Alternatives conference is renowned for offering the latest and best information in the peer recovery movement and provides an invaluable opportunity for peers to network with and learn from one another.

Objective 4 – Underserved Populations:

The needs of Transgender seniors have been highlighted by recent system evaluation activities. Most transgender seniors have lost their peers to HIV and other life-threatening issues. They are facing the last chapter of their lives searching for social connections. A funding increase would allow for targeted outreach to the underserved transgender senior population, who, while having opportunities for social group opportunities – through the Transgender Pilot Program – have not, as a group, been the focus of any peer-based one-to-one programming.

Through a budget increase and these additional objectives, the *Addressing the Needs of Socially Isolated Older Adults* program, would strengthen the data and results of its evaluation activities, would further develop staff skills, and deepen learning in regard to working effectively with underserved and marginalized seniors using a peer-based model.

Sincerely,



Irene Sung, MD
Interim Director, Behavioral Health Services



STAFF ANALYSIS— SAN LUIS OBISPO COUNTY

Innovation (INN) Project Name: Holistic Adolescent Health
Total INN Funding Requested: \$660,000
Duration of INN Project: Four (4) years
MHSOAC consideration of INN Project: October 2019

Review History:

Approved by the County Board of Supervisors: July 16, 2019
 Mental Health Board Hearing: June 19, 2019
 Public Comment Period: May 17, 2019 - June 18, 2019
 County submitted INN Project: July 25, 2019
 Date Project Shared with Stakeholders: June 4, 2019 and August 6, 2019

Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D):

Primary Purpose of INN Project:	
<input type="checkbox"/>	Increases access to mental health services to underserved groups
<input checked="" type="checkbox"/>	Increases the quality of mental health services, including measured outcomes
<input type="checkbox"/>	Promotes interagency and community collaboration related to Mental Health Services, supports or outcomes
<input type="checkbox"/>	Increases access to mental health services, including but not limited to services provided through permanent supportive housing
This Proposed Project meets one of the following criteria:	
<input checked="" type="checkbox"/>	Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
<input type="checkbox"/>	Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
<input type="checkbox"/>	Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
<input type="checkbox"/>	Supports participation in a housing program designed to stabilize a person’s living situation while also providing supportive services on site

Project Introduction:

In collaboration with the Community Action Partnership of San Luis Obispo (CAPSLO) and two local SLO county high schools, San Luis Obispo County is requesting authorization to use up to \$660,000 of innovation spending authority over a four-year period.

The project proposes to incorporate mindfulness skills training and voluntary one-on-one health coaching (provided by trained Health Educators), who will provide additional support for interested students in the areas of mental, physical, and sexual health education into the current health curriculum for students aged 13-18. This new interwoven health education model will add 15 sessions of mindfulness training in conjunction with the current health curriculum to deliver a more holistic approach.

What is the Challenge or Problem?

San Luis Obispo reports an 11% increase in child abuse and a 17% increase in foster children, which both increase the potential risk of mental health issues. Suicide rates are reported to be 50% higher than the state rate. In the County, 33% of 11th graders reported feeling chronic sadness and feelings of hopelessness within the previous 12-month period. The County reports 19% of ninth graders in one school district have considered suicide, while another 5% considered suicide in a neighboring school district.

San Luis Obispo lacks a school-based curriculum that integrates mental, physical, and social health practices into school programs. The current student curriculum lacks a connection between these three components necessary for holistic health and wellbeing.

With the increasing need for teens to be able to cope effectively with stress, anxiety, depression and other behavioral symptoms, school officials and staff are seeking resources to help students. The County asserts the incorporation of mindfulness skills training and voluntary one-on-one coaching for teens will be instrumental in detecting early signs of behavioral health issues, ultimately leading to earlier intervention efforts.

What is the Innovation?

San Luis Obispo would like to test if incorporating mindfulness training and one-on-one coaching into the existing health curriculum will result in adolescents (ages 13-18) making better, more positive choices regarding their health and overall wellbeing. The Community Action Partnership of San Luis Obispo (CAPSLO), a nonprofit community-based organization, has been providing health education for the County's local high schools and middle schools since 1977, in compliance with California Department of Education requirements. The current sexual health curriculum, also in compliance with Department of Education requirements, utilizes the Positive Prevention PLUS program and is considered evidence based. Additionally, in partnership with another community-based organization (Community Health Centers), school-based programs for adolescents have also been centered on fitness and nutrition and prevention of obesity.

In continuing their partnership with San Luis Obispo County, CAPSLO will expand upon the current curriculum at two high schools within two of the County's school districts who currently receive very limited services through CAPSLO. These specific school districts were selected due a large number of ninth grade students (33% in Lucia Mar Unified School District and 31% San Luis Coastal Unified School District) who had indicated experiencing feelings of chronic sadness or hopelessness. Further, 19% and 15% of those same students in those two school districts indicated they had seriously considered attempting suicide, respectively (CalSCHLS, 2018). Implementing these comprehensive wellness models at these two school sites is extremely important in detecting and providing early intervention efforts.

This project will provide training to Health Educators and project staff located at the two selected high schools. The County, in partnership with CAPSLO, will develop elements of a new curriculum and delivery model to include 15 sessions of mental, physical, and sexual health education along with voluntary one-on-one meetings with a Health Educator up to twice per month as part of the student's health classes. Health Educators will receive an estimated 200 hours of medically accurate and evidence-based training in the following areas (**see pgs 14-15 of project plan for complete areas of trainings**):

Mental Health:

motivational interviewing, mindfulness training, and cognitive behavioral therapeutic approaches

Physical Health and Nutrition:

dietary guidelines and USDA nutrition guides, diabetes education

Sexual Health (includes social and emotional health):

LGBT ally / youth engagement, transgender toolkit, Positive Prevention PLUS sexual health education, trauma informed classroom management, domestic violence disclosure and mandated reporting

Once Health Educators have completed their training, they will be evaluated by other trainers by participating in mock teaching sessions and co-teaching and will receive ongoing support from supervisors and trainers. With the inclusion of mindfulness training and one-on-one health coaching, it is the goal that students will learn more effective ways to reduce stress, negative emotional reactivity, and make better behavioral health decisions.

This project will utilize Health Educators and project staff to provide a comprehensive, student-driven whole health approach and will allow for the collection of data to identify areas of student needs. This project will also focus on obtaining data regarding physical health outcomes resulting from intentional use of mindfulness practices.

Learning Objectives and Evaluation

San Luis Obispo County seeks to learn whether the utilization of mindfulness training as well as one-on-one coaching embedded within high school health curriculum results in changes/improvements in mental, physical, and sexual behavior among teens 13-18

years old. The project will meet the primary purpose of increasing the quality of mental health services, including measured outcomes. Students between the ages of 13-18 attending either Morro Bay High School or Lopez Continuation High will be targeted, with the County anticipating that approximately 120 students will be served annually for an expected total of 360 students.

To guide their project, SLO has identified several learning goals aimed at determining whether or not the holistic approach to health curriculum, inclusive of mindfulness training and on-on-one coaching, can increase an individual's ability to cope with stress and anxiety, and make healthier decisions relative to mental, physical, and sexual well-being. Additionally, the County hopes to learn what types of methods are effective and appropriate in detecting mental health related issues. The learning goals identified by the County are appropriate and meet the primary purpose and overall need presented by the County.

To gather the data necessary, the County will contract with an outside evaluator to develop pre- and post- assessment surveys, which will also provide the county with baseline data. Specific measures will come from survey items as well as key indicators from motivational interviews and include measures relative to perceived stress levels and behavioral intent as they relate to an ability to alleviate stress, and make healthy decisions relative to nutrition, physical activity and relational communication.

At the conclusion of the project, SLO will share findings and lessons learned through quarterly reports, newsletters and social media platforms. Additionally, the County will create a report inclusive of testimonials of students, parents, and school staff that will be shared with local and state agencies and stakeholders.

Additional Regulatory Requirements:

The Community Program Planning Process

San Luis Obispo held their 30-day public comment period beginning May 17,2019 through June 16, 2019, followed by their Behavioral Health Board meeting on June 19, 2019. Board of Supervisor approval was received on July 16, 2019.

The County began their robust stakeholder engagement process in October 2018 to collaborate, research, and yield new proposed innovation projects based upon community input and expressed need. Stakeholders submitted innovation ideas thru the County's "Innovation Creation Station" which allows stakeholders to submit innovation ideas and concepts to be vetted for community feedback. The County's innovation stakeholder group then met to score all the received innovation ideas and ranked them by priority which led to the development of two projects, this project included.

The County held various public planning sessions which includes, but is not limited to the following community stakeholders: family members and consumers, Behavioral Health Board members, members of underserved / unserved communities (Promotores, the Gay and Lesbian Alliance, and members of the cultural competence committee), consumers and representatives from the National Association of Mental Illness (NAMI), the Peer

Advisory and Advocacy Committee, mental health providers, peer advocates and members from various county and communities agencies (probation, County Office of Education, Drug and Alcohol counselors). Planning sessions included community members from LGBTQ, Veterans, Youth and Older Adults and individuals experiencing homelessness. The County states stakeholders, including consumers and family members, have been and will continue to be actively involved in all phases of the innovation project.

The County received letters of support for this project during their Behavioral Health Board meeting from various organizations within their community and six comments were received which was included in the final plan. (**see pgs 8-9 of project plan**). Based on communications and interactions with the County, Commission staff feels strongly that the County worked in good faith to incorporate stakeholder feedback and concerns into this finalized project.

Commission staff originally shared this project with stakeholders on May 17, 2019 and again on June 4, 2019 while the County was in their 30-day public comment period and comments were to be directed to the County for inclusion, if substantive feedback was given. No letters of support or opposition were received by Commission staff when shared with stakeholders on the two dates referenced above. On August 6, 2019, the final version of this project was shared with stakeholders. The sharing of the project in August 2019 yielded one comment in response but was neither supportive or oppositional, more so providing suggestive changes, none of which were deemed substantive. Considering transparency and with permission granted from the stakeholder, the feedback received was shared with the County.

Additionally, this project was shared with the Youth Project Planning Committee on August 16, 2019 and yielded two comments in response. The first comment, although positive, cautioned the County to ensure the youth-centered curricula includes methods to avoid youth tokenization. The second comment appreciates the use of mindfulness skills training among adolescents and appreciates the holistic approach.

As part of MHSAs General Standards, San Luis Obispo County will depend heavily upon community collaboration via a diverse and culturally appropriate stakeholder advisory board during all phases of this project. The County intends to utilize culturally and linguistically appropriate staff to engage the youth and will monitor the project for any discrepancies in services which will be tracked and analyzed as part of the dissemination of project findings. This project is client-driven to engage youth as its target population and is focused on the needs of the consumers with the support of family members with emphasis based on recovery, wellness, and resilience.

The Budget

San Luis Obispo is requesting approval to utilize \$660,000 of MHSAs Innovation funding over a four (4) year project duration. Personnel costs in the amount of \$266,301 represent 40% of the total budget and cover the expenses of hiring the following staff:

- 2 Health Educators

- 1 Sexual Health Education Coordinator
- 1 Wellness Project Supervisor
- 1 Youth Programs Administrative Assistant
- 1 Youth Programs Director
- 1 Division Director

Direct and indirect costs in the amount of \$333,699 (50% of total project) cover expenses to maintain program supplies, vehicle maintenance, leasing of office space and related utility expenses, office equipment maintenance, and telephones for program staff.

Evaluator costs are estimated to be \$60,000 (9% of total project) and will cover data collection, analysis, and statewide dissemination. This amount allotted for evaluation appears to be adequate considering the current health curriculum has been provided for over 40 years to the district and evaluation will focus primarily on the additional elements of mental health and mindfulness.

If the utilization of mindfulness skills training combined with the existing health curriculum proves to be successful in reaching the learning objectives, the County may consider sustaining this project by seeking funding from stakeholder grants, local partnerships, community groups and health agencies.

Pursuant to Assembly Bill 114, there are no funds subject to reversion that are being utilized for this innovation project and no other funding will be utilized to leverage the cost of this project.

Review of CCR Section 3930 requirements:

The proposed project appears to meet the minimum requirements listed under MHSIA Innovation regulations.

Comments:

This innovation from San Luis Obispo is timely as the Commission has shown support for recent projects related to youth and mental health and the provision of support and coping skills for youth may result in the detection and prevention of mental illness that may disrupt functionality later in life.

References:

<https://capslo.org/>

CalSCHLS (2018). California Health Kids Survey. Retrieved from:
https://data.calschls.org/resources/Lucia_Mar_Unified_1718_Sec_CHKS.pdf

CalSCHLS (2018). California Health Kids Survey. Retrieved from:
https://data.calschls.org/resources/San_Luis_Coastal_Unified_1718_Sec_CHKS.pdf



STAFF ANALYSIS— SAN LUIS OBISPO

Innovation (INN) Project Name: San Luis Obispo Threat Assessment Program (SLOTAP)

Total INN Funding Requested: \$879,930.40

Duration of INN Project: Four (4) Years

MHSOAC consideration of INN Project: October 2019

Review History

Approved by the County Board of Supervisors: July 16, 2019
 Mental Health Board Hearing: June 19, 2019
 Public Comment Period: May 17, 2019 to June 18, 2019
 County submitted INN Project: September 10, 2019
 Date Project Shared with Stakeholders: May 17, 2019 and September 13, 2019

Statutory Requirements (WIC 5830(a)(1)-(4) and 5830(b)(2)(A)-(D)):

Primary Purpose of INN Project:	
<input type="checkbox"/>	Increases access to mental health services to underserved groups
<input type="checkbox"/>	Increases the quality of mental health services, including measured outcomes
<input checked="" type="checkbox"/>	Promotes interagency and community collaboration related to Mental Health Services, supports or outcomes
<input type="checkbox"/>	Increases access to mental health services, including but not limited to services provided through permanent supportive housing
This Proposed Project meets one of the following criteria:	
<input type="checkbox"/>	Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
<input checked="" type="checkbox"/>	Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
<input type="checkbox"/>	Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
<input type="checkbox"/>	Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services on site

Project Introduction:

San Luis Obispo is requesting authorization to use up to \$879,930.40 of innovation spending authority over a four-year period to develop a pilot training program for threat assessment that will adapt mainly legal and criminal based threat assessment models used in larger counties, as well as provide an opportunity for the expansion of this practice, if effective to other counties..

The project proposes to deliver a new system to learn, assess, and intervene during imminent threats. It will promote interagency and community collaboration by working with law enforcement, mental health systems and the educational system to create a more cohesive approach to the prevention and intervention of school-based threats.

What is the Challenge or Problem?

The County reports that due to the fragmented agency and departmental information sharing and/or processes regarding training, assessing, managing, or handling serious or potential threats, they are left vulnerable and unable to effectively manage school bases threats (page 35). Individual organizations (law enforcement, education, behavioral health) in the county are managing threats and performing assessments but there is no collaboration or communication between these entities. Furthermore, there is no standardized training developed or performed in each of these agencies.

The County is also concerned that these threats should not be characterized as being made by persons with mental health issues only and the lack of strategies to either remediate stigma or help with post-traumatic stress for the victims of an incident poses other challenges.

There have been 5 documented threats or adverse actions in the county and in its surrounding areas, however the county feels that without a coordinated system, it is at a disadvantage for assessing and preventing these types of situations (especially in the schools). There is no coordinated information sharing, training or reporting between law enforcement, educational institutions and behavioral health entities who respond to various threats or perform certain assessments, that would enable the county to be able to manage any potential threats.

What is the Innovation?

As a response to these isolated, inconsistent and ineffective methods of recognizing or addressing threats (page 35), the County is proposing to establish a pilot training program with 4 key components:

- (1) Development and implementation of a SLO-centric threat assessment model,
- (2) Collaboration and training,

- (3) Educating the community, students, parents, mental health professionals and Community Based Organizations (CBO)
- (4) Mental Health Capacity Building,

“By creating an integrated system, all agencies involved will gain a holistic understanding of the psychological, social, and family components that might explain the result of threat behavior. This in turn will lead to a focus on variables needing intervention and prevention rather than highlighting only the threatening behavior for discipline (page 37)”.

The County reports that it had initially looked at the threat assessment programs in San Diego and Los Angeles Counties and additionally, Commission staff recommended that the County discuss their plan with Glenn County who has just completed an Innovation regarding threat assessment in schools. The obvious differences between the counties is size and none replicate the geo-socio-economic demographics of San Luis Obispo. Apart from population, the programs in each of these communities, differs from SLO in that they are not inclusive of the all the entities SLO is proposing, and San Diego and Los Angeles counties' programs are centered around the use of law enforcement and Glenn County's is focused more in the schools.

By considering a multi-disciplinary approach to collaboration and training, and through inclusive training of multiple agencies and persons, the County believes that this will create a “common language” for community entities to better identify, refer persons for mental health services, manage situations and communications, and possibly prevent threats. Finally, building the mental health capacity is designed as part of the program in order to assist in finding the best way to assist person(s) in a threatening situation (i.e. CBT, hospitalization, family therapy).

The County is hoping that this training will assist with destigmatizing the public impression of who makes threats, that the collaboration will broaden the scope and knowledge about threats and that information shared between entities will serve to educate the community at every level; ultimately reducing threats and reducing criminalization of youth in cases of threats.

The county may wish to provide more information on the actual structure of the training program (i.e. number of sessions, length of each session, location of trainings, classroom, vs community based, etc.)

Learning Objectives and Evaluation:

With limited knowledge of the extent to which active shooting and other threats affect the county, San Luis Obispo (SLO) County is proposing to not only develop a coordinated method for gathering this information, but to also develop a coordinated training response model for impending threats. The County anticipates that 50 individuals from the mental health field, law enforcement, and educational institutions will participate in the project each year.

To guide their project, SLO has identified several learning goals aimed at learning the best approaches to developing a collaborative threat assessment system and training model. Further, the County hopes to determine whether this model helps to increase knowledge among mental health practitioners and lead to better threat assessment and reduced occurrences of threats or gestures (**see pg. 38 of project plan**). With the use of the training and threat model, the County hopes to see a decrease in threats through referrals as well as an increase in the number of MH professionals providing therapy to individuals identified as making serious threats.

Data will be collected using surveys, pre- and post-test assessments, and other qualitative methods. The evaluation contains measures to better understand knowledge (results of pre- and post-assessment surveys), interagency collaboration (documents relative to interagency meetings and other qualitative information), as well as decreases in potential threats through referral (number of threats and levels, number of threat referrals), as well as increases in MH professionals available for therapy (number of trainings and presentations), among others.

The County will contract with an outside evaluator to oversee the evaluation and complete the final evaluation report. At the conclusion of the project, the County will share lessons learned and findings in several ways, including holding a report forum, through social media avenues, local media, as well as presentations to local and state leaders. Additionally, the County plans on having semi-annual “review conferences” with trainees to review training practices relative to the threat assessment model.

Additional Regulatory Requirements:

The Community Program Planning Process

San Luis Obispo held their 30-day public comment period beginning May 17, 2019, followed by their Behavioral Health Board meeting on June 19, 2019. Board of Supervisor approval was received on July 16, 2019.

The County began their robust stakeholder engagement process in October 2018 to collaborate, research, and yield new proposed innovation projects based upon community input and expressed need. Stakeholders submitted innovation ideas thru the County’s “Innovation Creation Station” which allows stakeholders to submit innovation ideas and concepts to be vetted for community feedback. The County’s innovation stakeholder group then met to score all the received innovation ideas and ranked them by priority which led to the development of two projects, this project included.

The County held various public planning sessions which includes, but is not limited to the following community stakeholders: family members and consumers, Behavioral Health Board members, members of underserved / unserved communities (Promotores, the Gay and Lesbian Alliance, and members of the cultural competence committee), consumers and representatives from the National Association of Mental Illness (NAMI), the Peer Advisory and Advocacy Committee, mental health providers, peer advocates and members from various county and communities agencies (probation, County Office of Education, Drug and Alcohol counselors). Planning sessions included community

members from LGBTQ, Veterans, Youth and Older Adults and individuals experiencing homelessness. The County states stakeholders, including consumers and family members, have been and will continue to be actively involved in all phases of the innovation project.

Based on communications and interactions with the County, Commission staff feels strongly that the County worked in good faith to incorporate stakeholder feedback and concerns into this finalized project.

Commission staff initially shared this project with stakeholders on May 17, 2019 and again on June 4, 2019 while the County was in their 30-day public comment period and comments were to be directed to the County for inclusion, if substantive feedback was given. No letters of support or opposition were received. On August 6, 2019, the final version of this project was shared with stakeholders. Commission staff received one comment in response but was neither supportive or oppositional, more so providing suggestive changes, none of which were deemed to require another public comment period and the county did respond to the observations as will be described below. Considering transparency and with permission granted from the stakeholder, the feedback received was shared with the County.

As part of MHSa General Standards, San Luis Obispo County will depend heavily upon community collaboration via a diverse and culturally appropriate stakeholder advisory board during all phases of this project. The County intends to utilize culturally and linguistically appropriate staff to engage the youth and will monitor the project for any discrepancies in services which will be tracked and analyzed as part of the dissemination of project findings. This project is client-driven to engage youth as its target population and is focused on the needs of the consumers with the support of family members with emphasis based on recovery, wellness, and resilience.

The final version of this project plan was shared with stakeholders on September 13, 2019 due to changes that were made to the document subsequent to the initial public comment period. Further, additional comments are included in the text of the proposals (**see pgs 8-9 of project plan**).

The following summarized stakeholder comments were submitted to Commission staff related to this project:

- Stakeholder commented if this project, and all other innovation projects, allows for learning and partnership to neighboring counties and dissemination for statewide learning.
- Stakeholder commented that County should consider de-escalation tactics training for project team members.

Other comments received were neither supportive or oppositional, more so providing suggestive changes, none of which were deemed substantive; however, all comments were shared in detail with the County by Commission staff and the final draft of the proposal addresses some of the identified issues by stakeholders. To date, the

Commission has not received any comments from its September posting of the final proposal.

The Budget

The county is requesting authorization to spend \$879,930.40 of Innovation funds for this project. \$71,760, or less than 1% (.081) of the budget is being allocated for county to hire a grant coordinator and two student interns to manage the program. \$37,383.40 or 4% is being budgeted for direct operating costs which primarily include prorated costs of the SLOTAP manager's office during the project.

\$644,100 or 73.1% of the budget is being allocated for actual contractor/trainer costs for this program and includes the salary for the Threat Management Coordinator and the Clinical Threat Management Expert. This amount also covers costs associated with training and assessment materials, and subscriptions to APA related threat assessment documents and evaluation costs. Amount allotted for evaluation (\$60,000 or 6.9% of the total innovation project amount) appears to be adequate for the overall dollar amount of this innovation project.

\$126,687 or 14.3% of the budget is being allocated to workshops and travel costs, one time set up and non-recurring costs (phone, internet access, office furniture, and computer peripherals).

Review of CCR Section 3930 requirements:

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations.

County of San Luis Obispo Mental Health Services Act

PROPOSAL FOR THE INNOVATION COMPONENT OF THE
THREE-YEAR PROGRAM AND EXPENDITURE PLAN



INNOVATION PLAN FY 2019-2023

**County of San Luis Obispo
Behavioral Health Department**



County of San Luis Obispo Innovation Plan

Executive Summary

The County of San Luis Obispo’s Behavioral Health Department (SLOBHD) is excited to put forth this plan to utilize Mental Health Services Act (MHSA) Innovation (INN) component funds to test new methods to serve and engage the community mental health field. The goal of the proposed Innovation projects is to build capacity within the community by learning new and adapted models for promoting positive mental health and reducing the negative impact of mental illness and stigma.

Over a 7-month period, the SLOBHD worked collaboratively with local stakeholders, including consumers and family members, to develop the County’s INN Plan, which consists of two INN projects. The plan consists of new and novel mental health practices or approaches that will contribute to informing the County and its stakeholders as to improved methods for addressing mental health disparities.

The County of San Luis Obispo’s INN Plan consists of two distinct projects with an average duration of 36 months. The total cost of the two projects, including administrative services, is projected to be approximately \$1.5 million. The projects will be funded with the County’s INN funds. However, every effort will be made to access revenue through Federal Financial Participation for appropriate projects. The table below depicts the projected expenditures for each project and for administration from FY19-20 through the first half of FY22-23.

INN Project Budgets	FY 19-20	FY 20-21	FY 21-22	FY 22-23	Total
Holistic Adolescent Health	\$135,000	\$182,500	\$182,500	\$160,000	\$660,000
SLOTAP	\$218,282	\$216,862	\$215,922	\$228,864.40	\$879,930.40
TOTAL INN Budget	\$353,282	\$399,362	\$398,422	\$388,864.40	\$1,539,930.40

MHSA funds will be used to implement the following two new projects with planning and services expected to begin in October of 2019, after any procurement processes have been completed. The projects were selected based on MHSA’s required outcomes, general standards, the community’s input and priorities, and the feedback from the Mental Health Services Oversight & Accountability Commission (MHSOAC). Innovation represents a significant opportunity to engage new systems and gain knowledge around many difficult mental health system issues. The projects listed herein are:

Holistic Adolescent Health:

The Holistic Adolescent Health Innovation Project is designed to test the development of a new health curriculum and delivery model for youth 13-18 years of age. With the addition of mindfulness training, the project implements a comprehensive approach to mental, physical, and social health. The delivery method of the new curricula includes: 1) a blended health education model provided in 15 sessions comprised of mental health, physical health, and sexual health education to students through their regular health classes, and 2) a one-on-one health coaching program providing in-depth mental, physical, and sexual health support.

A learning goal of this project will be to determine if the new curricula and delivery model are effective in positively impacting youth's engagement in healthy and constructive habits, behavior, and choices.

San Luis Obispo Threat Assessment Program (SLOTAP)

The SLOTAP project aims to provide a highly-trained community-based and academically-informed training model and system to learn, assess, and intervene when cases of threat become apparent or imminent. The innovation project is also designed to create a new learning and language model between the mental health system (MHS), law enforcement (LE), and educational institutions (EI) employing a new curriculum derived from proven and effective models, but tailored to San Luis Obispo and directed to the coordinating efforts between MHS, LE, and EI. The innovation project is meant to educate and decrease the criminalization and stigmatization of youth in cases of threats. The project will test the new, never-before-implemented, coordinated, and collaborative curriculum over the course of three years with a sample of MHS, LE, and EI throughout the County. The learning goal of the project will be to assess the training model to determine the skills and attitudes that can be measured to establish a baseline for MHS, LE, and EI to support and engage clients who may pose a threat.

The Innovation proposals were finalized on May 10, 2019 and a draft was made public for a 30-day review on May 17, 2019. A public hearing was held as part of the Behavioral Health Board's (BHB) June 19, 2019 regular meeting and received approval from the BHB. The plan was approved by the County's Board of Supervisors July 16, 2019. The Innovation Work Plan will be submitted and approved by the Mental Health Services Oversight and Accountability Commission in August 2019.

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Community Program Planning and Local Review Processes

County Name: San Luis Obispo

Work Plan Name: County of San Luis Obispo Innovation Plan

Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. Please include the methods for obtaining stakeholder input.

A new planning round of innovation was officially launched in September 2017. The first Innovation Stakeholder meeting took place in October 11, 2018, where ongoing and new Innovation Stakeholders assembled to review the innovation guidelines, begin a larger conversation, and collaborated on a new round of research and experiment-based projects. The meetings also provided stakeholders and the community with presentations regarding the current innovation round, including the implementation, successes, and challenges of the current four projects.

INNOVATION STARTS HERE!

INNOVATION ROUND 2018-2019

DO YOU HAVE A BRAND-NEW, CREATIVE IDEA FOR MENTAL HEALTH PRACTICE THAT HAS NEVER BEEN DONE BEFORE?

IF YOU ANSWERED "YES" TO THE QUESTION ABOVE, THE COUNTY OF SAN LUIS OBISPO BEHAVIORAL HEALTH DEPARTMENT WANTS TO HEAR FROM YOU! ACCESS THE LINK BELOW AND SUBMIT YOUR IDEAS!

<https://www.surveymonkey.com/r/SR75RBY>

WHEN: THURSDAY, OCTOBER 11TH
TIME: 4:00PM - 5:00PM
LOCATION: FRENCH HOSPITAL COPELAND HEALTH EDUCATION PAVILION - 1ST FLOOR

Nestor Veloz-Passalacqua, M.P.P.
nvelozpassalacqua@co.slo.ca.us
805.781.4064
County of San Luis Obispo
Behavioral Health Department

CALIFORNIA DEPARTMENT OF MENTAL HEALTH SERVICES
CALIFORNIA

The stakeholder meetings were conducted by Frank Warren, MHA Coordinator and Nestor Veloz-Passalacqua, INN Coordinator. Stakeholder meetings included community members, family focus groups, and members of existing groups. New stakeholders from local non-profit organizations and the local California State University joined the stakeholder group in a larger effort made by the County to incorporate community representation. The stakeholder group and meetings were designed with the purpose of encouraging the development of learning projects and developing new creative initiatives to test potential solutions for difficult challenges in the mental health field.

In the spirit of Innovation, the County Stakeholder process ensured the maximization of time and knowledge of the community members who had come to the Innovation Planning Team, as well as the optimization of project development by using a user-friendly online tool. For this short-term round of innovation, Stakeholders and the Innovation Planning Team were provided with an online project development toolkit consisting of Innovation

definitions and guidelines and a worksheet to walk them through the creation and development of the Innovation project. The goal for the stakeholder group was to develop projects outside of the stakeholder meetings and bring the proposals to the group for revision and final approval.

The Innovation stakeholders were given the opportunity to submit proposals and concepts to be considered as new projects. The County continued the use of the “Innovation Creation Station,” which is an online survey built by the County to assist innovators in developing their ideas and answering key questions necessary to meet the Innovation component guidelines. The online survey tool allowed stakeholders to provide concise narratives and complete thoughtful proposals. Technical assistance was provided to innovators and stakeholders throughout the development phase of the proposals by answering questions regarding the online survey tool, answering innovation questions, and generally preparing the innovation planning team presentations.

The INN Coordinator began communication with the Mental Health Services Oversight and Accountability Commission (MHSOAC) to receive feedback on the proposed projects and provide additional assistance to the innovators. All proposals were reviewed to assure adherence to the Innovation guidelines. In order to determine the level of prioritization for each project, the County provided stakeholders with an online tool for ranking purposes prior to funding estimations so stakeholders and the community would make recommendations based on the merits of the projects rather than on the costs associated with the project. The first complete draft of proposals became available in the month of January and stakeholders were given a week to review the proposals and provide a ranking. The online ranking system allowed every member of the stakeholder group (those wishing to complete their ranking on paper were provided printed surveys) to “score” each proposal anonymously based on the project’s merits, need/problem definition, learning goal, implementation, operation, and sustainability. This process allowed the County to be provided with a list of ranked projects. Results were disseminated to the Innovation Stakeholder group and to the innovators. All four projects continued to refine and work on their projects’ narrative. The Mental Health Services Oversight and Accountability Commission provided additional feedback, which was taken into consideration for the final number of innovations projects moving forward, reducing the number of proposed projects from three (3) to two (2). This allowed the team to focus time and resources on the two proposals listed on this work plan, while continuing to work on the finalization piece for the last remaining projects to be presented the following fiscal year.

Road to Innovation
NEW ROUND, NEW IDEAS

STEP 01
OCT. 11TH LAUNCH

- INNOVATION PLANNING LAUNCH
- IDEA STATION IS OPEN TO PUBLIC
- GROUP FACILITATION, ENGAGEMENT, TECHNICAL ASSISTANCE & CONSULTATION TO STAKEHOLDERS

STEP 02
DEC 7th, 2018
INNOVATION IDEA SUBMISSION DEADLINE

- INNOVATION TEAM VERIFIES SUBMITTALS, INNOVATORS CLARIFY AND REFINE PROJECTS.

STEP 03
JANUARY 2019

- COMMUNITY PRIORITIZES IDEAS
- FINE TUNING OF PROPOSED PROJECTS

STEP 04
MAY 2019

- INNOVATION PROJECTS POSTED FOR COMMUNITY FEEDBACK AND BEHAVIORAL HEALTH BOARD APPROVAL.

STEP 05
JUNE 19 - JULY 19

- BOARD OF SUPERVISORS AND OAC APPROVAL
- BEGIN RFP PROCESS

NEW INNOVATION PROJECT BEGINS
JULY 1st, 2019

The Innovation proposals were finalized on May 10, 2019, and a draft was made public for a 30-day review on May 17, 2019. A public hearing was held as part of the Behavioral Health Board’s (BHB) June 19, 2019 regular meeting and received approval from the BHB. The plan was approved by the County’s Board of Supervisors July 16, 2019. The Innovation Work Plan will be submitted and approved by the Mental Health Services Oversight and Accountability Commission in August 2019.

Identify the stakeholder entities involved in the Community Program Planning Process

The County's Innovation Planning Team is the stakeholder group consisting of 10-20 representatives of various community groups including consumers, family members, and underserved cultural communities. The Innovation Planning Team met two times between October 2018 and March 2019 and will reconvene to oversee the launch of Innovation programs and participate in reviews thereafter.

Below is a list of stakeholders that participated in San Luis Obispo County's Innovation Planning Process:

- Behavioral Health Board (BHB) members (including family members and consumers).
- Members of underserved communities, including Promotores Collaborative (representing the Center for Family Strengthening), participants of the County's Cultural Competence Committee which advises the department on how to improve services for underserved ethnic and cultural groups, and the Gay and Lesbian Alliance (GALA).
- Consumers and family members (youth and adult) as well as organizations that represent them such as the Peer Advisory and Advocacy Committee and the National Association of Mental Illness.
- Community mental health system providers, including staff and peer advocates from Transitions Mental Health Association (TMHA), Wilshire Community Services (WCS), California Polytechnic State University, Community Action Partnership of San Luis Obispo (CAPSLO), and Family Care Network.
- Other County agencies, including Probation, Office of Education (administrators, teachers, counselors), and Drug and Alcohol Services.
- Staff and managers, including the Behavioral Health Director, clinicians, case managers, and medical professionals of the County Behavioral Health Department.

Ethnic representation in the Planning sessions included members of the Latino, Asian, African-American, and Native American communities. Providers specializing in cultural-based services were integral in developing Innovation needs and proposals. Cultural groups represented throughout the Planning sessions included LGBTQ, Veterans, Youth, Older Adults, Spiritual, and individuals experiencing homelessness.

List the dates of the 30-day stakeholder review and public hearing. Attach substantive comments received during the stakeholder review and public hearing and responses to those comments. Indicate if none received.

The plan was posed for 30-day review stakeholder and public review on May 18th, 2019. Notice of the INNOvation Plan's availability for review and of the June 19th, 2019 public hearing was posted on the SLOBHD website and sent to members of the INNOvation Planning Process, all SLOBHD staff, SLO County Behavioral Health Board, and the County Board of Supervisors. Notification flyers were posted at the SLOBHD offices and County libraries, and a legal notice was published in the Tribune, the only countywide daily newspaper.

At the conclusion of the 30-day review period, three total comments were received using the feedback survey made available electronically and in hard-copy. The comments, as originally written and posted, are listed below for the two projects:

Holistic Adolescent Health:

1. "A careful understanding when introducing children to mental health issues esp. drug use and availability, perceived mentorship for guidance to develop the individual autonomy so precious and required to understand how to live a life. An example as I have witnessed in criminalizing medical and mental health issues, by forcibly and opinionated leadership by of community institutions unqualified for the role, such as police, courts, and religious organization. This would especially be relative to SLO County history of police overreach and breaches of civil liberties, and opinionated, judgmental church activities. Also the lack represented in the schools for a focus on character development and coping strategies for the tumults of adolescent in society of overt exposure of aberrant behavior modeling."

San Luis Obispo Threat Assessment Program:

1. "As a representative of SLCUSD I look forward to working with Dr. Holifield on this project. Having effective threat assessment protocols and practices are becoming increasingly important in public education. Schools districts cannot develop these programs on their own or in isolation. Working with a menta health professional and community groups in establishing a solid protocol/process is important in getting it right."
2. "Demonizing is not helpful in assessing societal problems rationally. Much of the approach I have seen living here for 35 years, is that approach is quick to establish itself in policy and has actually exasperated the problems. Self-righteous, opiniated, low consciousness strategies are fueling contempt and recruiting more aberrance, to support growth of an industry of self-perpetuating occupation of incarceration and spinoff industry."

At the June 19, 2019 Behavioral Health Board meeting, Nestor Veloz-Passalacqua (INNOvation Coordinator) presented the County's proposed INNOvation Work Plan for FY 2019-2023. A total of four letters of support were received for both projects. The Holistic Adolescent Health project received a joint letter of support from multiple organizations, which include the Gay and Lesbian Alliance of the Central Coast, Tranz Central Coast, Central Coast Coalition for Inclusive Schools, #Out4MentalHealth Task Force, Diversity Coalition of San Luis Obispo County, Your True Gender, The Queer Crowd, 5 Cities Hope LGBTQ+ Organization, QueerSLO, and Santa Maria House of Pride and Equality. SLOTAP received letters of support from Transitions Mental Health Association, San Luis Coastal Unified School District, and California Polytechnic State University. There were a total of six written comments, which are listed below:

1. "2 projects are very needed in our community. They both have the potential to greatly increase the quality of life for all community members. I think the Holistic Adolescent Health component is especially critical for our area and has the potential to be an excellent model for other communities"
2. "Please note my positive comments for this plan and both projects. I strongly support the plan and both projects"
3. "Threat assessment program – please do not spend SLO CO funds at Cal Poly. Instead coordinate with Cal Poly on the INNOvation program using State funding for Cal Poly students."
4. "It is sad that we live in a time when we must worry about the possibility of mass shootings in America. I am pleased that SLO County is willing to take steps toward the assessment and identification of potential threats. Any efforts to pay attention to this growing problem deserves our applause and support."
5. "Both projects are meeting a need in community."
6. "Please make sure the curriculum is evidenced-based for the outcomes you are hoping for. Confidentiality for young adults so won't be impacting their future for armed services or police"

work or public office. Is it possible to use school-based professionals who know the students best and have built a rapport with for on-going support.”

Verbal comments made during the presentation included the following:

1. “I would like to see a train-the-trainer (SLOTAP) option or program that would include hospitals as well”
2. “I am concerned to include Cal Poly since they have their own money to train their staff and provide services.”
3. “I like the fact that the INNnovation Planning group took on these projects and are presenting them and moving forward.”

Based on the public comments made, the County responded the following:

1. It is the County’s intention to build a system in which individuals trained under SLOTAP become a resource to the County and to other Mental Health Professionals, Educational Staff, and Law Enforcement in order to maintain a consistent infrastructure of individuals supporting the system in years to come.
2. It is important to mention that any youth attending our local university is, first and foremost, a community member, whether they are in the college or not. It is the project’s intention that in cases of threats any community member, regardless of their educational affiliation, is presented with the appropriate services. It is the intention of the project to train Mental Health Professionals, Educational Staff, and Law Enforcement from various regional areas of the County in order to best develop a cadre of specialized professionals who can best engage with individuals from all different backgrounds, including young community members attending college regardless of the services that educational institutions may have. The project funds the intervention for approximately a total of 150 attendees for the four-years of testing who are primarily Mental Health Professionals (County and local mental health providers), Law Enforcement (Sheriff and City Police), and Educational Staff (School District staff, teachers, and counselors, and the Local university). There is currently no local, state, or federal funding supporting universities to place a threat assessment. The INNnovation project is about creating a cohesive and collaborative system and model, removing the only and larger educational institution from the project hinders the very nature and inherent practice and goal of the project. The project maintains Cal Poly as a potential source for training as it is aligned with the objectives.
3. Our Community Planning Process stems from transparency and engaging the community in forums, meetings, and spreading information to all regions in order to increase awareness, educational opportunities, and create proposals that speak directly to the need of our community county wide.

The Innovation proposals were finalized on May 10, 2019 and a draft was made public for a 30-day review on May 17, 2019. A public hearing was held as part of the Behavioral Health Board’s (BHB) June 19, 2019 regular meeting and received approval. The plan was approved by the County’s Board of Supervisors July 16, 2019. The Innovation Work Plan will be submitted and approved by the Mental Health Services Oversight and Accountability Commission in August 2019.

**INNOVATIVE PROJECT PLAN
RECOMMENDED TEMPLATE**

COMPLETE APPLICATION CHECKLIST	
<p>Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:</p>	
<p><input type="checkbox"/> Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to the Board of Supervisors.</p> <p style="text-align: center;"><i>(Refer to CCR Title 9, Sections 3910-3935 for Innovation Regulations and Requirements)</i></p>	
<p><input type="checkbox"/> Local Mental Health Board Approval</p>	<p>Approval Date: June 19, 2019</p>
<p><input type="checkbox"/> Completed 30-day public comment period</p>	<p>Comment Period: May, 19 - June 19, 2019</p>
<p><input type="checkbox"/> BOS approval date</p>	<p>Approval Date: July 16, 2019</p>
<p>If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: _____</p> <p><i>Note: For those Counties that require INN approval from MHOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.</i></p>	
<p>Desired Presentation Date for Commission: August 2019</p>	
<p><i>Note: Date requested above is not guaranteed until MHSOAC staff verifies <u>all requirements</u> have been met.</i></p>	

County Name: San Luis Obispo County

Date Submitted: May 19, 2019

Project Title: Holistic Adolescent Health

Total amount requested: \$660,000

Duration of project: Four years

Purpose of Document: The purpose of this template is to assist County staff in preparing materials that will introduce the purpose, need, design, implementation plan, evaluation plan, and sustainability plan of an Innovation Project proposal to key stakeholders. *This document is a technical assistance tool that is recommended, not required.*

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that “The County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports”. As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT

An Innovative Project must be defined by one of the following general criteria. The Proposed project:

- **Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention**
- Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- Supports participation in a housing program designed to stabilize a person’s living situation while also providing supportive service onsite

CHOOSE A PRIMARY PURPOSE

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- Increases access to mental health services to underserved groups
- **Increases the quality of mental health services, including measured outcomes**
- Promotes interagency and community collaboration related to Mental Health Services or support of outcomes
- Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

San Luis Obispo County lacks a coordinated school-based health curriculum to provide high school students with a comprehensive mental, physical, and social health education. Community Action Partnership of San Luis Obispo (CAPSLO), in collaboration with local schools, has determined that the current compartmentalized curricula limit the ability of county youth to attain a whole-person/holistic view of health or to balance the inter-related aspects of mental, physical, and social health engagement processes. With students reporting ever-greater struggles to cope with overwhelming stress and anxiety, school officials and staff are asking for resources on how to help teens manage in the currently overcharged social environment. This need became a priority as it addresses two areas of concern, one being actively engaging youth ages 13-18 and, secondly, incorporating a comprehensive approach for mental, physical, and social health with mindfulness.

The number of suicide ideation and suicide attempts by U.S. children doubled between 2008 and 2015 from .66% of children in 2008 to 1.82% in 2015 (Plemmons, et al, 2018). Significant increases were noted in all groups, but the annual increases were higher in adolescents 15 to 17 years of age and adolescents 12 to 14 years. Although increases were noted in both girls and boys, the average annual increase was higher for girls (Plemmons, et al, 2018). One in nine high school girls attempted suicide in 2015 (California Health Care Foundation, p. 2). Young women are also more than twice as likely as young men to report chronic sad or hopeless feelings (California Health Care Foundation, p. 5). In 2015, 50% of youth who identified as lesbian, gay, or bisexual reported that they had seriously considered suicide in the past 12 months (California Health Care Foundation, p. 6).

According to the Kidsdata.org website, Adverse Childhood Experiences (including child abuse, exposure to violence, family substance abuse, divorce, and poverty) greatly increase the likelihood of major depressive episodes in adolescents, and a majority of youth do not receive mental health treatment. Half of all mental illnesses appear by the mid-teens. It is not uncommon for adolescent substance use to begin as a strategy for self-medicating in order to manage early psychiatric symptoms and frequently leading to the co-occurrence of mental illnesses and substance use disorders (California Health Care Foundation, p. 2).

Locally, it has been identified that 7.5% of Central Coast youth have experienced a serious emotional disturbance (California Health Care Foundation, 2018, p. 6). According to the *Community Health Improvement Plan*, of the 11th grade students in San Luis Obispo County surveyed in 2015-2016, 33% reported experiencing chronic sadness or hopeless feelings in the past 12 months (2018).

San Luis Obispo County has seen an 11% increase in total cases of substantiated child abuse from 2010 to 2015 (from 9.8 to 11.3 per 1,000). In December 2016, 378 children were in foster care in San Luis Obispo County, an increase from 17% since 2010 (Diringer, 2018, p. 5-7). On average a child in foster care is 2x more likely to develop PTSD than a war veteran (Family Care Network, 2019). Lesbian, gay, bisexual, and

transgender students report much higher rates of abuse and feeling unsafe at school (California Health Care Foundation, p. 6). The County's rate of forcible rape is much higher than the State rate and the county suicide rate is consistently above the State rate – 50% higher (Diringer, 2018, p. 7). According to the *California Healthy Kids Survey*, 33% of 9th Grade students in the Lucia Mar Unified School District (LMUSD) and 31% of those in the San Luis Coastal Unified School District (SLCUSD) had experienced chronic sadness or hopelessness. The numbers for non-traditional students rose to 44% and 53%, respectively. Nineteen percent of students in Grade 9 in the LMUSD and 15% of those in SLCUSD had considered suicide, and those rates again increased to 22% and 38%, respectively, for those in a non-traditional school setting (CaSCHLS, 2018).

In discussing the state of school-based health services, the *2018 California Children's Report Card* reports that although some efforts are being made to “improve school climate and teacher training to support student wellness, and increased screening and referral for mental health and trauma services,[...] more must be done to develop a [coordinated system of care] that meets kids' needs.” San Luis Obispo County has designated the improvement of the social and emotional support network for teens in SLO County as one of two Social and Emotional Wellness Priorities (Community Health Improvement, 2018). The County believes teaching mental health coping skills to teens is a vital determinant of the overall health of youth and an important component of early intervention efforts.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) Provide a brief narrative overview description of the proposed project.

The Innovation Project is designed to test the co-creation of a new health curriculum and delivery model for youth ages 13-18. With the addition of mindfulness training, the Project implements a comprehensive approach to mental, physical, and social health. Adding a mindfulness skill-building component to the existing high school health curriculum would enhance the ability of adolescents to make positive life choices related to their own health and well-being. There are no studies regarding a supportive model that integrates mindfulness into an existing health curriculum covering physical, sexual, and social health for teens ages 13-18 in a school-based environment.

The Innovation Project is part of an ongoing collaboration between the Community Action Partnership of San Luis Obispo (CAPSLO) and local high schools. CAPSLO is a 501(c)(3) non-profit community-based organization with a 40-year history of providing sexual health education in local high schools and middle schools. Since 2010, CAPSLO has expanded the availability of comprehensive, evidence-based, sexual health curriculum to high-need schools on the Central Coast of California. CAPSLO also partners with Community Health Centers (CHC) to provide local high schools with school-based obesity prevention programs that focus on students' nutrition and fitness practices.

CAPSLO works closely with school administrators and faculty to identify student needs, engage students, and create programs that encourage student buy-in. More importantly, the Project encourages teens to take ownership of and proactively manage their own health and well-being. The Innovation Project develops and employs a new curriculum which focuses on the needs of and utilizes

feedback from San Luis Obispo County adolescents. It also incorporates a new health education delivery model which integrates training on mindfulness skills into the existing health curriculum provided at high schools. The County posits that better physical and social-emotional health outcomes can be achieved through the implementation of this new curriculum and delivery model that includes: 1) 15 sessions on mindfulness skills and knowledge, and 2) one-on-one coaching and follow-up with youth. Because physical health and social-emotional wellness are inextricably tied together, the new curriculum and delivery method will help youth gain perspective on how all behaviors are interconnected and better understand how to cope effectively with stress, anxiety, and other symptoms.

Proposed Sites

The new health education model will be introduced and implemented at two school sites. The selected schools, Morro Bay High School in the San Luis Coastal Unified School District and Lopez Continuation High School in the Lucia Mar Unified School District, have requested support as part of the schools' ongoing health education classes offered each semester. This new model uses an existing health education curriculum and adapts it, while retaining the evidence-based components of the existing curriculum, to include the new mindfulness elements and additional health information in order to better meet the needs of local teens.

Key Components

- Blended health education model that provides 15 sessions of mental health, physical health, and sexual health education to students through their regular health classes.
- Health Educator one-on-one health coaching program that provides individual mental, physical, and sexual health education support for interested students.

The in-class component builds on and expands the current curriculum. The Innovation Project will include mental health, physical health, and sexual health education units. The mental health units will include Mindfulness Awareness Practices (MAPs) such as the STOP process (Stop, Take a Breath, Observe, and Proceed), body awareness scans, breathing, meditation, and feelings identification. The physical health units will include the U.S.D.A.'s MyPlate nutrition education, training on how to read nutrition labels, meal planning, setting SMART (Specific, Measurable, Attainable, Realistic, Time-bound) goals, setting fitness and nutrition goals, and fitness coaching (2018). Sexual health units will focus on healthy relationships, pregnancy and STI prevention, and birth control methods.

Health coaching involves students meeting one-on-one with a Health Educator up to two times per month for approximately 30 minutes per session throughout the school year. The discussions are student-driven and focus on setting and meeting health goals, further developing mindfulness skills, and additional education on specific topics of personal interest to the student. Each session will include mindfulness training.

The proposed and appointed new curricula will be conducted by the Health Educators. The Health Educators will receive approximately 200 hours of extensive training covering topics related to all aspects of the blended health education model to be delivered through the Innovation Project. Trainings prepare staff to provide a professional, medically accurate, evidence-based education which is culturally inclusive, developmentally appropriate, and trauma-informed. The curricula will also cover social and emotional health, in addition to mental, physical, and sexual health. Staff will be trained in the following areas:

Mental Health:

- Motivational Interviewing;
- Mindfulness through an evidence-based program such as Trails to Wellness;
- Cognitive Behavioral Therapy approaches.

Physical Health and Nutrition:

- The Dietary Guidelines for Americans 2015-2020;
- USDA MyPlate nutrition guide;
- Diabetes education;
- National Academy of Sports Medicine (NASM);
- Health at Every Size paradigm.

Sexual Health (as mandated by the State Education Code), including social and emotional health:

- Positive Prevention PLUS sexual health education curriculum as mandated by the State;
- Foundations Core Skills Training;
- Trauma Informed Classroom Management/Trauma Stewardship;
- Positive Youth Development;
- Domestic Violence Disclosure and Mandated Reporter;
- LGBT Ally/Youth Engagement, Inclusive Schools Network, Teaching Transgender Toolkit.

After completing the training sessions, Health Educators participate in an evaluation process before presenting to students in the classroom and engaging students through one-on-one health coaching. This process includes observing trainers, presenting mock teaching sessions, and co-teaching. Through the training and evaluation periods, Health Educators receive ongoing support and feedback from supervisors, trainers, and peers.

Through both the high school health classes and on-site, one-on-one health coaching and nutrition consulting by trained Health Educators, Innovation Project Staff will provide participating teens with mindfulness tools to help them achieve stress reduction, reduce emotional reactivity, and improve health behaviors. Emphasis will be placed on offering regular opportunities to practice the new skills. The specific elements selected for each module will be designed to address the needs of emerging adults who often feel they have few emotional resources from which to draw.

The Innovation Project will develop the mindfulness training from various evidence-based programs intended to help students calm their minds to manage stress and lead healthier lives. The emphasis will be on teaching practical skills that students can use to manage stress by focusing their minds and gaining perspective around the issues and challenges they may be facing. The program will train participants in mind-body skills such as abdominal breathing and guided imagery, which have been shown to increase both self-care and the motivation to continue practicing stress reduction. Mindfulness training emphasizes the cultivation of positive emotions such as gratitude and compassion. Behavioral health activity outcomes to be tracked include self-compassion, awareness of intentional behavioral activities, perceived stress levels, the consumption of healthy foods/drinks, increased body awareness, the amount and quality of sleep, and emotional comfort levels within relationships. Staff will employ motivational interviewing techniques to elicit student-driven behavior change. Our approach also utilizes the tenants of cognitive behavioral therapy to enable students to act intentionally rather than reacting reflexively in both stressful and everyday situations.

By using a combination of in-class instruction, one-on-one health coaching, and mindfulness learning strategies, the Innovation Project will be evaluated in the following ways: Students who participate in

the Innovation Project will take a pre-test to assess student knowledge, behaviors, and attitudes prior to any instruction or coaching through the project. Post-tests will be conducted at the end of coursework and again following the coaching period to determine the effects of mindfulness on health behaviors such as stress reduction, activity level, consumption of sugary beverages, consumption of fruits and vegetables, self-regulation in sexual settings, and self-awareness and improvement within relationships. The data will be both quantitative and qualitative. A satisfaction survey will provide important program feedback from students to guide continuous quality improvement.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

The project introduces a new practice or approach to the overall mental health system, including but not limited to, prevention and early intervention.

C) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

The approach of the Project utilizes staff to create a more comprehensive mental, physical and sexual health program that is student-driven and allows health educators to respond to requests for information as well as identify the areas of greatest need and trends in student health needs. Teen suicides rates have doubled in recent years; college mental health referrals requested by students have strained many university health centers; school counselors, teachers and staff are overwhelmed (Plemmons, et. al, 2018) (Center for Collegiate Mental Health Annual Report, 2017). Though many studies have looked at various potential solutions, incorporating mindfulness awareness practices into existing health curricula may promise the best results. All known studies have tracked mindfulness-based stress reduction (MBSR) programs on adults and youth, the academic benefits to students, or students with diagnosed issues such as attention deficit disorders. However, this project will focus on tracking physical health outcomes through increases in the intentional behaviors resulting from MAPs.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

Approximately 120 participants will be served in classrooms per academic year across the two sites, with an expected total of 360 participants served over the three academic years of the INNOVATION Project testing period. Health Educators will partner with staff at Morro Bay High School and Lopez Continuation High School to offer the blended INNOVATION Project model. Each academic year, approximately 120 students will be reached via classroom presentations, with approximately 40 of those students participating in one-on-one- health coaching.

E) Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate)

The participants will be youth ages 13-18 from Morro Bay High School and Lopez Continuation High independent of age, gender, sexual orientation, race, ethnicity, language, or disability. Efforts will be made to provide culturally competent services to all participants.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

The INNOvation Project incorporates mindfulness and coping skills training into an existing high school health curriculum and will introduce this model to two school sites not currently being served by CAPSLO staff. Through trained Health Educators, students' intentional behavioral health outcomes will be tracked. These include perceived levels of stress and self-compassion, body awareness, activity level, consumption of sugary beverages, consumption of fruits and vegetables, comfort level within the context of personal relationships, and intended sexual health decisions. Although many studies have reported on the impact of mindfulness training in school settings, none referenced programs that had been added to an existing high school health curriculum using a blend of comprehensive physical health, nutrition and fitness, sexual health, and mindfulness as a cohesive holistic health program. One study looked at the impact of mindfulness on resting and ambulatory blood pressure and heart rate in youth, but not on additional youth health outcomes (Barnes, 2004). Health is often taught in a compartmentalized fashion. This proposal seeks to test a model for comprehensive health education that includes mental, physical, and sexual health components, and tests the link between mindfulness practices and healthy behavior decisions. In addition, this project seeks to identify whether the utilization of one-on-one coaching of students produces a more profound change in knowledge, skills, and health practices when coupled with classroom instruction, as opposed to classroom instruction alone.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

Multiple searches were conducted on various research, scientific and government websites to determine where gaps in behavioral science research exist. Below is an exhaustive list of the research conducted to validate the gap in research and literature related to mindfulness.

Barnes, V. A., Davis, H. C., Murzynowski, J. B., & Treiber, F. A. (2004). Impact of meditation on resting and ambulatory blood pressure and heart rate in youth. *Psychosomatic Medicine*, 66(6), 909-914.

Bennett, K. & Dorjee, D. (2016). The impact of a mindfulness-based stress reduction course (MBSR) on well-being and academic attainment of sixth form students. *Mindfulness*, 7(1), 105-114. <https://doi.org/10.1007/s12671-015-0430-7>

Bluth, K., Roberson, N., & Gaylord, S. (2015). A pilot study of mindfulness intervention for adolescents and the potential role of self-compassion in reducing stress. *Explore*, 11(4), 292-295. <https://doi.org/10.1016/j.explore.2015.04.005>

Botha; E., Gwin, T., & Purpora, C. (2015). The effectiveness of mindfulness-based programs in reducing stress experienced by nurses in adult hospital settings: A systematic review of quantitative evidence protocol. *JBI Database of Systematic Reviews and Implementation Reports*, 13(10), 21-29. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/26571279>

Calma-Birling, D., & Gurung, R. (2017). Does a brief mindfulness intervention impact quiz performance? *Psychology Learning & Teaching*, 16(3), 323-335. <https://doi.org/10.1177/1475725717712785>

Cevasco, M. (2017). *Examining the social-emotional impact of a brief mindfulness program for students in special education*. (Unpublished doctoral dissertation). University of Washington.

Daily, L. (2018). *Association of Mindfulness and Resilience with Stress, Depression, and Anxiety among Freshman Undergraduate Students*. (Unpublished doctoral dissertation). St. Louis University.

Dunning, D. L., Griffiths, K., Kuyken, W., Crane, C., Foulkes, L., Parker, J., & Dalgleish, T. (2018). The effects of mindfulness-based interventions on cognition and mental health in children and adolescents: A meta-analysis of randomized controlled trials. <https://doi.org/10.31234/osf.io/rj5mk>

Edwards, M., Adams, E., Waldo, M., Hadfield, O., & Biegel, G. (2014). Effects of a mindfulness group on Latino adolescent students: Examining levels of perceived stress, mindfulness, self-compassion, and psychological symptoms. *Journal for Specialists in Group Work*, 39(2), 145-163.

Ennis, H. (2018). Credibility in mindfulness training for young people. *Psychology Teaching Review*, 24(1), 59-62.

Erbe, Ryan & Lohrmann, David. (2015). Mindfulness meditation for adolescent stress and well-being: A systematic review of the literature with implications for school health programs. *The Health Educator*, 47.

Galla, B. (2016). Within-person changes in mindfulness and self-compassion predict enhanced emotional well-being in healthy, but stressed adolescents. *Journal of Adolescence*, 49, 204-217.

Greeson, J. M., Juberg, M. K., Maytan, M., James, K., & Rogers, H. (2014). A randomized controlled trial of Koru: A mindfulness program for college students and other emerging adults. *Journal of American College Health*, 62(4), 222-33.

Herman, P.M., Anderson, M.L., Sherman, K.J., Balderson, B.H., Turner, J.A., Cherkin, D.C. (2017). Cost-effectiveness of mindfulness-based stress reduction vs cognitive behavioral therapy or usual care among adults with chronic low-back pain. *Spine*, 42(20), 1511-1520. Retrieved from <https://ncch.nih.gov/research/results/spotlight/behavioral-therapy-cost-effective>

Mendelson, T., Greenberg, M. T., Dariotis, J. K., Gould, L. F., Rhoades, B. L., & Leaf, P. J. (2010). Feasibility and preliminary outcomes of a school-based mindfulness intervention for urban youth. *Journal of Abnormal Child Psychology*, 38(7), 985-994.

Metz, S. M., Frank, J. L., Reibel, D., Cantrell, T., Sanders, R., & Broderick, P. C. (2013). The effectiveness of the learning to BREATHE program on adolescent emotion regulation. *Research in Human Development*, 10(3), 252-272.

Ong, J., Manber, R., Segal, Z., Xia, Y., Shapiro, S., & Wyatt, J. (2014). Randomized controlled trial of mindfulness meditation for chronic insomnia. *Sleep*, 37(9), 1553-1563. Retrieved from <https://ncch.nih.gov/research/results/spotlight/090114>

Palozzi, R., Wertheim, E., Paxton, S., & Ong, B. (2017). Trait mindfulness measures for use with adolescents: A systematic review. *Mindfulness*, 8(1), 110-125. <https://doi.org/10.1007/s12671-016-0567-z>

Parish, K.A. (2011). *Quieting the cacophony of the mind: The role of mindfulness in adult learning*. Kay Annette Parish. BiblioBazaar.

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LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) What is it that you want to learn or better understand over the course of the INN Project and why have you prioritized these goals?

The Innovation Project’s goals are as follows:

- The County and its stakeholders hope to learn if the model effectively increases the ability of teens ages 13-18 to cope with stress and anxiety.
- The County and its stakeholders hope to learn if incorporating the teaching of mindfulness practices in conjunction with other health-focused curriculums increase teens' ability to make healthy decisions regarding their mental, physical, and sexual well-being.
- The County and its stakeholders hope to learn if inclusion of one-on-one coaching increases the likelihood that students will practice what they learned in health classes.
- The County and its stakeholders hope to learn better methods to increase prevention and early detection of mental health-related issues.

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

The overarching goal is to assess whether incorporating the key element of mindfulness training into a high school health curriculum, thereby creating a balanced approach to wellness education that addresses mental health, physical health, and sexual health, will positively impact health behaviors and outcomes. By testing a new health curriculum delivery model that includes these components, the Innovation Project hopes to determine whether mental, physical, and sexual behavior changes occur and, if so, whether they positively impact a young person's measurable health outcomes.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

Through collaboration with an external evaluator, the Innovation Project will identify and develop questions for pre- and post-assessment surveys to measure goals and objectives. These will include whether mindfulness training is an effective curriculum component for enhancing the current health education model to improve health behaviors and outcomes, while reducing student feelings of stress, anxiety, and/or depression.

The Innovation project's aims/outcomes are the following:

- Increase the mood stability and overall feelings of well-being of the participating students;
 - a) Metrics include pre- and post-surveys of participating students
 - b) Metrics include data from motivational interviews
- Increase the overall student level of physical fitness activity and nutrition knowledge;
 - a) Metrics include pre- and post-surveys of participating students
 - b) Metrics include data from motivational interviewing
- Increase the students' ability to identify and cope with feelings, especially negative emotions such as depression and/or anxiety;
 - a) Metrics include pre- and post-surveys of participating students
 - b) Metrics include data from motivational interviews
- Increase student intentionality regarding behaviors related to health;
 - a) Metrics include pre- and post-surveys of participating students

- b) Metrics include data from motivational interviews
- Determine if one-on-one coaching improves the likelihood that students will utilize the knowledge and tools taught in classroom setting;
 - a) Metrics include pre- and post-surveys of participating students
 - b) Metrics include data from motivational interviews
- Establish a referral process for youth who may need additional assistance;
 - a) Metrics include pre- and post-surveys of participating students
 - b) Metrics include data from motivational interviews
- Increase overall student level of sexual health* knowledge and awareness as it relates to: identifying signs of healthy and unhealthy relationships, identifying how to respond to pressures from peers, media, and society to engage in high-risk behaviors, identifying abstinence as the only 100% safe method to avoid an unplanned pregnancy, sexually transmitted infections (STIs), HIV, and identifying community resources for STI/HIV testing, contraceptive methods, and other sexual and reproductive health services;
 - a) Metrics include pre- and post-assessments of participating students

*Participant learning outcomes, as they relate to sexual health, will adhere to the Evidence Based Program (EBP), Positive Prevention PLUS, which complies with the California Education Code 51935.

Testing and Evaluation of Outcomes

- CAPSLO staff working on the Innovation Project will collaborate with diverse stakeholders and an outside evaluation agency to use culturally-appropriate data collection instruments and metrics to measure perceived stress levels and behavioral intent as they relate to stress alleviation, healthy decision-making, nutrition, physical activity, and relational communication.
- Pre-Instruction surveys will be administered at the beginning of the in-class curriculum.
- Prior to individual coaching, health coaches will evaluate student physical health as well as knowledge and behaviors through free response questions and pre-instruction surveys.
- Physical health outcomes measured will include body mass index and cardiovascular endurance. Other assessments will include student knowledge of food labels, My Plate, sleep, and healthy lifestyle recommendations.
- Post-instruction surveys will be administered at the conclusion of classroom curriculum.
- Health coaching surveys will assess changes to students' behavior by tracking their patterns of sleep, food/drink intake, attainment of fitness goals, and level of physical activity. Innovation Project participants will have the opportunity to share their lived experiences in the form of a retrospective focus group. The narrative data will be coded and transcribed by the evaluation agency.

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

The County plans to select a contract provider who will best execute the project. The County has outstanding contractual partnerships across the community mental health system, as well as strong relational partnerships with many community schools, colleges, health providers, and law enforcement agencies. The Behavioral Health Department, including the MHSA Administrative Team, is well-equipped to conduct a fair and successful procurement process (in partnership with County Purchasing) and expedite a contract to be sure INNnovation Project timelines presented herein are met.

The County Innovation Component Coordinator, Nestor Veloz-Passalacqua (Administrative Services Officer II), is the community liaison for all Innovation (and Prevention & Early Intervention) projects and evaluation. Nestor coordinates the stakeholder planning process and will be the one to develop any Requests for Proposal (RFP) to select providers. The MHSA Administrative Team also includes Frank Warren (Division Manager), the County MHSA Coordinator, who manages all aspects of MHSA, including contracts and plan monitoring. Briana Hansen, Accountant III, is the fiscal lead and works with each provider to develop accurate budgeting and spending plans. Kristin Ventresca, the CSS Coordinator (Administrative Services Officer II), also provides contract management and oversight. Nestor utilizes California Polytechnic State University statistics and public policy students who assist in data collection, technical assistance for providers, and reporting as part of paid internship positions.

All Innovation Project providers will meet regularly with Nestor and the team before and during the start-up phase to finalize plans, conduct data collection tests, and develop tools. Some plans may need to be adjusted (based on hiring, procurement of materials, etc.) and Nestor will work with each contractor to provide support and guidance to keep the projects on time. After the launch of each project, Nestor will work with the contractors to provide quarterly reports and data collection. The MHSA Administrative Team will conduct spot checks, review project materials, and review quarterly reports to ensure quality and regulatory compliance.

Additionally, the County will establish a contract with an Evaluator to manage the analysis of data, as well as provide technical assistance to the projects to be sure tools are developed which accurately measure the results of each objective. This Evaluator will provide regular reports to the MHSA Administrative Team and MHSA Advisory Committee (stakeholder group), as well as the final report which will be provided to the MHSOAC.

COMMUNITY PROGRAM PLANNING

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under 5 served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

A new round of Innovation Projects was launched in October 2018. The first Innovation Stakeholder meeting took place in October 11, 2018, at which new and current Innovation Stakeholders were present to review the innovation guidelines and begin a larger conversation and collaboration process for research and testing new meaningful ideas in our community. Community members ranging from psychologists, to educators, and think tank members were present, as well as mental health providers and partners. The County made available information containing steps to successfully submit an innovation idea, along with providing technical assistance in developing the narrative piece of the proposal. One of the most enthusiastic and eager organizations was CAPSLO. At an initial meeting they presented the first iteration of their idea to integrate and develop a new mental health curriculum that included mindfulness, physical, health, and social-emotional development. This project is part of larger collaboration between CAPSLO

and local high schools, focusing on the development of a new curriculum and delivery model. The project continued to be refined as County staff, CAPSLO, and school representatives were involved. The project's curriculum and delivery method would allow youth to experience a cohesive and comprehensive education focused on mindfulness, physical fitness and nutrition, and sexual health as part of a holistic high school health program. The original project design is the result of community engagement between CAPSLO, local school districts, and youth. Additionally, the Behavioral Health Department has provided technical assistance to refine and coordinate efforts to make the proposal a priority in reference to what the community needs are. The project design utilized feedback from schools identifying the need for additional support and a comprehensive curriculum that addresses the needs in teen developmental areas, including the need to build a curriculum and delivery model that leads to youth being connected to mental health services and a recovery process when needed. The County continues to provide ongoing technical support and procedural information to the development and completion of this proposal. The continued collaboration between stakeholders, community members, and school staff affirms the community-wide acknowledgment of the dire need for a cohesive and comprehensive curriculum so that county youth are provided with an opportunity to feel engaged and to help them achieve success and mental health wellbeing.

The Innovation Project team has solidified their efforts with CAPSLO, schools, and stakeholders to emphasize and facilitate proper coordination and implementation of the proposal. The staff and appropriate partners, such as CAPSLO, school representatives, and stakeholders, will continue to meet regularly during the project development, implementation, and evaluation to identify and address challenges, and to coordinate proper engagement for the intervention being tested. Currently, the County Innovation Coordinator has received feedback from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to ensure Innovation Project guidelines and regulations are met. The feedback and edits have been implemented into the proposal. Part of the efforts for a successful proposal includes the continued collaboration and coordination with the County and community-based organizations to ensure the inclusion of a wide representation of staff, and to ensure planning efforts reflect the community collaboration and the impact on the youth population.

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration

The Project is designed to facilitate a strong collaboration that includes youth, community-based organizations, school districts, County Behavioral Health Department, and family and community members. The Project fosters and maintains community collaboration through a process of consistent stakeholder advisory group interaction and by representing diverse racial/ethnic, cultural, and linguistic communities. The Project works with family advocates, mental health providers, school district staff, families, parents/caregivers, and other professionals to enhance and develop a cohesive and comprehensive classroom curriculum.

B) Cultural Competency

The Project is designed to impact diverse youth from across the County. The project employs culturally and linguistically appropriate staff who will engage clients through service delivery that fosters equal access to services without disparities. Additionally, through the project design, the stakeholder advisory group incorporates culturally and linguistically appropriate guidance in the administration, implementation, delivery, and evaluation processes. Cultural competency will be achieved by providing participants with the opportunity to participate in the project in which all services will be delivered in the participant's primary language. Services will engage and retain diverse individuals through recruitment by a trusted source. The stakeholder advisory group will monitor the project for disparities in services using process data and community data provided by the project data analyst.

C) Client-Driven

The Project is designed to engage staff who work primarily with youth, which is ultimately the population that will be impacted by the Innovation Project. Individual student experiences and individualized information will provide guidance and lead to a better participant understanding of the curriculum, the best practices, and continual fine-tuning of the approach necessary to identify and engage with those youth who may benefit from a cohesive and comprehensive course.

D) Family-Driven

The Project is designed to engage youth and their direct family support network as the primary agents of information. Their involvement will shape program decision-making and determine which elements of the curriculum and approach are essential to assist youth in developing a mindful, healthy, and informed lifestyle.

E) Wellness, Recovery, and Resilience-Focused

The Project services maintain the philosophy, principles, and practices of the Recovery Vision. Prevention and Early Intervention often prevents or mitigates behavioral and social problems; therefore, early referrals and connection to mental health resources and supports are a focus of the Project. Youth and parental empowerment and social connections are critical to the well-being of the students. Youth are also supported by the Project offering information on accessing services in the community.

F) Integrated Service Experience for Clients and Families

The Project involves an integrated community approach and resource knowledge experience among stakeholders involved. Project partners and staff work on providing seamless coordination between County agencies and community providers as a referral resource available to youth in order to create a larger system of mental health care coordination.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

Each student participant will be given in-class time to complete pre- and post-assessments to determine their level of knowledge related to health information, attitudes, and behaviors. In addition, students will be asked to complete a satisfaction survey, designed to gather feedback regarding their perceptions of the quality and usefulness of the information received, their reflections on staff preparedness and sensitivity to the needs of students, their recommendations for changes or improvements, and their overall satisfaction with the program.

An advisory group of stakeholders at each school will gather the perspectives and recommendations for continuous quality improvement. The advisory groups will include a variety of school personnel, parents, students, and community members with backgrounds in health/behavioral health, fitness, or mindfulness. There will be regular updates on the program, results, feedback, and support. Research questions will also be shared with advisory groups to ensure that questions are age-appropriate and sensitive to the cultural backgrounds of students.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety or keep particular elements of the INN project without utilizing INN Funds following project completion. Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

In addition to the staff training and administrative costs of implementing the program at two sites, there will be project costs associated with the staffing, design of assessments, data collection, reporting and evaluation. After the initial training and joint implementation costs are incurred, stakeholders hope grants and partnerships with local government, individual schools, community groups, and health agencies (such as CHC) will protect the continuity of care for students if the model proves to be effective. Also, any savings to the County derived from the process of teaching students to better cope with stress and anxiety can be expanded by implementing the model at other local schools. This could prevent the development of more debilitating mental health problems, which would add to the drain on the County's Health Agency. Early intervention through the process of educating and coaching students will potentially lessen the number of teens and young adults needing additional, expensive mental health services. Any teens needing additional health services will be referred to medical professionals, school counselors, or mental health service agencies both during and after the project period.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

The Innovation Project will produce quarterly reports with detailed information on the program accomplishments and challenges. Online quarterly newsletters will also become available and will be posted on social platforms such as Instagram and Facebook pages. Content will be developed in concert with student participants and school personnel to communicate how the project is evolving and what is being learned. We plan to include testimonials from students, parents, and school staff. At the end of the four-year grant, there will be a comprehensive and detailed report available to the County and the stakeholders.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

Teen Health and Wellness

School-based Wellness Training
Holistic Adolescent Health
Comprehensive Teen Health Education

TIMELINE

A) Specify the expected start date and end date of your INN Project

- Start: October 1, 2019 End: September 30, 2023

B) Specify the total time frame (duration) of the INN Project

- Four years

C) Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

Ramp up/Planning: October - December 2019

- Develop and finalize the curriculum
- Plan and solidify implementation logistics with school sites
- Hire and train Health Educators
- Contract with research partner
- Develop data collection tools
- Coordinate the health curriculum delivery schedule with health teachers

Implementation Cohort 1: January - June 2020

- Provide 15 in-classroom health modules to approximately 60 students, ages 13-18 years, across two high school sites. Administer pre- and post- instruction assessments. Recruit student participants for one-on-one health coaching sessions.
- Provide health coaching to approximately one-third (20) of the students from the in-classroom modules who opt to receive a series of six one-on-one health coaching sessions.
- Administer pre- and post-coaching assessment to student participants.
- Communicate with Research Partner and receive evaluation/assessment results for Cohort 1.

Implementation Cohort 2: August - December 2020

- Provide 15 in-classroom health modules to approximately 60 students, ages 13-18 years, across two high school sites. Administer pre- and post- instruction assessments. Recruit student participants for one-on-one health coaching sessions.
- Provide health coaching to approximately one-third (20) of the students from the in-classroom modules who opt to receive a series of six one-on-one health coaching sessions.
- Administer pre- and post-coaching assessment to student participants.
- Communicate with Research Partner and receive evaluation/assessment results for Cohort 2.

Implementation Cohort 3: January - June 2021

- Provide 15 in-classroom health modules to approximately 60 students, ages 13-18 years, across two high school sites. Administer pre- and post- instruction assessments. Recruit student participants for one-on-one health coaching sessions.

- Provide health coaching to approximately one-third (20) of the students from the in-classroom modules who opt to receive a series of six one-on-one health coaching sessions.
- Administer pre- and post-coaching assessment to student participants.
- Communicate with Research Partner and receive evaluation/assessment results for Cohort 3.

Implementation Cohort 4: August - December 2021

- Provide 15 in-classroom health modules to approximately 60 students, ages 13-18 years, across two high school sites. Administer pre- and post- instruction assessments. Recruit student participants for one-on-one health coaching sessions.
- Provide health coaching to approximately one-third (20) of the students from the in-classroom modules who opt to receive a series of six one-on-one health coaching sessions.
- Administer pre- and post-coaching assessment to student participants.
- Communicate with Research Partner and receive evaluation/assessment results for Cohort 4.

Implementation Cohort 5: January - June 2022

- Provide 15 in-classroom health modules to approximately 60 students, ages 13-18 years, across two high school sites. Administer pre- and post- instruction assessments. Recruit student participants for one-on-one health coaching sessions.
- Provide health coaching to approximately one-third (20) of the students from the in-classroom modules who opt to receive a series of 6 one-on-one health coaching sessions.
- Administer pre- and post-coaching assessment to student participants.
- Communicate with Research Partner and receive evaluation/assessment results for Cohort 5.

Implementation Cohort 6: August - December 2022

- Provide 15 in-classroom health modules to approximately 60 students, ages 13-18 years, across two high school sites. Administer pre- and post- instruction assessments. Recruit student participants for one-on-one health coaching sessions.
- Provide health coaching to approximately one-third (20) of the students from the in-classroom modules who opt to receive a series of six one-on-one health coaching sessions.
- Administer pre- and post-coaching assessment to student participants.
- Communicate with Research Partner and receive evaluation/assessment results for Cohort 6.
- Begin developing final evaluating program results.
- Explore possible community partnerships and leverage funding opportunities.
- Explore possible opportunities to publicize and disseminate results.

Ramp down/Evaluation: January - July 2023

- Collaborate with the Research Partner to publish results of the study.
- Secure funding needed for replication if this holistic teen health education model proves successful.

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

- A) **BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)**
- B) **BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)**
- C) **BUDGET CONTEXT (are MHSA funds being leveraged with other funding sources?)**

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, “\$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total \$15,000”) and identify the key personnel and contracted roles and responsibilities that will be involved in the project. Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

The four-year budget is designed to withstand increases in personnel and operating costs such as rents. The program is not leveraging other funds at this time. Salaries for the four years include a 2% COLA increase and any anticipated promotions. Fringe benefit costs includes the following: FICA, SUI, Health Insurance, Disability Insurance, Workers Compensation, and Retirement. We anticipate that most fringe benefit items will increase and are calculated with per annual increases.

Personnel Expenditures

Health Educators @ 50% FTE (2 Employees): Each Educator will deliver curriculum content at the two schools and collect pre/post-test and satisfaction survey data; assist in the refinement of the instruction model.

Sexual Health Education Coordinator @ 9% (1 Employee): The Coordinator will manage curriculum development and implementation with the two school sites; assist in the development of data collection tools; communicate regularly with the Wellness Project Supervisor and Youth Programs Director regarding the status of work at each of the two sites.

Wellness Project Supervisor @ 10% (1 Employee): The Supervisor will monitor staff time, program implementation objectives, and development of reports; coordinate with San Luis Obispo County Behavioral Health representatives and Philliber Research staff in developing planning adjustments and data collection procedures.

Youth Programs Administrative Assistant @ 9% (1 Employee): The Administrative Assistant will help with collecting and mailing data to Philliber Research, report preparation, scheduling planning meetings, preparing invoices, vouchers, purchases, and other assistance as needed.

Youth Programs Director @ 9% (1 Employee): The Youth Programs Director will facilitate contracts, budgeting, and reporting for the project; work with Wellness Project Supervisor, San Luis Obispo County Behavior Health, and Philliber Research on development of performance measures; ensure that stakeholders are included in the planning and feedback processes.

Division Director @ 2% (1 Employee): The Director will monitor and approve written agreements and budgets for the Innovation Project.

Operating Expenditures

Program Supplies: Supplies required for the operation of the program, duplication, materials, print cartridges, signs, evaluation tools and rosters.

Local Mileage: Reimburse staff for the use of personal vehicles for program business.

Vehicle Maintenance: Ongoing upkeep of organization vehicles used by staff for program business, such as preparing events. This includes fuel, maintenance and DMV fees.

Rent: Includes the space used by staff at the San Luis Obispo Office.

Utilities: Includes gas, water, trash, and electricity for program office.

Janitorial: Services for program office.

Equipment Repair and Maintenance: Includes the upkeep and maintenance of office equipment, including copiers, computers, and printers.

Liability Insurance: The share of the cost of liability insurance for the program office, program employees, and vehicles.

Printing: Includes staff business cards, program brochures, referral cards, training materials for health clinics, social workers and parent education workshops, and promotional flyers for teen events and school administrators and students.

Telephone: Phone service for program staff.

Indirect: The agency indirect rate for expenses is 8%, which include administrative costs.

Contracts

Evaluation Consultant: Design of evaluation tools to measure achievement of E-B curriculum objectives and outcomes, and efficacy of CAG community mobilization and program dissemination activities; measure program outcomes to determine the extent to which they are the result of the program; design a comprehensive community needs assessment; prepare an implementation study report; and prepare a final outcome evaluation report that summarizes results of the study.

Other Expenditures

Other expenditures include costs for project County Innovation Evaluator of \$15,000 per year. The County Innovation is responsible for the overall coordination, evaluation, and auditing process of all innovation projects' data collection, analysis, and state reporting.

PERSONNEL COSTS (salaries, wages, benefits)		Ramp up Period FY 19/20	Program Year 1 FY 20/21	Program Year 2 FY 21/22	Program Year 3 And Eval Period FY 22/23	TOTAL
1.	Salaries	\$52,344	\$76,910	\$77,502	\$59,545	\$266,301
2.	Direct Costs	\$18,241	\$28,828	\$28,786	\$21,834	\$97,689
3.	Indirect Costs	\$5,647	\$8,459	\$8,503	\$6,510	\$29,119
4.	Total Personnel Costs	\$76,232	\$114,197	\$114,791	\$87,889	\$393,109
OPERATING COSTS		FY 19/20	FY 20/21	FY 21/22	FY 22/23	TOTAL
5.	Direct Costs	\$19,596	\$34,750	\$34,200	\$31,950	\$120,496
6.	Indirect Costs	\$1,568	\$2,780	\$2,736	\$2,556	\$9,640
7.	Total Operating Costs	\$21,164	\$37,530	\$36,936	\$34,506	\$130,136
NON-RECURRING COSTS (equipment, technology)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	TOTAL
8.		\$0	\$0	\$0	\$0	N/A
9.		\$0	\$0	\$0	\$0	N/A
10.	Total Non-recurring costs	\$0	\$0	\$0	\$0	N/A
		\$0	\$0	\$0	\$0	N/A
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	TOTAL
11.	Direct Costs	\$20,930	\$14,605	\$14,605	\$20,930	\$71,070
12.	Indirect Costs	\$1,674	\$1,168	\$1,168	\$1,675	\$5,685
13.	Total Consultant Costs	\$22,604	\$15,773	\$15,773	\$22,605	\$76,755
OTHER EXPENDITURES (please explain in budget narrative)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	TOTAL
14.		\$0	\$0	\$0	\$0	N/A
15.		\$0	\$0	\$0	\$0	N/A
16.	Total Other Expenditures	\$15,000	\$15,000	\$15,000	\$15,000	\$60,000
		\$0	\$0	\$0	\$0	N/A
BUDGET TOTALS						
Personnel (line 1)		\$52,344	\$76,910	\$77,502	\$59,545	\$266,301
Direct Costs (add lines 2, 5 and 11 from above)		\$58,767	\$78,183	\$77,591	\$74,714	\$289,255
Indirect Costs (add lines 3, 6 and 12 from above)		\$8,889	\$12,407	\$12,407	\$10,741	\$44,444
Non-recurring costs (line 10)		\$0	\$0	\$0	\$0	N/A
Other Expenditures (line 16)		\$15,000	\$15,000	\$15,000	\$15,000	\$60,000
TOTAL INNOVATION BUDGET		\$135,000	\$182,500	\$182,500	\$160,000	\$660,000

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)

ADMINISTRATION:

A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	TOTAL
1.	Innovative MHSA Funds	\$135,000	\$182,500	\$182,500	\$160,000	\$660,000
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding*					
6.	Total Proposed Administration					

EVALUATION:

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	TOTAL
1.	Innovative MHSA Funds					
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding*					
6.	Total Proposed Evaluation					

TOTAL:

C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	TOTAL
1.	Innovative MHSA Funds					
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding*					
6.	Total Proposed Expenditures	\$135,000	\$182,500	\$182,500	\$160,000	\$660,000

*If "Other funding" is included, please explain.

Resource References:

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County Name: San Luis Obispo

Date Submitted: May 19, 2019

Project Title: SLOTAP (San Luis Obispo Threat Assessment Program)

Total amount requested: \$879,930.40

Duration of project: 4 years

Purpose of Document: The purpose of this template is to assist County staff in preparing materials that will introduce the purpose, need, design, implementation plan, evaluation plan, and sustainability plan of an Innovation Project proposal to key stakeholders. *This document is a technical assistance tool that is recommended, not required.*

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation Project is defined as a project that “The County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports”. As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Section 1: Innovations Regulations Requirement Categories

CHOOSE A GENERAL REQUIREMENT

An Innovative Project must be defined by one of the following general criteria. The Proposed project:

- Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population**
- Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- Supports participation in a housing program designed to stabilize a person’s living situation while also providing supportive service onsite

CHOOSE A PRIMARY PURPOSE

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- Increases access to mental health services to underserved groups
- Increases the quality of mental health services, including measured outcomes
- Promotes interagency and community collaboration related to Mental Health Services or support of outcomes**
- Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

PRIMARY PROBLEM

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

San Luis Obispo County lacks the infrastructure, as well as a coordinated and collaborative model and system to assess and intervene as necessary with school-based threats. The lack of structure and current siloed agencies leave our County vulnerable to situations of threat. Little or no information is available locally as agencies work independently without a cohesive plan and model to intervene and educate the community in cases of threats.

Presently, none of the educational, law enforcement, or mental health institutions in San Luis Obispo County have the infrastructure, coordinated model, and a regular data base that monitors the number of apparent threats made, whether level of threat, type of threat, by whom, and whether the threat warrants a multi-agency response. San Luis Coastal Unified School District provided the following information based upon a review of threat assessment reports from the past several years. These cases are frequencies and presented in a range as each year may differ.

High Level Threats	Requiring Multi-Agency Response	Requiring Mobile Crisis or Hospitalization	Amount of Staff Time (Paperwork and Follow-up)	Ongoing Monitoring
9-12 per year	2-4 per year	2-3 per year	2-3 weeks	2 months

It should also be noted that there have been several cases in the last five years that have required multi-agency involvement, one including FBI involvement with a student and parent.

Cal Poly noted that neither the university nor campus police track data related to threats on campus. There is not a formal threat assessment team; therefore, data related to level, type of threat, and threat source are not obtained. Administrators indicated that they have had four high level cases in the past three years. One situation involved a student making a bomb threat on a public bus. Another involved a student making several threats via email and verbal statements in classrooms over a two-year period. Another involved an employee stalking and threatening another employee. Finally, a student made several threats against a political speaker who was coming to campus. This garnered the involvement of the FBI. An out-of-state, private, and price-prohibitive Threat Assessment was conducted. Although the student was expelled, charges made, and treatment recommended, the individual remained in the community. There was not a specific recommendation or guidance from the Threat Assessment Report about how local agencies should continue to monitor for potential threats from the individual.

In 2014, the FBI released *A Study of Active Shooter Incidents in the United States Between 2000 and 2013*, which reviewed 160 incidents involving an individual who attempted to kill people in a confined/populated area. Only twelve incidents, or 7.5%, occurred at institutions of higher education; however, nearly one quarter of the incidents studied occurred at educational settings and these accounted for some of the highest casualty counts. The individuals who engaged in violence included

students, former students, employees, and a visitor (Blair & Schweit, 2014). The report also contains information regarding incidents occurring at commerce and employment settings, which may be relevant findings for the San Luis Obispo community.

The Center for Homeland Defense and Security's K-12 School Shooter database (www.chds.us) indicates that in 2018, there have been 92 school shooting incidents, double the number of incidents for 2016 and 2017, with the most frequent ages of the perpetrator between 16 and 17 years. Thus, nationally, incidents are increasing. More recently, there have been incidents that have occurred locally and regionally. These have included the following incidents as captured by headlines:

1. A 17 year old Morro Bay High School student was arrested this week on suspicion of making threats against the school, police say. March 26th, 2018.
2. Atascadero High student threatened to 'shoot up' school. March 14th, 2018
3. Isla Vista Mass Murder, May 23, 2014
4. Individual in mental health therapy makes a threat toward Ventura Schools. www.vcstar.com/story/news/education/2018/08/29/ventura-unified-school-district-potential-threat-parents
5. Borderline Bar and Grill Shooting, Thousand Oaks, CA. November 7th, 2018

Although threat assessments and monitoring have become a staple practice in educational institutions, recent case study reviews have noted that isolated, inconsistent, and ineffective implementation of threat assessment and monitoring can leave educational institutions vulnerable to violent incidents (Goodrum et. al 2018, White 2017). With the increasing, ongoing threats and lack of a coordinated and collaborative model system, San Luis Obispo County is at a disadvantage to assess and engage youth in these situations.

Threat Assessment Models are available in Los Angeles and San Diego. These models stem from a legal and criminal perspective that does not support a comprehensive and collaborative community-based approach to threat assessment. Based on their large and available funding streams, resources, and infrastructure they address and engage threats with a different lens, which is not applicable in the provincial and dispersed community makeup of San Luis Obispo County. Due to the vulnerability the County is experiencing in terms of fragmented information and processes to handle threats, the County is interested in piloting an innovation project which will adapt the threat assessment model of these larger counties in order to determine which parts may be useful for a smaller county. Additionally, because there is no coordinated system of exchanging threat assessment information between responding agencies/institution, the County is proposing to develop such a collaborative as well as provide a learning mechanism to other interested counties. By creating an integrated system and infrastructure, all partnered agencies involved will gain a holistic understanding of the psychological, social, and family components that might explain the result of the threat behavior. This, in turn, will lead to a focus on proper referrals, intervention, and prevention.

PROPOSED PROJECT

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

- A) Provide a brief narrative overview description of the proposed project.**

The project is designed to develop a coordinated and collaborative training model and system to learn, assess, and intervene when cases of threat become apparent or imminent. The innovation project is also designed to create a new learning and language model between the mental health system (MHS), law enforcement (LE), and educational institutions (EI) employing a new curriculum derived from proven and effective models, but tailored to San Luis Obispo and directed towards coordinating efforts between MHS, LE, and EI. The innovation project is meant to educate and decrease the criminalization and stigmatization of youth in cases of threats. Education becomes an important outcome of this project as it allows the participants to align their professional lens to a mental health approach to best engage with the community and de-stigmatize notions of mental illness associated with threats. This will be accomplished by creating a community-based approach imbedded in the training component and system to be tested by the participants.

Through education and ongoing training, community partner teams and the public involved in the referral, assessment, and monitoring of threats will learn the psychological, behavioral, social, and familial signs strongly associated with threatening behavior. With further education, the teams will begin to recognize components of threatening behavior that may likely warrant a mental health treatment response. This will refocus community partners toward prevention and intervention responses rather than prosecution. Although threat assessment models are available in Los Angeles and San Diego, these models stem from a legal and criminal perspective that does not support a comprehensive and collaborative community-based approach to threat assessment. Based on their large and available funding streams, resources, and infrastructure they address and engage threats with a different lens, which is not applicable in the provincial and dispersed community makeup of San Luis Obispo County.

Key Components:

Development and Implementation of a SLO-Centric Threat Assessment Model in County-Examine Community Model

The project builds a unique model upon examining diverse approaches to threat assessment and creating protocols to identify, manage threats of target-based violence, and follow-through. Threat Assessment Teams can implement preventative strategies to school, campus, workplace, or community violence.

Collaboration and Training

The project creates a system of collaboration and experts trained in the new threat assessment process based on a multi-disciplinary team approach from various backgrounds (education, mental health, and law enforcement), employing fact-based predictors of violence, and applying an individualized and preventative approach. A single model across multiple agencies creates a common language that allows for expedient and clear communication.

Educating the Community-Students, Parents, Mental Health Professionals and CBO's.

This process requires educating students, parents, school employees, coworkers, supervisors, etc. on how to identify behaviors that may reveal an individual's potential intent to do harm to others and empowering them with the ability to lead and achieve the referral process. Referrals are provided by the following process: 1) assess the components, 2) manage threats, and 3) obtain appropriate mental health support if warranted. By educating community individuals on making specific referrals, this likely prevents a situation in which information and knowledge slips through the system. Education

empowers community stakeholders to report information to appropriate persons to initiate a Threat Assessment Process.

Mental Health Capacity Building

This step is about the development of a community-based system to receive reports from the community, accurately assess the potential violence, and respond with appropriate support strategies to stabilize and mitigate the threat. This includes finding the proper therapeutic intervention approach (inpatient hospitalization, medication, family therapy, CBT) as well as monitoring potential reduction in violence.

B) Identify which of the three project general requirements specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.

Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population

C) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.

Threat Assessment Teams are presently operating to some level in the San Luis Obispo County, yet these are siloed approaches and there is not a coordinated and collaborative system and model focused on assessment approaches, access to school resource officers, and mental health treatment and engagement. Historically, research has indicated that K-12 districts, campus-based, or university-based systems have run their threat assessment and threat responses in isolation either in their assessments, law enforcement responses, or mental health intervention. A direct collaborative system and integrated model has yet to be put into place. By creating an integrated system, all agencies involved will gain a holistic understanding of the psychological, social, and family components that might explain the result of the threat behavior. This, in turn, will lead to a focus on variables needing intervention and prevention rather than highlighting only the threatening behavior for discipline.

D) Estimate the number of individuals expected to be served annually and how you arrived at this number.

Approximately 50 participants every fiscal year will be part of the Innovation Project, which will include participants from the Mental Health field, Law Enforcement, and Educational Institutions.

E) Describe the population to be served, including relevant demographic information (age, gender identify, race, ethnicity, sexual orientation, and/or language used to communicate)

The participants will be Mental Health Professionals, Law Enforcement, Educational Institution Staff. A large sample will be drawn from the County to cover all regional areas.

RESEARCH ON INN COMPONENT

A) What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

Unlike the START Program from LA County and the San Diego Program, which are both centralized, comprehensive programs in a large urban area stemming from legal and criminal lenses, the SLOTAP Program proposal aims to develop a system within a mostly provincial area with limited access to resources. It will focus by creating a community-based approach and training model that supports the logistical infrastructure and coordinated and collaborative system between MHPs, LE, and EI staff. The SMART program in Glenn County is a multi-agency crisis response focusing only on K-12 student behaviors beyond those of threat assessment such as suicide behavior, violence, and bullying. SLOTAP creates a new system and infrastructure never tested before in a medium-size county focused on a community-based approach centered in prevention, intervention, referral, and monitoring for various age groups (children to adults). The SLOTAP's monitoring process focuses on response to various types of psychological intervention for all individuals rather than focusing on crisis relapse using wrap-around models. LA, San Diego, and Glenn counties' programs focus on students and parents who make high-level threats, a reactive model. What is unique of SLOTAP is the use of a comprehensive community-based model to engage parents in the K-12 and college area to educate them about threat assessment and include them in the referral and preventative model. SLOTAP is also designed to support individuals who are determined not to pose a high-level threat but may need mental health support. This approach reduces stigmatization and criminalization of individuals who go through the threat assessment process.

B) Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

There are Threat Assessment programs and models that are in place, but there is not a specific training model targeted to MHPs, LE, and EI staff to work in a coordination to address, assess, intervene, and provide services as described by the Innovation Project. The proposed INNnovation project aims to develop first the curriculum, model, and infrastructure for participants (MHPs, LE, and EI staff) in order for them to properly communicate and share only potential and pertinent client information among their jurisdictions. These elements will help us understand what processes and agreements must be established for organizations to coordinate communication and collaboration.

LEARNING GOALS/PROJECT AIMS

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices. (See Attachment 1)

A) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?

The Innovation Project's goals/aims are the following:

1. Provide Stakeholder/Participant Training - The County and its stakeholders hope to learn more about the best approaches for teaching and training of threat assessment procedures for MHPs, LE, and EI staff in a community with limited resources.

2. Develop a Community Threat Assessment System - The County and its stakeholders seek to understand the best components that make an efficient, coordinated, and collaborative system and model related to threat assessment for MHPs, LE, and EI staff.
3. Community Education and Outreach on Warning Signs - The County and its stakeholders seek to learn better methods to increase prevention and early detection and engagement as it relates to threat assessment.
4. Increase Knowledge of Mental Health Intervention Approaches - The County and its stakeholders seek to better understand how MHPs should approach and treat individuals who have made threats or gestures towards homicidal violence.

The Innovation Project's objectives/metric outcomes are the following:

- a) Increase the level of skill and knowledge for MHPs, LE, and EI staff to identify and prevent school and community threats as defined and assessed by a training model.
 - 1) Metrics include the number of pre/post retrospective surveys, the number of reports testing objective and training/consulting expert progress. And a Multiple-Choice Pre-test of the adopted Threat Assessment Principles will be conducted.
- b) Increase the level of interagency collaboration through the development and use of the coordinated and collaborative training system and model for threat assessment.
 - 1) Metrics include documentation of interagency meetings, case review questionnaire, number of coordinated collaborative threat assessments, awareness of potential stereotypes via reflections and open-ended responses, and communication assessment within interagency SLOTAP team.
- c) Decrease the number and level of potential threats identified through referral.
 - 1) Metrics include the number of threats and their levels before the participants attend training and after the participants attend training, the number of threat referrals, and source of referral (parent, teacher, student, etc.).
- d) Increase the number of MH professionals available to provide therapy to individuals who make serious threats.
 - 1) Metrics include documented training and presentations to MH professionals on threat assessment process, pre/post survey of MH professionals receiving referrals, and the number of referrals provided to MH professionals based upon threat assessment recommendations.

B) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

These learning goals are directly related to the innovative components previously described, namely, the testing of a new, never-before-designed, coordinated, and collaborative training system and model focused on threat assessment.

EVALUATION OR LEARNING PLAN

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

The Innovation Project will collect the following data for each goal:

1. The number of participants involved in each training or workshop

2. The number of threat assessments conducted, including type of threat and level of threat
3. The number of mental health referrals provided during the training period stemming from threat assessments
4. The number of case consultation conferences held annually
5. Pre- and post- assessment/evaluations conducted before and after each training process
6. Case Review Questionnaires

Section 3: Additional Information for Regulatory Requirements

CONTRACTING

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County’s relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

The County plans to select a contract provider who will best execute this project. The County has outstanding contractual partnerships across the community mental health system, as well as strong relational partnerships with many community schools, colleges, health providers, and law enforcement agencies. The Behavioral Health Department, including the MHSA Administrative Team, is well equipped to conduct a fair and successful procurement process (in partnership with County Purchasing) and expedite a contract to be sure INNnovation Project timelines presented herein are met.

The County Innovation Component Coordinator, Nestor Veloz-Passalacqua (Administrative Services Officer II), is the community liaison for all Innovation (and PEI) projects and evaluation. Nestor coordinates the stakeholder planning process and will be the one to develop any RFP to select providers. The MHSA Administrative Team also includes Frank Warren (Division Manager), the County MHSA Coordinator, who manages all aspects of MHSA, including contracts and plan monitoring. Briana Hansen, Accountant III, is the fiscal lead and works with each provider to develop accurate budgeting and spending plans. Kristin Ventresca, the CSS Coordinator (Administrative Services Officer II), also provides contract management and oversight. Nestor utilizes California Polytechnic State University statistics and public policy students in paid internships that assist in data collection, technical assistance for providers, and reporting.

All Innovation providers will meet regularly with Nestor and the team before and during the start-up phase to finalize plans, conduct data collection tests, and develop tools. Some plans may need to be adjusted (based on hiring, procurement of materials, etc.) and Nestor will work with each contractor to provide support and guidance to keep the projects on time. After the launch of each project, Nestor will work with the contractors to provide quarterly reports and data collection. The MHSA Administrative Team will conduct spot checks, review project materials, and review quarterly reports to ensure quality and regulatory compliance.

Additionally, the County will establish a contract with an Evaluator to manage the analysis of data, as well as provide technical assistance to the projects to be sure tools are developed which accurately measure the results of each objective. This Evaluator will provide regular reports to the MHSA Administrative Team and MHSA Advisory Committee (stakeholder group), as well as the final report which will be provided to the MHSOAC.

COMMUNITY PROGRAM PLANNING

Please describe the County’s Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or underserved populations, and individuals who reflect the cultural, ethnic and racial diversity of the County’s community.

A new round of innovation launched in October 2018. The first Innovation Stakeholder meeting took place on October 11, 2018, where new and current Innovation Stakeholders were present to review the innovation guidelines and begin a larger conversation and collaboration process for research and testing new meaningful ideas in our community. Community members ranging from psychologists, to educators, and think-tank individuals were present as well as mental health providers and partners. The County made available information containing steps to successfully submit an innovation idea, along with providing technical assistance in developing the narrative piece of the proposal. One of the most eager and profoundly interested community members was Dr. Joseph Holifield. At an initial meeting he presented the first iteration of his idea to integrate and develop a new coordinated and collaborative training model and system to learn, assess, and intervene when threats become apparent or imminent in the educational system. Dr. Holifield had based his idea on years of performing threat assessments and leading threat assessment teams in several local school districts (2000-2017). He blended his experience with new information about community-based models discussed at a recent Threat Assessment Conference he attended in August 2018. Dr. Holifield had also taught at Cal Poly for 15 years (2000-2015), and he covered the topic of School Shootings in one of his lectures. After each lecture, several students would typically approach him about ongoing concerns they had about students on campus. He recognized, at that time, there was not an internal system of review for threats. Based upon his academic knowledge and experiences with threat cases, he recognized that the community had a fragmented approach to threat assessment. Dr. Holifield reached out to community partners with whom he previously had been involved. By working privately outside of each system, he wanted to devote his time to assist in developing a system that would both work for both community partners as well as bring other agencies such as law enforcement and mental health to the table for a collaborative project. Having practiced psychology in the San Luis Obispo Community for 19 years, he also understood the current limitations in the community about mental health support for individuals who present with these issues.

This project is part of larger collaboration between local organizations around the creation of a coordinated and collaborative training system and model to best approach, treat, and assess threat situations in our community. The project continued to be refined as County staff, Dr. Holifield, California Polytechnic State University, and school district representatives were involved. The project design is the result of community engagement led by Dr. Joseph Holifield with local School Districts. Additionally, the Behavioral Health Department has provided support in the form of technical assistance to best refine and coordinate efforts to make the proposal a priority in reference to what the community needs are. Additional interest in implementation and processes came from California Polytechnic State University – San Luis Obispo. The project design became apparent as feedback included the need to build a training system and infrastructure to allow for better engagement and response to threats that are present in the community, assisting youth and college students in connecting to mental health services and a recovery process before a threat is made. The County continues to provide technical assistance and support in the development of the proposal, as well as providing procedural information to the development and completion of the proposal. The continued collaboration between stakeholders, community members, and advocates stems from understanding the dire need to ensure a coordinated and collaborative training approach bringing MHPs, LE, EI staff together to address and deescalate threat situations, while providing youth with an opportunity to feel better engaged and to help them experience success and mental health wellbeing.

The innovation project team has solidified its efforts with Dr. Holifield, school districts, Cal Poly, and stakeholders to emphasize and organize proper coordination and implementation of the proposal. The staff and appropriate partners, such as Dr. Holifield, school district representatives, and other stakeholders will continue to meet regularly during the project development, implementation, and evaluation to identify and address challenges, and to coordinate proper engagement for the intervention being tested. Currently the County Innovation Coordinator has received feedback from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to ensure Innovation guidelines and regulations are met. The feedback and edits have been implemented into the proposal. Part of our efforts for a successful proposal includes the continued collaboration and coordination with the County and community-based organizations to ensure the inclusion of a wide representation of staff, and to ensure planning efforts reflect the community collaboration and the impact on the youth population.

MHSA GENERAL STANDARDS

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320 (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standards could not be applied to your INN Project, please explain why.

A) Community Collaboration

The project is designed upon a stronger collaboration that includes youth, Law Enforcement, the County Probation Department, Educational Institutions (K-12 schools and Higher Education), County Behavioral Health Department, and family and community members. The project fosters and maintains community collaboration through a process of consistent stakeholder advisory group interaction representing diverse racial/ethnic, cultural, and linguistic communities. The project works with mental health providers, law enforcement agencies, a regional university, school district staff, families, parents/caregivers, and other professionals to enhance and develop an appropriate training model to best identify threats.

B) Cultural Competency

The project is designed to impact diverse communities from all regions of the County. The project employs culturally and linguistically appropriate staff who will engage clients in service delivery that fosters equal access to services without disparities. Additionally, the stakeholder advisory group incorporates into the project design culturally and linguistically appropriate guidance in the administration, implementation, delivery, and evaluation processes. This will be achieved by providing participants to be part of the project and by providing all services in the primary language of the participant. Services will engage and retain diverse individuals through recruitment by a trusted source. The stakeholder advisory group will monitor the project for disparities in services using process data and community data provided by the project data analyst.

C) Client-Driven

The project is designed to engage MHPs, LE, EI staff who work primarily with youth, which are ultimately the population that will be impacted by the Innovation project. Youths' and college students' experiences and information will provide guidance and better understanding to the participants regarding what best practices and approaches are available to identify and engage with youth who may be part of a threat.

D) Family-Driven

The project is designed to engage the participants within the support network of youth and their direct family support network as the primary agents of information. Their involvement will determine decisions as well as what elements of the coordinated and collaborative training system and approach are essential to identify potential threats and how to appropriately respond to them.

E) Wellness, Recovery, and Resilience-Focused

The project services maintain the philosophy, principles, and practices of the Recovery Vision. Early intervention often prevents or mitigates behavioral and social problems; therefore, early referrals and connection to mental health resources and supports are a focus of the project. Youth and parental empowerment and social connections are critical to the youth's well-being and are supported through offering community information to access services.

F) Integrated Service Experience for Clients and Families

The project involves an integrated community approach and resource knowledge experience. Project partners and staff work on providing a seamless system between County agencies and community providers as a referral source available to youth to create a larger system of mental health care coordination.

CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

The cultural competence goals have been incorporated into the project design and will be included in the project administration, delivery, and evaluation. Equal access to services without disparities will be achieved by providing all participants with equal opportunity to participate in the project and by providing the test in the primary language of the participant. The stakeholder advisory group will monitor the project for disparities in services using process data and community data provided by the project data analyst; adjustments will be immediately made to eliminate any disparities found.

INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE

Briefly describe how the County will decide whether it will continue with the INN project in its entirety or keep particular elements of the INN project without utilizing INN Funds following project completion. Will individuals with serious mental illness receive services from the proposed project? If yes, describe how you plan to protect and provide continuity of care for these individuals upon project completion.

The costs associated are for training program development and coordination, initiation, ongoing operation, and evaluation. If the evaluation indicates the coordinated and collaborative training system and model is effective, the County will work collaboratively with MHPs, LE, and EI staff, and other important youth-oriented and campus organizations that have been part of the project to help determine the best public and private funding sources to continue this service, and the challenges and success of the project as informed by evaluation results.

COMMUNICATION AND DISSEMINATION PLAN

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

There are several ways we plan to continuously disseminate information to stakeholders, including:

- Holding a final report forum, sponsored by the project’s Stakeholder Advisory Committee
- Use of social media and outreach with organization focused on youth development
- Partner newsletters and local media
- Presentations to partner boards of director and county leaders
- Holding semi-annual case review conferences among trainees to review training practices related to the adopted threat assessment model or approach.

Stakeholders will be involved through the planning, implementation, and evaluation of the project, as well as additional quarterly reporting meetings. Program participants will be invited at every possible opportunity to take part in sharing findings through written testimonials, participant feedback, and/or public presentations of findings. It is these real stories of real experiences that are most impactful.

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

SLOTAP, Mental Health, Campus, Threat, Assessment

TIMELINE

A) Specify the expected start date and end date of your INN Project

The Innovation Project is expected to start on October 1, 2019 and will end on October 1, 2023.

B) Specify the total timeframe (duration) of the INN Project

Four years starting October 2019 – October 2023

C) Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

The success of the INNnovation Project is predicated upon the professional administration, coordination, and collaboration amongst the implementation team, stakeholders, advisory committee, contractors, and experts to thoughtfully oversee the project. The County will be prepared to successfully put into place the major elements of the project in the six-month ramp-up, the intervention/testing period, and the six-month evaluation phase.

Ramp up/Planning: July - December 2019

- Develop and finalize the curriculum

- Plan and solidify implementation logistics
- Contract with speakers/subject expert matters/trainers
- Develop data collection tools
- Coordinate delivery and training schedule

Year One Major Milestones

- Begin the first Team Class with MHPs, LE, and EI staff
- Year-end report discussion with stakeholder advisory committee

Year Two Major Milestones

- Graduation of first Team Class
- Begin the second Team Class with MHPs, LE, and EI staff
- Review and consider results of first Team Class evaluation and next steps to solidify new lessons learned or revise curriculum
- Year-end report discussion with stakeholder advisory committee

Year Three Major Milestones

- Implementation of recommended pieces as discussed in year one and year two, if applicable
- Graduation of second Team Class
- Begin the third Team Class with MHPs, LE, and EI staff
- Year-end report discussion with stakeholder advisory committee

Ramp down/Evaluation: January - July 2023

- Review all evaluation done to date and implement any additional evaluative tool
- Collaborate with the Research Partner to publish results of the study
- Secure funding needed for replication if optimal teen health model proves successful
- Hold a project end forum to discuss lessons learned, sponsored by the stakeholder advisory group

What is listed above are only a few of the major milestones. Already, this project begins as a partnership among several organizations. As it moves forward, a significant emphasis will be to genuinely engage multiple groups and individuals at each step. The County sees this as the best approach to gain valuable information to better serve the community.

Section 4: INN Project Budget and Source of Expenditures

INN PROJECT BUDGET AND SOURCE OF EXPENDITURES

The next three sections identify how the MHSA funds are being utilized:

- A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)**
- B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)**
- C) BUDGET CONTEXT (are MHSA funds being leveraged with other funding sources?)**

BUDGET NARRATIVE

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, “\$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total \$15,000”) and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, “Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time...”). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

Personnel Expenditures

Assistant Grant Coordinator:

The Assistant Grant Coordinator will work under the direction of the Threat Management Coordinator and will be responsible for the day-to-day workflow activities associated with the program. The Assistant will monitor intern time, duties, and program implementation objectives, assist in the development and preparation of reports, prepare invoices, vouchers, and purchases, and provide other assistance as needed. The Assistant Grant Coordinator will update and maintain program content access to the community through brochures and website content. The Assistant Grant Coordinator will schedule ongoing trainings and planning meetings with community partners and contracted experts.

The Assistant Grant Coordinator will be a part-time position starting with 15 hours/week at \$23/hour with \$16,560 for the first 3 years and \$22,080 for final year.

Cal Poly Student Interns

There will be up to 2 interns recruited from the Cal Poly Psychology Department that will participate in data collection, outcome data entry, and will provide additional support with regard to literature reviews, research, and development data-based forms. There will be no cost as students will be gaining experience and obtaining course credit for their participation. (Up to 10 hours a week)

Operating Expenditures:

Rent/Lease Building: Prorated cost of Threat Assessment Manager’s Office to conduct SLOTAP business. Rent is part of an adjusted modified gross lease with basic utilities included such as garbage pick-up, and other utilities (electric, gas, water, etc.). Address is located at 11549 Los Osos Valley Road, Suite 200, San Luis Obispo, CA 934005. The prorated cost is adjusted base on yearly rent increase within the lease as well as increase in time space is utilized by Threat Management Coordinator.

Year 1- \$950/month X .50 (20 hours/week)= \$475.0/month prorated X 12 months=\$5,700

Year 2-\$988/month X .30 (hours/week)= \$741.0/month prorated X 12 months=\$8,892

Year 3-\$1,028/month X .75 (30 hours/week)= \$771.0/month prorated X 12 months=\$9,252

Year 4-\$1,069/month X .80 (32 hours/week))= \$855.0/month prorated X 12 months=\$10,262

Utilities/Internet: Business Internet/Phone-Prorated at same rent schedule at hours/week
Office Internet Connection and cell phone

Year 1=\$31.25/month X 12=\$375
Year 2=\$37.50/month X 12=\$450
Year 3=\$37.50/month X 12=\$450
Year 4=\$46.87/month X 12=\$562.40

Phone/Fax—Add-on

\$30/month extra added on to the internet provider
Years 1-4 (\$360/year X 4 Years=\$1,440)

Internet Research Access: Years 2-4

APA PsycINFO will be shifted to this line item after the first year.

Non-Recurring Expenditures:

Office Furniture and Tools

Laptop/Chromebook-\$600

SLOTAP will make a one-time purchase of a laptop/Chromebook in order to utilize to conduct program activities and communication via email. This purchase also includes a subscription to Microsoft Windows-Research that would include Word, Excel, PowerPoint, Access.

Printer-\$450

One time purchase of a basic color laser printer for the program.

Filing Cabinet-\$200

Filing Cabinet for storage of hard copies of program records and activities.

Office Phone-Business Phone-Conference Phone Capabilities-SLOTAP Program-\$175

Research and Threat Assessment Tools:

American Psychological Association (APA)-PsycINFO®

Centered on psychology and the behavioral and social sciences, the interdisciplinary content in PsycINFO® makes it one of the most highly utilized databases by students, researchers, educators, and practitioners worldwide, and an indispensable tool for the discovery of global scholarly research. With more than 4 million records and upwards of 4,000 expertly-indexed records added each week, this ever-expanding collection of behavioral and social science research, dissertations, and scholarly literature abstracts offers a broad view of the field. Abstracts included with all dissertation records since 1995, and nearly all records from 1967 to present.

The use of this tool will allow the Threat Management Coordinator to research and review scholarly articles that will assist in the design and refinement of threat assessment and intervention support to community partners and mental health professionals.

Cost:

Annual Subscription-\$140 for APA Members
\$560 through the life of the Grant

WAVR-21 3rd Edition- University and Mental Health Focused

Source: www.wavr21.com

The WAVR-21 is among the growing number of “structured professional judgement guides (“SPJs”). The WAVR-21 is not a psychological test or scale and does not generate a quantitative “score.” However, the WAVR-21 exemplifies the growing trend in risk assessment technology toward the use of SPJs. In this organized but non-quantitative format, responders refer to a list of factors, each of which has some form of coding criteria with a demonstrated relationship to violence. Such guidelines improve the consistency and transparency of assessment decision-making. Other structured guides exist to assess the violence risk associated with psychopathy, spousal abuse, stalking, released violent offenders, sex offenders, youth offenders, and discharged mental health patients. SPJs are also generally prescriptive: they identify interventions and actions to manage and mitigate a subject’s possible violence risk.

- 1) *The primary focus of the WAVR-21 is to assess the risk of workplace or campus homicidal targeted violence.* A term originally coined by the behavioral scientists of the US Secret Service, targeted violence refers to situations in which an individual intentionally commits an act of violence against an identified or symbolic target, whether people or places. Also referred to as *intended* violence, these acts are potentially foreseeable, as they are the result of an understandable, evolving and often discernable process of thinking, behavior, and preparation. Several of the WAVR-21 factors incorporate this “pathway to violence” escalation dynamic.
- 2) *The secondary purpose of the WAVR-21 is to capture other forms of problematic aggression.* The WAVR may be used to identify and assess the risk, frequency, and severity of non-homicidal aggression such as stalking, disruptive anger problems, menacing behavior, and bullying. These manifestations of aggression are common and problematic in organizational settings in themselves, and could also figure into the ultimate formulation of a subject who may pose a risk of targeted homicide. This view is consistent with contemporary theories that targeted violence is continuous, contextual, and dynamic.
- 3) *The item domains of the WAVR include both static and dynamic factors.* The WAVR items include psychological, behavioral, historical, and situational factors associated with targeted violence, including intimate partner violence posing a threat to a workplace or campus. In practice, threat assessment and threat management are intertwined. Dynamic risk factors (e.g., acute psychosis, access to weapons or targets) become the focus of interventions intended to reduce risk. Assessment and monitoring are ongoing, and an individual’s response to various interventions (e.g., escalation, de-escalation, or no apparent change) becomes part of the changing opinion of risk level.

Cost:

One Time Manual and Tool Kit- \$199.00
25 Additional Protocols/Forms- \$65.00
Team User Training - \$2,500.00

SAVRY-K-12 and Mental Health Focus

Source: Psychological Assessment Resources (PAR)- <https://www.parinc.com>

The SAVRY is composed of 24 items in three risk domains (Historical Risk Factors, Social/Contextual Risk Factors, and Individual/Clinical Factors), drawn from existing research and the professional literature on adolescent development as well as on violence and aggression in youth.

Features and benefits

- Based on the structured professional judgment (SPJ) model, the SAVRY helps you structure an assessment so that important factors will be emphasized when formulating a final professional judgment about a youth's level of risk.
- Addresses the primary domains of known risk and protective factors and provides clear operational definitions. Risk and protective factors are based on their relationship to adolescents—not to children or adults.
- Not designed to be a formal test or scale, there are no assigned numerical values or specified cutoff scores.
- Both reactive and proactive aggression—aggression subtypes that are extensively theoretically supported—are emphasized.
- Items have direct implications for treatment, including the consideration of dynamic factors that can be useful targets for intervention and risk reduction.

Test structure

- Each risk item has a three-level rating structure with specific rating guidelines.
- Six protective factor items are rated as either present or absent.

Costs

SAVRY Introductory Kit--\$138

SAVRY Team Training--\$1,500

Contracts

Trainers and Consultants:

Threat Management Coordinator: The Threat Management Coordinator is responsible for the overall effectiveness of all aspects of the program. Through the recommendations of expert trainers, the Threat Management Coordinator is responsible for the development of the community threat processes and guidance of community teams. In addition, along with MHS Innovation Team, the Threat Assessment Coordinator will be responsible for the development, collection, and evaluation of various components of the SLO-TAP program.

The Threat Management Coordinator will also be responsible for:

- 1) Coordinating and scheduling trainings for community partners from expert consultants
- 2) Developing presentations and local trainings with community partners (Educational Institutions, Law Enforcement, and Mental Health)
- 3) Assistance with Threat Assessment Team Design with community partners.
- 4) Outreach and recruitment of professionals within community partner agencies to receive additional training and become within agency experts
- 5) Consulting with community partners regarding Threat Assessment Design and Procedures. Assists with various aspects paperwork, procedures, partner meetings, etc.
- 6) Threat Consultation for community partner teams, either in person, via phone, or by encrypted HIPAA compliant Telehealth platform. Issues beyond the scope of training of the Threat Assessment Coordinator, will be directed to the Clinical Threat Management Expert for further consultation and response.
- 7) Under the supervision of the Community Threat Expert, assist in the design, implementation, and coordination of a community threat assessment program.
- 8) Provide community trainings to students, parents, faculty/staff about Threat Assessment Process
- 9) Explore intervention approaches that may be efficacious to treatment of individuals who make threats.

- 10) Outreach, networking, and recruitment of mental health professionals to be trained in the basic components of the Threat Assessment Process.
- 11) Consult and collaborate with community mental health professionals on intervention design and response to intervention for individuals receiving therapy due to psychological and social variables that led to a threat being made.
- 12) Coordination, assignment, and supervision of work responsibilities or student interns other personnel designated to perform activities associated with the SLOTAP Project.

The Threat Management Coordinator position will initially be part-time consultant position. The goal at the end-of-the grant period is that a full-time community position will be supported by either the County of San Luis Obispo or consortium of community partners. The proposed salary schedule is as follows:

\$90/hour starting at 30 hours a week the first year and for Year 2 and Year 3, and ending at 35 hours a week for the final year of the grant. (\$136,800 to \$151,200). This rate is approximately 1/4 the median rate of \$350/hour for threat private assessment professionals.

Clinical Threat Management Expert:

The role of the Clinical Threat Management Expert is to provide on-site training and mentoring for the Threat Management Coordinator and SLOTAP community partner threat teams or designated threat professionals. The Clinical Threat Management Expert should be certified as a Certified Threat Manager through the Association of Threat Assessment Professionals. If involved in case consultation for a threat deemed high-level, the Clinical Threat Management Expert will report to and work directly with the Threat Management Coordinator in consulting with the community partner teams.

Through the guidance of the Clinical Threat Management Expert and/or Threat Management Coordinator, community partner teams will have the opportunity to complete threat assessments side-by-side with the local Threat Management Coordinator and/or clinical expert. They will work side-by-side with community partner staff as they work with threat assessments in the replication of strategies and expertise modeled by the Clinical Threat Management Expert or through the Threat Management Coordinator at the guidance of the Clinical Threat Management Expert. The Clinical Threat Management Expert will assist SLOTAP in the initial design and community partner team training programs and ongoing clinical case reviews. The Clinical Threat Expert can be available for case consultations as well as to assist in the design of clinical forms, clinical reports, and clinical recommendations.

Onsite Clinical Training Workshops

The Clinical Workshops are designed to enhance the clinical knowledge and skills of practitioners from a broad spectrum of specialties (Education, Law Enforcement, Mental Health). Participation in the Clinical Workshops will be designed to increase site and SLOTAP staff in the ability to provide direct services to children and families affected by substance abuse and to serve as community leaders in the integration of services and systems for women, children, and families. A maximum of 20 participants at a time attend a full and one-half-day program, and through their participation are able to replicate the strategies and expertise developed. Money is also allotted for a refresher course in the third year of the grant program.

Training: Includes workshops, handouts, materials provided by trainer

Travel: Travel cost for the expert includes airfare, hotel, transportation, food.\

Consultation: Expert clinical consultation (threat cases, forms, clinical procedures, review of team threat assessment reports and feedback, etc.) available to Threat Management Coordinator and with Community Partner Team Members.

Costs

The fee for a 1 to 2 day site clinical training is \$8,000-\$10,000
Refresher Workshop (if needed Year 3--\$6,000)

Clinical consultation (Clinical Consultant Rate=\$350/hour). Consultation can occur in-person, phone, video-feed, or email.

Year 1-up to 4 hours month=48 hours Annual Total =\$16,800
Year 2- up to 5 hours month=60 hours Annual Total =\$21,000
Year 3-up to 4 hours month=48 hours Annual Total=\$16,800
Year 4-up to 2 hours month=24 hours Annual Total=\$8,400

Community Threat Expert:

The role of the Community Threat Expert will be to work with the Threat Management Coordinator and community partner administrative team in the planning and development of policies and procedures geared towards the coordinated effort of threat assessment, threat management, intervention, and threat monitoring. This is not an easy approach, since the County will be moving away from a purely single agency approach and towards an integrated and collaborative paradigm. The Community Threat Expert will assist in guiding the Threat Management Coordinator and Community Partners in reviewing current community systems that presently may interact or may be fragmented when a serious threat is made. The Community Threat Expert will guide and assist the Threat Management Coordinator and Community Partners in the design and implementation of a community-based threat assessment approach that integrates multiple systems (education, mental health, law enforcement) that serves to intervene and prevent individuals from carrying out an imminent, large scale threat to commit harm towards students, faculty, staff, and parents in San Luis Obispo County.

Costs

The fee for a 1-2 day community partner training and initial community consultation is estimated to be \$7200.

Community Expert consultation (Consultant Rate=\$250/hour). Consultation can occur in-person, phone, video-feed, or email.

Year 1-up to 2 hours month =up to 24 hours Annual Total =\$6,000
Year 2- up to 1 hour month=up to 12 hours Annual Total =\$3,000
Year 3-up to 2 hours month=up to 24 hours Annual Total=\$6,000
Year 4-up to 1.5 hours month=up to 24 hours Annual Total=\$4,500

Other Expenditures

Conferences

Money will be available for selected Community Partner Team members from EI, LE, or MH to attend conferences or participate in webinars focused on threat assessment topics. Organizations such as NaBITA (www.nabita.org) and Association of Threat Assessment Professionals (ATAP- www.atapworldwide.org) are directly focused on threat assessment and threat management. Other organizations such as American

Psychological Association (APA) and National Association of School Psychologists (NASP) may have focused workshops or presentations that may be related.

The purpose is to develop and grow expertise beyond the clinical training and community training by attending conferences at the national or state level or through webinar training. In turn, they can share information with their agencies and the community partners. A team approach to attending the conferences for the first 2 years is recommended.

The goal is to cover the cost of 1-3 individuals from the team for the first year to attend a threat assessment conference for the first two years. This excludes the Threat Management Coordinator. It is expected that by the end of the fourth year, that Community Partners will fund their own experts to attend these conferences or additional training.

Year 1=\$3,800

Year 2=\$2,800

Year 3=\$1,200

Year 4=\$0

Community Partner Discretionary Funds

In the design and implementation of a community threat assessment program, there may be community partner ideas, training needs, or intervention needs that have not been anticipated in the development of the grant proposal. Money has been set aside for the community partners to equally share on an annual basis. Any money utilized will have to be presented to the Threat Management Coordinator and MHSA Innovation Coordinator for final approval and must be directly related to threat assessment training or enhancement of the threat assessment process in the community. It is designed to increase alongside the increase of hours of Threat Management Coordinator as there is a decrease in the use of the Clinical and Community Threat Experts.

Year 1-\$10,500

Year 2-\$12,000

Year 3-\$13,500

Year 4-\$16,500

Anticipated examples include but are not limited to the following:

- 1) Sending someone to an additional conference or workshop on threat assessment or cover additional costs for an additional professional
- 2) Seeking legal consultation or opinions regarding their agencies' threat assessment design and procedures
- 3) Providing additional professional liability coverage to professionals who may provide intervention to or monitoring of students following a threat assessment
- 4) In Year 2, 3 and 4, provide an incentive stipend to professionals within community partner agencies in allocation of time spent on collecting agency data on threat assessment monitoring and/or providing monitoring of threats within the agency.

Other expenditures also include costs for project County Innovation Evaluator of \$15,000 per year. The County Innovation is responsible for the overall coordination, evaluation, and auditing process of all innovation projects' data collection, analysis, and state reporting.

PERSONNEL COSTS (salaries, wages, benefits)		Ramp up Period FY 19/20	Program Year 1 FY 20/21	Program Year 2 FY 21/22	Program Year 3 & Eval Period FY 22/23	TOTAL
1.	Salaries	\$16,560	16,560\$	\$16,560	\$22,080	\$71,760
2.	Direct Costs	\$	\$	\$	\$	\$
3.	Indirect Costs	\$	\$	\$	\$	\$
4.	Total Personnel Costs	\$	\$	\$	\$	\$
OPERATING COSTS		FY 19/20	FY 20/21	FY 21/22	FY 22/23	TOTAL
5.	Direct Costs	\$6,435	\$9,702	\$10,062	\$11,184.40	\$37,383.40
6.	Indirect Costs	\$	\$	\$	\$	\$
7.	Total Operating Costs	\$	\$	\$	\$	\$
NON-RECURRING COSTS (equipment, technology)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	TOTAL
8.		\$0	\$0	\$0	\$0	N/A
9.		\$0	\$0	\$0	\$0	N/A
10.	Total Non-recurring costs	\$6,387	\$0	\$0	\$0	\$6,387
		\$0	\$0	\$0	\$0	N/A
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	TOTAL
11.	Direct Costs	\$159,600	\$160,800	\$159,600	\$164,100	\$644,100
12.	Indirect Costs	\$	\$	\$	\$	\$
13.	Total Consultant Costs	\$	\$	\$	\$	\$

OTHER EXPENDITURES (please explain in budget narrative)						
		FY 19/20	FY 20/21	FY 21/22	FY 22/23	TOTAL
14.		\$0	\$0	\$0	\$0	N/A
15.		\$0	\$0	\$0	\$0	N/A
16.	Total Other Expenditures	\$29,300	\$29,800	\$29,700	\$31,500	\$120,300
		\$0	\$0	\$0	\$0	N/A
BUDGET TOTALS						
	Personnel (line 1)	\$16,560	\$16,560	\$16,560	\$22,080	\$71,760
	Direct Costs (add lines 2, 5 and 11 from above)	\$166,035	\$170,502	\$169,662	\$175,284.40	\$681,483.40
	Indirect Costs (add lines 3, 6 and 12 from above)	\$	\$	\$	\$	\$
	Non-recurring costs (line 10)	\$6,387	\$	\$	\$	\$6,387
	Other Expenditures (line 16)	\$29,300	\$29,800	\$29,700	\$31,500	\$120,300
	TOTAL INNOVATION BUDGET	\$218,282	\$216,862	\$215,922	\$228,864.40	\$879,930.40

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)						
ADMINISTRATION:						
A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	TOTAL
1.	Innovative MHSA Funds	\$218,282	\$216,862	\$215,922	\$228,864.40	\$879,930.40
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding*					
6.	Total Proposed Administration					
EVALUATION:						
B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	TOTAL
1.	Innovative MHSA Funds					
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding*					
6.	Total Proposed Evaluation					

TOTAL:						
C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/33	TOTAL
1.	Innovative MHSA Funds					
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding*					
6.	Total Proposed Expenditures	\$218,282	\$216,862	\$215,922	\$228,864.40	\$879,930.40

*If "Other funding" is included, please explain.

Attachment A: 30 Day Review Notice



NOTICE OF AVAILABILITY FOR PUBLIC REVIEW & COMMENT
And
NOTICE OF PUBLIC HEARING
County of San Luis Obispo
Behavioral Health Department
Mental Health Services Act

NOTICE OF AVAILABILITY FOR PUBLIC REVIEW

WHO: County of San Luis Obispo Behavioral Health Department
WHAT: The MHSA Innovation Plan for Fiscal Years 2019-23, is available for a 30-day public review and comment from May 19, 2019 through June 19, 2019.
HOW: To review the proposed plan,
 Visit:

To Submit Comments or Questions:
<https://www.research.net/r/SLOCoINNhttps://www.surveymonkey.com/r/Q3LQ8LH>

Comments must be received no later than June 18, 2019.

NOTICE OF PUBLIC HEARING

WHO: County of San Luis Obispo Behavioral Health Advisory Board
WHAT: A public hearing to receive comment regarding the Mental Health Services Act Innovation Plan for FY 2019-2023
WHEN: Wednesday, June 16, 2019, 3:00 p.m.
WHERE: Behavioral Health Campus, Library, 2180 Johnson Ave, SLO.

FOR FURTHER INFORMATION:

Please contact Nestor Veloz-Passalacqua, (805) 781-4064
nvelozpassalacqua@co.slo.ca.us



**COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
BEHAVIORAL HEALTH DEPARTMENT**

Michael Hill, *Health Agency Director*

Anne Robin, LMFT *Behavioral Health Director*

Toby Ewing, Ph.D.
Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

November 4, 2019

Dear Mr. Ewing,

The County of San Luis Obispo Behavioral Health Department (SLOBHD), through its proposed Innovation Workplan for Fiscal Year 2019-2023, is committed to ensure the two current proposals meet the expectations and requirements of the Mental Health Services Act (MHSA). Both projects are the result of community collaboration, input, and creative-thought process. Per the Mental Health Services Oversight and Accountability Commission (MHSOAC) staff analysis, SLOBHD is prepared to address the following two considerations:

1. **The inclusion of individuals with lived experience in program planning, development, and implementation:** Both projects, the Holistic Adolescent Health (HAH), and the Behavioral Health Assessment and Response Project (BHARP), formerly known as SLOTAP, address this request based on their design and community process. During the planning and proposal development individuals with lived experience, such as youth, loved-ones, experts, and community members with direct contact on the subject at hand, were part of the problem definition, creative design, formulations of ideas, and solutions. These key stakeholders will continue to be part of the development, implementation, and evaluation of the projects.
2. **The name change for the San Luis Obispo Threat Assessment Program:** The Innovation project name has changed to Behavioral Health Assessment and Response Project (BHARP).

SLOBHD is eager to commence the planning and application phases of each project addressing the two above requests respectively. SLOBHD appreciates the feedback and information provided in order to successfully execute these two projects.

Sincerely,

Nestor Veloz-Passalacqua, M.P.P.
Administrative Services Officer II
Ethnic Services Manager
County of San Luis Obispo Behavioral Health Department

The Health Agency complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or any other protected class

County of San Luis Obispo Health Agency

2180 Johnson Avenue | San Luis Obispo, CA 93401 | (P) 805-781-4719 | (F) 805-781-1273
slobehavioralhealth.org

Calendar of Tentative Commission Meeting Agenda Items

Proposed 11/8/19

Agenda items and meeting locations are subject to change

December 2019: No Meeting Scheduled

January 23: Sacramento, CA

- **MHSOAC Final Strategic Plan**
The Commission will be presented with the Final MHSOAC Strategic Plan.
- **MHSOAC Rules of Procedure**
The Commission will consider amendments to the Rules of Procedure.
- **Overview of Governor's Proposed Budget for Fiscal Year 2020-21**
The Commission will be presented with an overview of the Governor's proposed budget for fiscal year 2020-21 and its impact on the community mental health system.
- **Legislative and Budgetary Priorities**
The Commission will consider legislative and budget priorities for the current legislative session.
- **Executive Director Report Out**
The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.

February 27: Sacramento, CA

- **Use of County Innovation Funds**
Commission staff will provide an overview of county uses of Innovation funds since implementation of Assembly Bill 1467 (Chapter 23, Statutes of 2012).
- **Legislative and Budgetary Priorities**
The Commission will consider legislative and budget priorities for the current legislative session.
- **Executive Director Report Out**
The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.

Enclosure 8: DHCS Status Chart of County RERs Received
November 21, 2019 Commission Meeting

Attached below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated November 8th, 2019. This Status Report covers the FY 2016-17 through FY 2018-19 County RERs.

For each reporting period, the Status Report provides a date received by the Department of the County's RER and a date on which Department staff completed their "Final Review."

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. MHSOAC staff process data from County RERs for inclusion in the Fiscal Reporting Tool only after the Department determines that it has completed its Final Review. FY 2017-18 RER data has not yet been incorporated into the Fiscal Reporting Tool due to format changes.

The Department also publishes on its website a web page providing access to County RERs. This page includes links to individual County RERs for reporting years FY 2006-07 through FY 2015-16. This page can be accessed at: <http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx>. Additionally, County RERs for reporting years FY 2016-17 through FY 2017-18 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx.

Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these reports through its Fiscal Reporting Tool at <http://mhsoac.ca.gov/fiscal-reporting> for Reporting Years FY 2012-13 through FY 2016-17 and a data reporting page at https://mhsoac.ca.gov/resources/documents-and-reports/documents?field_county_value=All&field_component_target_id=46&year=all for Reporting Years FY 2012-13 through FY 2017-18 .

On October 1, 2019, DHCS published a report detailing MHSA funds subject to reversion as of July 1, 2018, covering allocation year FY 2015-16 for large counties and 2008-09 for WET and CFTN funds, updating a July 1, 2018 report detailing funds subject to reversion for allocation years FY 2005-06 through FY 2014-15 to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). Both reports can be accessed at the following webpage:

<https://www.dhcs.ca.gov/services/MH/Pages/MHSAFiscalRef.aspx>

Enclosure 8: DHCS Status Chart of County RERs Received
November 21, 2019 Commission Meeting

DCHS MHSA Annual Revenue and Expenditure Report Status Update
FY 2005-06 through FY 2017-18, all Counties are current

County	FY 17-18 Electronic Copy Submission Date	FY 17-18 Return to County Date	FY 17-18 Final Review Completion Date	FY 18-19 Electronic Copy Submission Date	FY 18-19 Return to County Date	FY 18-19 Final Review Completion Date
Alameda	3/25/2019	3/26/2019	4/9/2019			
Alpine	5/10/2019	5/13/2019	5/15/2019			
Amador	12/19/2018	12/19/2018	12/21/2018			
Berkeley City	12/28/2018	1/2/2019	1/8/2019			
Butte	6/26/2019		6/26/2019			
Calaveras	1/10/2019		1/11/2019			
Colusa	3/28/2019	4/25/2019	4/30/2019			
Contra Costa	12/31/2018	1/7/2019	1/22/2019			
Del Norte	12/31/2018		1/2/2019			
El Dorado	12/28/2018	1/3/2019	1/25/2019			
Fresno	12/28/2018	1/2/2019	1/2/2019			
Glenn	12/31/2018	1/7/2019	2/11/2019			
Humboldt	12/20/2018	12/21/2018	1/2/2019			
Imperial	12/26/2018		1/2/2019			
Inyo	3/19/2019	3/20/2019	3/22/2019			
Kern	1/4/2019		1/7/2019			
Kings	1/31/2019	2/4/2019	2/11/2019			
Lake	7/12/2019		7/16/2019			
Lassen	1/8/2019	1/14/2019	1/31/2019			

Enclosure 8: DHCS Status Chart of County RERs Received
November 21, 2019 Commission Meeting

County	FY 17-18 Electronic Copy Submission Date	FY 17-18 Return to County Date	FY 17-18 Final Review Completion Date	FY 18-19 Electronic Copy Submission Date	FY 18-19 Return to County Date	FY 18-19 Final Review Completion Date
Los Angeles	12/31/2018	1/14/2019	1/29/2019			
Madera	12/31/2018	1/7/2019	2/4/2019			
Marin	12/21/2018	12/21/2018	12/21/2018			
Mariposa	12/20/2018	1/3/2019	1/31/2019			
Mendocino	12/31/2018		1/3/2019			
Merced	12/21/2018	12/21/2018	12/31/2018			
Modoc	1/16/2019	1/16/2019	1/24/2019			
Mono	12/28/2018	1/3/2019	1/17/2019			
Monterey	3/5/2019	3/6/2019	9/4/2019			
Napa	12/28/2018	1/2/2019	1/4/2019			
Nevada	12/21/2018		12/21/2018			
Orange	12/28/2018	1/2/2019	1/31/2019			
Placer	1/18/2019		1/22/2019			
Plumas	9/16/2019	9/17/2019	10/4/2019			
Riverside	12/31/2018		1/29/2019			
Sacramento	12/31/2018	1/2/2019	1/2/2019			
San Benito	3/8/2019	3/8/2019	3/18/2019			
San Bernardino	12/31/2018		1/2/2019			
San Diego	12/26/2018		1/15/2019			
San Francisco	12/31/2018	1/3/2019	1/30/2019			
San Joaquin	12/31/2018		1/7/2019			

Enclosure 8: DHCS Status Chart of County RERs Received
November 21, 2019 Commission Meeting

County	FY 17-18 Electronic Copy Submission Date	FY 17-18 Return to County Date	FY 17-18 Final Review Completion Date	FY 18-19 Electronic Copy Submission Date	FY 18-19 Return to County Date	FY 18-19 Final Review Completion Date
San Luis Obispo	12/14/2018	12/18/2018	12/28/2018			
San Mateo	12/31/2018		1/2/2019			
Santa Barbara	12/21/2018	1/3/2019	1/14/2019			
Santa Clara	12/27/2018		1/2/2019			
Santa Cruz	12/31/2018	1/3/2019	1/7/2019			
Shasta	12/13/2018	12/17/2018	1/2/2019			
Sierra	12/28/2018		1/2/2019			
Siskiyou	9/3/2019	9/3/2019	9/24/2019			
Solano	12/31/2018	1/3/2019	2/21/2019			
Sonoma	1/16/2019	1/29/2019	2/1/2019			
Stanislaus	12/26/2018		1/3/2019			
Sutter-Yuba	1/7/2019	1/28/2019	1/31/2019			
Tehama	6/20/2019		8/12/2019			
Tri-City	12/31/2018	1/3/2019	1/30/2019			
Trinity	1/30/2019		2/7/2019			
Tulare	12/19/2018	12/21/2018	12/26/2018			
Tuolumne	12/11/2018	12/12/2018	12/12/2018	10/21/2019	10/23/2019	
Ventura	12/20/2018		12/21/2018			
Yolo	1/30/2019	1/31/2019	1/31/2019			
Total	59	39	59	1	1	0

2019 Legislative Report to the Commission As of November 8, 2019

SPONSORED LEGISLATION

Senate Bill 10 (Beall)

Title: Mental health services: peer support specialist certification.

Summary: Would require the State Department of Health Care Services to establish, no later than July 1, 2020, a statewide peer certification program, as a part of the state's comprehensive mental health and substance use disorder delivery system and the Medi-Cal program.

Status/Location: 10/13/19 Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.

Governor's Message: To the Members of the California State Senate: I am returning Senate Bill 10 without my signature. This bill would require the Department of Health Care Services (DHCS) to establish a new state certification program for mental health and substance use disorder peer support specialists. Peer support services can play an important role in meeting individuals' behavioral health care needs by pairing those individuals with trained "peers" who offer assistance with navigating local community behavioral health systems and provide needed support. Currently, counties may opt to use peer support services for the delivery of Medicaid specialty mental health services. As the Administration, in partnership with the Legislature and counties, works to transform the state's behavioral health care delivery system, we have an opportunity to more comprehensively include peer support services in these transformation plans. I look forward to working with you on these transformations efforts in the budget process and future legislation, as improving the state of the state's behavioral health system is a critical priority for me. This proposal comes with significant costs that should be considered in the budget process. Sincerely, Gavin Newsom

Senate Bill 11 (Beall)

Title: Health care coverage: mental health parity.

Summary: Would require the Department of Managed Health Care and the Department of Insurance annually to report to the Legislature the information obtained through activities taken to enforce state and federal mental health parity laws.

Status/Location: 5/17/19 Failed Deadline pursuant to Rule 61(a)(5). (Last location was APPR. SUSPENSE FILE on 5/13/2019) (May be acted upon Jan 2020).

Co-Sponsors: The Kennedy Forum; Steinberg Institute

SPONSORED LEGISLATION

Senate Bill 12 (Beall)

Title: Mental health services: youth.

Summary: This bill would require the commission, contingent on appropriation, to administer an Integrated Youth Mental Health Program for purposes of establishing local centers to provide integrated youth mental health services, as specified. The bill would authorize the commission to establish the core components of the program, subject to specified criteria, and would require the commission to develop the selection criteria and process for awarding funding to local entities for these purposes.

Status/Location: 8/30/19 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. SUSPENSE FILE on 6/26/2019)(May be acted upon Jan 2020).

Assembly Bill 46 (Carrillo)

Title: Individuals with mental illness: change of term.

Summary: Current law refers to an insane or mentally defective person in provisions relating to, among other things, criminal proceedings, correctional facilities, and property tax exemptions. This bill would state the intent of the Legislature to enact legislation to replace derogatory terms, including, but not limited to, “insane” and “mentally defective,” with more culturally sensitive terms when referring to individuals with mental illness.

Status/Location: 6/26/19 Approved by the Governor. Chaptered by Secretary of State - Chapter 9, Statutes of 2019.

Co-Sponsors: Disability Rights California

SUPPORTED LEGISLATION

Senate Bill 66 (Atkins)

Title: Medi-Cal: federally qualified health center and rural health clinic services.

Summary: This bill will facilitate the ability to transition patients from primary care to an onsite mental health specialist on the same day, to ensure that a patient receives needed care and follows through with treatment. This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit.

Status/Location: 9/15/19 Failed Deadline pursuant to Rule 61(a)(15). (Last location was INACTIVE FILE on 9/11/2019)(May be acted upon Jan 2020).

SUPPORTED LEGISLATION

Senate Bill 582 (Beall)

Title: Youth mental health and substance use disorder services.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, when making grant funds available on and after July 1, 2021, to allocate at least 1/2 of those funds to local educational agency and mental health partnerships, as specified. The bill would require this funding to be made available to support prevention, early intervention, and direct services, as determined by the commission. The bill would require the commission, in consultation with the Superintendent of Public Instruction, to consider specified criteria when determining grant recipients.

Status/Location: 8/30/19 Failed Deadline pursuant to Rule 61(a)(12). (Last location was APPR. SUSPENSE FILE on 8/14/2019)(May be acted upon Jan 2020).

Senate Bill 604 (Bates)

Title: Mental Health Services Act: centers of excellence.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, by January 1, 2021, to establish one or more centers of excellence to provide counties with technical assistance to implement best practices related to elements of the act. The bill would require those centers of excellence to be funded with state administrative funds provided under the act. In implementing these provisions, the bill would require the commission to determine the areas of focus for the centers of excellence, including, but not limited to, the areas of service delivery that need improvement.

Status/Location: 5/16/19 May 16 hearing: Held in committee and under submission.

Assembly Bill 43 (Gloria)

Title: Mental health.

Summary: This bill would require the commission, in consultation with specified state, local, and private entities, to develop a strategy for the collection, organization, and public reporting of information on mental health funding, mental health programs, services, and strategies, funded by the Mental Health Services Act or other sources, and mental health outcomes, as specified. By authorizing a new use of MHSA moneys, this bill would amend the act. The bill would require the commission to make the information available as prescribed to the public and policymakers. The bill would authorize the commission, subject to available funding, to develop an innovation challenge and utilize one or more hackathons, open coding initiatives, or other approaches to an effective strategy to collect, display, and make publicly available relevant information to support the intent of the provisions.

Status/Location: 8/30/19 In committee: Held under submission.

SUPPORTED LEGISLATION

Assembly Bill 512 (Ting)

Title: Medi-Cal: specialty mental health services.

Summary: Current law requires the State Department of Health Care Services to implement managed mental health care for Medi-Cal beneficiaries through contracts with mental health plans, and requires mental health plans to be governed by various guidelines, including a requirement that a mental health plan assess the cultural competency needs of the program. This bill would require each mental health plan to prepare a cultural competency assessment plan to address specified matters, including disparities in access, utilization, and outcomes by various categories, such as race, ethnicity and immigration status.

Status/Location: 10/13/19 Vetoed by Governor.

Governor's Message: To the Members of the California State Assembly: I am returning Assembly Bill 512 without my signature. This bill would require each county mental health plan to meet mental health disparities reduction targets developed by the Department of Health Care Services and imposes additional reporting requirements and processes on county mental health plans. Although I support the intent and efforts of this bill to reduce mental health disparities, the new requirements imposed by this bill would result in significant General Fund cost pressures that are better considered through the state's annual budget process. Sincerely, Gavin Newsom

Assembly Bill 713 (Mullin)

Title: Early Psychosis Intervention Plus (EPI Plus) Program.

Summary: Current law establishes the Early Psychosis and Mood Disorder Detection and Intervention Fund and authorizes the commission to allocate moneys from that fund to provide competitive grants to counties or other entities to create or expand existing capacity for early psychosis and mood disorder detection and intervention services and supports. Currently, implementation of the grant program is contingent upon the deposit into the fund of at least \$500,000 in nonstate funds for those purposes. This bill would delete the prohibition on General Fund moneys being appropriated for purposes of those provisions and would delete the requirement that the minimum \$500,000 deposit be from nonstate funds.

Status/Location: 7/12/19 Failed Deadline pursuant to Rule 61(a)(10). (Last location was HEALTH on 6/6/2019)(May be acted upon Jan 2020).

SUPPORTED LEGISLATION

Assembly Bill 1126 (O'Donnell)

Title: Mental Health Services Oversight & Accountability Commission.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, by January 1, 2021, to establish technical assistance centers and one or more clearinghouses to support counties in addressing mental health issues of statewide concern, with a focus on school mental health and reducing unemployment and criminal justice involvement due to untreated mental health issues.

Status/Location: 5/16/19 In committee: Held under submission.

Assembly Bill 1352 (Waldron)

Title: Community mental health services: mental health boards.

Summary: The Bronzan-McCorquodale Act governs the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Current law generally requires each community mental health service to have a mental health board consisting of 10 to 15 members who are appointed by the governing body and encourages counties to appoint individuals who have experience with and knowledge of the mental health system. This bill would require a mental health board to report directly to the governing body, and to have the authority to act, review, and report independently from the county mental health department or county behavioral health department, as applicable.

Status/Location: 10/2/19 Approved by the Governor. Chaptered by Secretary of State - Chapter 460, Statutes of 2019.

Assembly Bill 1443 (Maienschein)

Title: Mental health: technical assistance centers.

Summary: Would require, subject to available funding, the Mental Health Services Oversight and Accountability Commission to establish one or more technical assistance centers to support counties in addressing mental health issues, as determined by the commission, that are of statewide concern and establish, with stakeholder input, which mental health issues are of statewide concern. The bill would require costs incurred as a result of complying with those provisions to be paid using funds allocated to the commission from the Mental Health Services Fund. The bill would state the finding and declaration of the Legislature that this change is consistent with and furthers the intent of the act.

Status/Location: 8/30/19 In committee: Held under submission.

OPPOSED LEGISLATION

Senate Bill 665 (Umberg)

Title: Mental Health Services Fund: county jails.

Summary: Current law prohibits Mental Health Services Act (MHSA) funds from being used to pay for persons incarcerated in state prison or parolees from state prisons. The 2011 Realignment Legislation addressing public safety and related statutes, requires that certain specified felonies be punished by a term of imprisonment in a county jail, rather than the state prison, and provides for mandatory supervision, a period of suspended execution of a concluding portion of the sentence that is supervised by the county probation officer. This bill would, until January 1, 2023, authorize a county to use MHSA funds, if that use is included in the county plan, to provide services to persons who are incarcerated in a county jail or subject to mandatory supervision, except persons who are incarcerated in a county jail for a conviction of a felony unless for purposes of facilitating discharge.

Status/Location: 9/6/19 In Assembly. Read first time. Held at Desk.