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Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Meeting
February 27, 2020

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

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

Additional Public Location

State Capitol, Room 2082
Sacramento, CA 95814

Mental Health Services
Oversight & Accountability Commission
1325 J Street, Suite 1700, Sacramento, California 95814
Phone: (916) 445-8696 * Email: mhsoac@mhsoac.ca.gov * Website: www.mhsoac.ca.gov

Commission/Teleconference Meeting Notice

Date: Thursday, February 27, 2020, at 9:00 a.m.
Location: 1325 J Street, Suite 1720 Darrel Steinberg Conference Room, Sacramento, CA 95814.
Additional location: State Capitol, Room 2082, Sacramento CA 95814.

Call-in Number: 866-817-6550; Code: 3190377 (listen only)

Our Commitment to Excellence

The Commission's 2020-2023 Strategic Plan articulates three strategic goals:

1) Advance a shared vision for reducing the consequences of mental health needs and improving wellbeing – and promote the strategies, capacities and commitment required to realize that vision.
2) Advance data and analysis that will better describe desired outcomes; how resources and programs are attempting to improve those outcomes; and, elevate opportunities to transform and connect programs to improve results.
3) Catalyze improvement in state policy and community practice by (1) providing information and expertise; (2) facilitating networks and collaboratives; and, (3) identifying additional opportunities for continuous improvement and transformational change.

Our Commitment to Transparency

The public is invited and welcome to attend all noticed meetings. A complete meeting agenda packet is available for inspection at the meeting. Per the Bagley-Keene Open Meeting Act, public meeting notices and agenda are available on the internet at www.mhsoac.ca.gov at least 10 days prior to the meeting. Further information regarding this meeting may be obtained by calling (916) 445-8696 or by emailing mhsoac@mhsoac.ca.gov

Our Commitment to Public Participation

- The Commission welcomes participation at its meetings and members of the public may address the Commission on any agenda item.
- The public is requested – but is not required – to fill out a "Public Comment Card" to address the Commission on any agenda item before the Commission acts on the item. The Commission also accepts public comments via email and U.S. Mail.
- The General Public Comment period is an opportunity to address the Commission on matters not listed on the agenda. Comments are limited to three (3) minutes per speaker, unless the Chair of the Commission decides a different time allotment is needed.

Our Commitment to Those with Disabilities

- Pursuant to the American with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in any Commission meeting or activities, may request assistance by calling (916) 445-8696 or by emailing mhsoac@mhsoac.ca.gov. Requests should be made one (1) week in advance whenever possible.

Commission Meeting Agenda

All matters listed as "Action" on this agenda, may be considered for action as listed. Any item not listed may not be considered at this meeting. Items on this agenda may be considered in any order at the discretion of the Chair.

9:00 AM **Call to Order and Welcome**

Chair Lynne Ashbeck will convene the Mental Health Services Oversight and Accountability Commission meeting and make announcements.

Transition Age Youth Representative

9:05 AM **Consumer/Family Voice**

Hector Ramirez will open the Commission meeting with a story of recovery and resilience.

9:20 AM **Roll Call**

Roll call of Commissioners to verify the presence of a quorum.

9:25 AM **General Public Comment**

General Public Comment is reserved for items not listed on the agenda. No debate nor action by the Commission is permitted on such general public comments, as the law requires formal public notice prior to any deliberation or action on an agenda item.

9:40 AM **Action**

1: Consent Calendar

All matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action.

1. Approval of the minutes from the January 23, 2020 meeting.

- Public Comment
- Vote

9:50 AM **Action**

2: Approve Early Psychosis Intervention Outline for Request for Applications and Contract Authority for Training and Technical Assistance

Presenter: Tom Orrock, Chief of Commission Grants

The Commission will consider approval of an outline for the Request for Applications to provide support for the Early Psychosis programs and authority to enter into a contract for Training and Technical Assistance to support the Early Psychosis programs.

- Public Comment
- Vote

10:50 AM **Action**

3: Award Stakeholder Contracts

Presenter: Tom Orrock, Chief of Commission Grants

The Commission will consider awarding contracts to the highest scoring proposals received in response to the six Request for Proposals for stakeholder advocacy on behalf of the following six populations: clients and consumers; families of clients and consumers; parents and caregivers; diverse racial and ethnic communities; LGBTQ; and Veterans.

- Public Comment
- Vote

11:30 AM **Lunch Break**

12:15 PM **Action**

4: El Dorado Innovation Project Extension

Presenters: Jamie Samboceti, MFT, Behavioral Health Deputy Director; Sabrina Owen, MFT, Manager of Mental Health Programs; Ren Strong; Program Manager; and Heather Longo, MHSA Coordinator, all from the El Dorado County Health and Human Services Agency.

El Dorado County seeks approval of $2,158,704 in additional Innovation spending authority to extend the Community HUBS Program. The Commission originally approved $2,760,021 in Innovation spending authority for this project (as *Community-Based Engagement and Support Services*) on August 25, 2016. This item was removed from the consent agenda at the January 23, 2020 meeting and referred back to the Commission for further discussion.

- Public Comment
- Vote

1:15 PM **Action**

5: Identify Legislative Priorities for 2020

Presenters: Gavin White, Legislative Assistant, Office of Assembly Member James C. Ramos; Norma Pate, Deputy Director of Legislation

The Commission will consider legislative and budget priorities for the current legislative session, including Assembly Bill 2112 (Ramos) which addresses the needs of youth at risk of suicide.

- Public Comment
- Vote

2:00 PM **Information**

6: Receive Help@Hand Innovation Project Update

Objective 3a. Support and evaluate multi-county collaboratives striving to improve data analysis, the transfer of knowledge, and the management capacity required to improve results.

Presenters: Jeremy Wilson, MPPA, Program Director & PIO CalMHSA; Sharon Ishikawa, Ph.D., MHSA Coordinator, Orange County Health Care Agency Behavioral Health Services; Keris Jän Myrick, MBA, MS Chief of Peer and Allied Health Professions, Los Angeles County Department of Mental Health

The Commission will hear a progress report on the Help@Hand (formerly Tech Suite) multi-county Innovation collaborative project.

The Commission approved this multi-county Innovation project during 2018-19 from twelve counties and two cities authorizing up to $102 million to explore the feasibility and utility of mobile applications in supporting Prevention and Early Intervention strategies such as early detection, stigma reduction, and increased access to services.

3:00 PM **Information**

7: Receive Innovation Incubator Update

Presenter: Jim Mayer, Chief of Innovation Incubation

The Commission will hear an update on the options for committing the remaining incubator funds in the Commission's budget directed toward incubating major collaborative projects with innovative potential. The presentation will include a review of the project work plan and accomplishments to date. Staff expect to present to the Commission one or more project contract outlines for approval at the April 2020 meeting.

- Public Comment

3:30 PM **Adjournment**

AGENDA ITEM 1

Action

February 27, 2020 Commission Meeting

Consent Calendar

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will consider approval of the following items placed on the Consent Calendar. 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. Items removed from the Consent Calendar may be held over for consideration at a future meeting at the discretion of the Chair.

Approval of the January 23, 2020 MHSOAC Meeting Minutes:

Enclosure (1): January 23, 2020 Meeting Minutes

Mental Health Services
Oversight and Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM
Governor

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
January 23, 2020

MHSOAC
Darrell Steinberg Conference Room, Suite 1720
1325 J Street
Sacramento, CA 95814

866-817-6550; Code 3190377

Members Participating:

Lynne Ashbeck, Chair
Mara Madrigal-Weiss, Vice Chair
Ken Berrick
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
David Gordon
Gladys Mitchell
Khatera Tamplen

Members Absent:

Mayra Alvarez
Reneeta Anthony
Senator Jim Beall
John Boyd, Psy.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

[Note: Agenda Item 5 was taken out of order and taken after Agenda Items 6, 7, and 8. These minutes reflect this Agenda Item as taken in chronological order and not as listed on the agenda.]

CONVENE AND WELCOME

Chair Lynne Ashbeck called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:04 a.m. and welcomed everyone.

Chair Ashbeck reviewed the meeting protocols.

Announcements

Chair Ashbeck made the following announcements:

- The format of the agenda has been revised and is subject to change.
    - The Consent Calendar is a new agenda item for routine or noncontroversial items to increase efficiency.
    - The General Public Comment section has been moved to the front of the meeting to provide stakeholders with the opportunity to bring items to the Commission's attention that are not on the agenda.
    - The meetings will adjourn earlier to allow Commissioners to catch their flights home.

Transition Age Youth Representative

Chair Ashbeck 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. She welcomed Heather Shumway, a Senior at Encina High School in Sacramento and the youth representative for the Coalition for a Safe and Healthy Arden Arcade, and asked her to introduce herself. Heather Shumway introduced herself and said she wanted to be here because youth should be represented in decisions about mental health.

New Personnel

Chair Ashbeck asked Dawnté Early to introduce new Commission staff.

Dawnté Early, Ph.D., Chief, Research and Evaluation, introduced new staff members Mary Bradsbury and Mike Howell. Both are researchers in the Research and Evaluation Division. Dr. Early stated Ms. Bradsbury and Mr. Howell are part of the UCSF embedded staff contract that the Commission approved in July of 2019.

Dr. Early congratulated Ashley Mills on her promotion to Research Supervisor and asked her to introduce her new staff members.

Ashley Mills, Research Supervisor, Policy and Research Section, Research and Evaluation Division, introduced new staff members Tim Smith who is a researcher working on policy research projects in the Research and Evaluation Division, and Kimberly McFadden, UC Intern for the winter quarter through mid-March.

Chair Ashbeck congratulated Ms. Mills on her promotion and welcomed new staff members on behalf of the Commission.

Consumer/Family Voice

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

Arden Tucker shared the story of being bullied throughout high school. She was so tormented by the physical and emotional abuse by the second year that her interest in academics ceased. There was no solace at home because home life often mirrored what she experienced in school. She began using drugs on a daily basis to make it through the school day. Consequently, she was held back as a sophomore.

Ms. Tucker stated, during her fifth year, she rarely used drugs because of her determination to get her grades up so she could attend college. She made the honor roll the last year of high school and was able to attend college. As a parting gift, a few of her teachers gave her a good book and a tennis racket as a positive focus during the summer prior to going away to school. She learned that she is good at tennis.

Ms. Tucker stated she experienced her first episode of major depression in her early twenties. She was living what seemed to be the ideal life – when she was not at work, which was a great job working with children at a residential treatment center, she was on the tennis court. She began struggling with depression six and a half years into her job at the residential treatment center. She stated she did not realize how serious her struggles were until a coworker asked her if she was feeling suicidal. She stated she immediately went into denial, but her denial only intensified the depression and further diminished her desire to live with the psychic pain.

Ms. Tucker stated she was diagnosed with depression and bipolar disorder. She stated her therapist convinced her to try a short-term in-patient hospitalization but, because she did not improve, she was transferred to State Hospital where she stayed for a year and a half. She stated, at that time, no therapy was provided – she was simply warehoused.

Ms. Tucker stated before her year and a half was up, she was put into an experimental residential program where she lived rent-free, and meals were provided. She attended group sessions and was encouraged to find employment and save money for housing. She stated obtaining a job and saving money for housing significantly decreased rehospitalization.

Ms. Tucker stated many years later, she experienced a resurgence of depression and became angry because she was never told that her depression may revisit her. She spent the next 11 years being hospitalized in in-patient and outpatient and bouncing from therapist to therapist.

Ms. Tucker stated finding a therapist as an LGBTQ woman of color is almost impossible. She stated she found a therapist who also ran a group and remained with this therapist for many years. After her therapist moved away, she went into the public

mental health system – calling the access line, getting on a waiting list to get medication and see a psychiatrist. She had to wait a long time for another therapist.

Ms. Tucker stated the next barrier was the termination of her long-term disability, which only lasted two years. While attending another program, she found an advertisement from Crossroads Employment Services that assists individuals with finding employment. She was hired four days later as a receptionist with Crossroads and remained with the company for several years. Her boss encouraged her to become a mental health advocate and allowed her to go to meetings during work hours. She stated she has remained a mental health consumer advocate to this day.

Ms. Tucker stated her journey towards healing was not easy. She often took one step forward only to have to take two steps back. She encouraged, however, that, when that happens, to then take the next step or even two more steps forward because it just might hold an amazing self-discovery and a possibility for other opportunities to develop.

Ms. Tucker stated she has been asked to do public speaking engagements and trainings on mental health issues, has served on numerous mental health boards, committees, collaboratives, focus groups, and councils through the years, and has been honored with the Clifford W. Beers Award. After a few years of working in mental health, Ms. Tucker went back to school and received her master's degree in Counseling in 2014.

Ms. Tucker stated her advocacy, community work, and part-time private practice have aided her in remaining focused on the days when depression would have her in a fog, in combating the tapes that run in her head that try to suggest that she is less than others, in remembering that she is not her diagnosis.

Ms. Tucker stated she learned that isolation is her enemy and connection with others can assuage those feelings of loneliness that seek to invade her inner peace. She stated giving back not only helps others feel better, it also ignites the warmth within the giver that feeds their soul. She stated paying it forward helps build resilience. She stated, on her journey to wellness, she worked hard to remember that she and she alone can find what her recovery looks like and feels like and whether it is attainable or not. Everyone is capable of recovery. It is not controlled by others' perspectives, expectations, or values.

Ms. Tucker stated the most important takeaway from her story is to keep climbing up the hill; although the hill never ends, there is joy is the climb.

<u>Questions and Discussion</u>

Commissioner Tamplen stated her appreciation that Ms. Tucker stated the journey to wellness is hard and nonlinear. She agreed with Ms. Tucker's statements that individuals are not their diagnosis and that giving back lifts spirits.

Commissioner Mitchell suggested asking past speakers to come back to the Commission to provide an update on where they are now.

Roll Call

Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

GENERAL PUBLIC COMMENT

Poshi Walker, LGBTQ Program Director, Cal Voices, formerly Mental Health America of Northern California (NorCal MHA), and Co-Director, #Out4MentalHealth, thanked the Commission for moving the General Public Comment section to the front of the meeting. Arden Tucker's story demonstrates intersectionality, a concept which is discussed in the Year 2 Report. The speaker stated intersectionality is where oppressions come together and make everything worse.

Poshi Walker appreciated Chair Ashbeck's comment about trying to spend time on issues important to the Commission. The speaker brought to the Commission's attention that, by August of 2020, #Out4MentalHealth, Access, and many other contractors will have spent three years advocating at the state and local levels for the reduction of disparities and the increase of positive mental health outcomes. The Legislature and the MHSOAC has funded this effort with over 16 million Mental Health Services Act (MHSA) dollars.

Poshi Walker stated some contractors plan to have a legislative briefing to discuss what has been accomplished in the last three years and provide recommendations. It is important that Commissioners hear about the work that has been done, especially as the Commission will vote to approve the Request for Proposals (RFPs) for these contracts. It is important to see not only what has been accomplished and the lessons learned, but also to see if changes to these contracts may be warranted or needed. The speaker encouraged Commissioners to request a future agenda item of at least an hour prior to August of 2020 to hear updates from contractors.

Pete Lafollette, consumer and advocate, stated this is a time of un-layering of larger, broader truths to see the light of day.

Joy Burkhard, Founder and Director, 2020 Mom, spoke about maternal mental health and asked for support and attention to this issue. The speaker asked the Commission to consider including maternal mental health as a specialized population, similar to veterans and LGBTQ populations.

ACTION

1: Consent Calendar

- Approval of the minutes from the November 21, 2019, meeting.
- Approval of $2,158,704 in Innovation funding to support El Dorado County's extension of their Community HUBS Program approved by the Commission in August 2016.

Chair Ashbeck stated all matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action.

Chair Ashbeck stated there are two public comments on the El Dorado County extension request. She pulled the approval of the El Dorado County extension off the Consent Calendar to be discussed later. She asked for a motion to approve the November 21, 2019, Meeting Minutes.

Action: Commissioner Berrick made a motion, seconded by Commissioner Mitchell, that:

- *The Commission approves the November 21, 2019, Meeting Minutes as presented.*

Motion carried 7 yes, 0 no, and 2 abstain, per roll call vote as follows:

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

The following Commissioners abstained: Commissioner Bunch and Chair Ashbeck.

Chair Ashbeck asked the representatives of El Dorado County to provide their public comment on the second Consent Calendar item, approval of $2,158,704 in Innovation funding to support El Dorado County's extension of their Community HUBS Program, which was approved by the Commission in August 2016.

Public Comment

Steve Clavere, Chair, El Dorado County Behavioral Health Commission, spoke on the speaker's own behalf and not as a member of the county commission. The speaker stated that the summary of opposition in the staff analysis in not quite accurate. It indicates that the letters of opposition reflect a concern surrounding the possibility of reverted funds being returned to the county. The speaker suggested that the funds will instead be returned to the state. The speaker noted that the entities in opposition to the extension do not have any issues with the funds being returned to the state.

Steve Clavere clarified the concerns that there is not a single mental health position in the Community HUBS Program. The implementing staff of this project are Public Health job classifications performing Public Health duties and Education Department positions performing Education Department duties. The staff have no mental health training; they conduct developmental screenings, not mental health screenings, and engage in developmental activities. Public Health nurses do protective factor surveys. The speaker stated, while there is some overlap, mental health and child development are separate disciplines with different areas of expertise and different screening instruments. It is unclear how developmental screening activities accurately identify mental health problems.

Steve Clavere stated the true impact this has on mental health services can be determined at this point. This project is in its fourth year, in the second year of operation. The speaker stated the most recent data from fiscal year 2017-18, which is the best year, shows 48 out of 824 referrals, or 5.8 percent, for mental health. Out of those 48, 17 were scheduled to receive services, reducing the percent of the original 824 down to 2 percent, proving that the input on mental health services is miniscule.

Steve Clavere stated, for the past four years, MHSA funds have been budgeted to pay for 40 percent of the cost of this project. If this extension is approved, that portion will increase to 65.4 percent in the final year for a possible 2 percent result in services rendered.

Steve Clavere stated the representatives of the El Dorado County Behavioral Health Commission view themselves as mental health advocates rather than being referred to as “the opposition.” The El Dorado County Behavioral Health Commission fully supports the Community HUBS concept; however, it believes that the MHSA share should be much more closely proportionate to the results, specifically to the number of actual mental health referrals made. The speaker asked the MHSOAC to ensure that the direction and guidance it provides will ensure the integrity of the MHSA.

Kathleen Guerrero, Executive Director, First 5 El Dorado Children and Families Commission, provided copies of her testimony to staff. The speaker stated the Community HUBS program was written as a systems change approach to provide prevention and early intervention services.

Kathleen Guerrero responded to concerns that have been raised such as locations in libraries, distribution of literature, reducing stigma and long-term mental health costs, and increased client screening and treatment. The speaker noted that there are three other partners that contribute funding above and beyond the MHSA funding to the large integrative project.

Lynnan Svensson, Nursing Program Manager, Community HUBS program, El Dorado County, spoke in support of the extension of the Community HUBS Program. The speaker read a story received from a public health nurse about how the Community HUBS Program helps members of the community.

Commissioner Questions and Discussion

Chair Ashbeck asked Commissioners if they would like to invite staff to comment on the project and provide more information, hear the concerns and continue to make a motion to approve the extension, or ask El Dorado County to present a full presentation at a future Commission meeting.

Commissioner Bunch stated the letters of dissent did not feel noncontroversial. She stated the need for the Commission to address the concerns of Mr. Clavere and the National Alliance on Mental Illness (NAMI) in El Dorado County.

Commissioner Mitchell noted that staff turnover seems high and asked if the additional funding will be mostly used to expand the staffing to run the HUBS.

Sharmil Shah, Psy.D., MHSOAC Chief of Program Operations, summarized the background and goals of the original Commission-approved Community HUBS Program. She stated the county is requesting the additional amount of funding along with a nine-month time extension to address four areas – staffing, limited family engagement staff, technology and infrastructure, and data analysis and reporting.

Commissioner Brown stated this item has become controversial. Two respected mental health-connected organizations within the county have shared their concerns. He stated the mental health connection to this project is minimal. He asked if this project is in keeping with the spirit of the MHSA. These issues merit inviting the county to present their responses to the concerns at a future Commission meeting. He asked the county to also address their lack of collaboration with the rest of the community.

Commissioner Brown made a motion to continue this item to the next available Commission meeting agenda.

Commissioner Mitchell asked if the HUBS are working and if they are working in the spirit of mental health.

Commissioner Bunch stated there are specific concerns listed in the letter from NAMI that need to be addressed before moving forward. She seconded the motion.

Action: Commissioner Brown made a motion, seconded by Commissioner Bunch, that:

- Have representatives of El Dorado County present at the next available Commission meeting their request for approval of additional Innovation funding to support the County's extension of their Community HUBS Program.

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

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

ACTION

2: <u>Youth Drop-In Centers Outline for Request for Applications</u>

Presenter:

- Tom Orrock, Chief of Stakeholder Engagement and Commission Grants

Chair Ashbeck stated the Commission will consider approval of an outline for the Youth Drop-In Centers Request for Applications. She asked staff to present this agenda item.

Commissioner Berrick recused himself from the discussion and decision-making with regard to this agenda item and left the room pursuant to Commission policy.

Tom Orrock, Chief of Stakeholder Engagement and Commission Grants provided an overview, with a slide presentation, of the background, community engagement, stakeholder feedback, the proposed outline for the Request for Applications (RFA) to fund youth drop-in centers, and next steps.

Commissioner Questions

Commissioner Tamplen asked about the criteria for the technical assistance centers and if experience with youth engagement is included in the criteria.

Executive Director Ewing stated this is a competitive process for the RFA. There will not be an RFA for the technical assistance centers because they are relatively specialized. This will give the Commission the opportunity to negotiate with different vendors on how to do the technical assistance and support.

Executive Director Ewing stated this agenda item is for a competitive procurement to be done through an RFA. There is a budget item later in today's agenda that seeks authorization to allocate funds for technical assistance. He ensured that the provider of those services will be well-versed in the model and in youth engagement.

Heather Shumway asked about insurance coverage for the drop-in centers. Often, opportunities for good programs or specialists are limited due to the lack of insurance coverage.

Mr. Orrock stated these programs will be no- or low-cost youth drop-in centers. The consensus among stakeholders was that the insurance and payment responsibilities should happen behind the counter to help reduce the barrier for youth to participate in the programs.

Heather Shumway asked about the possible locations for the drop-in centers.

Mr. Orrock stated counties or programs that are interested in implementing this program will submit proposed plans in their applications in terms of location and how it will be accessible. This is a program to increase accessibility for youth who have mental health needs and other needs.

Commissioner Gordon stated there is interest in the replication of the work that is going on in Santa Clara County; yet, the need for safe spaces in the community is universal. He stated it may not be possible to replicate Santa Clara County's work in some areas and there are areas that cannot afford it. He stated the need to be open to not just a replication of Santa Clara County but a locally designed program for a particular county.

Executive Director Ewing stated the headspace model is an approach that is aggressively youth-driven, with branding and the array of services, that is tailored to respond to the needs of each target population at each location. How grant recipients will implement the model will be determined for each situation and population it serves.

Commissioner Bunch stated Heather Shumway made a good point about it not just being about what the space looks like, but what a barrier paperwork can be. She gave the example of a coffeeshop in Oklahoma where a counselor sat at a corner table with a piece of paper with "want to talk?" on it. She stated he told her that many individuals stopped at his table to talk. He was able to engage with youth and direct them to mental health services just by putting a sign on his table.

Executive Director Ewing stated head space model is almost a franchise model, where the core elements that the evidence shows works are adapted through the leadership and engagement of the young people, who are the target audience in each community.

Commissioner Brown asked about the one-week period of time between the RFA being released and the deadline for the intent to apply.

Executive Director Ewing stated the deadline can be amended if that is an issue. He stated the interest and awareness is high and noted that staff has already begun to receive letters from counties expressing interest in applying.

Commissioner Gordon stated the first two minimum qualifications of at least two years of experience providing mental health services to youth ages 12 to 25, and at least one year of experience partnering with youth on projects related to mental health and wellness are general criteria that do not suggest that the applicant is already running some sort of drop-in center.

Mr. Orrock agreed that those general requirements could be met in other programs within the county.

Executive Director Ewing stated one of the points of deliberation during the community engagement was if the Commission would use these funds to support any youth drop-in program or if the funding would be limited to youth drop-in programs that have fidelity to the headspace model.

Executive Director Ewing stated the intent of the Legislature was to bring this model to the United States, recognizing that there is flexibility within the model. The first two minimum qualifications require a foundation of working with youth and providing mental health services, but the challenge will be to ascertain the amount and type of experience necessary to provide the quality of care that will lead to success.

Commissioner Gordon encouraged the Commission, given the severity of need in this area statewide and the vast diversity of capability, to leave it open to entities that cannot reach the level of what Santa Clara is doing, but that it would give them space to participate and to at least try. The technical assistance phase will bring entities up to a higher standard than perhaps they can begin with.

Executive Director Ewing stated Commissioner Gordon’s concern is consistent with discussions during the community engagement phase of why staff suggests a healthy allocation for technical assistance and support.

Public Comment

Poshi Walker stated Cal Voices has concerns about the outline, specifically supplantation. Cal Voices works with many counties with LGBTQ youth drop-in centers that are already being supported by MHSA funds and is concerned that they will be cut in order to fund this new program. The speaker stated the need to prioritize the LGBTQ trauma-focused cognitive behavioral therapy (CBT) work and assessments in these youth drop-in centers, specifically for LGBTQ rejecting behaviors.

Poshi Walker stated the need to ensure the use of community-defined practices and that, if there is already an LGBTQ drop-in center in the area, developing a youth drop-in center does not reduce or remove funding, but that the already-established center must be incorporated into this plan.

Tiffany Carter, Statewide Advocacy Liaison, ACCESS California, Cal Voices, stated the importance of including youth with lived experience in the criteria for eligibility and not only including youth at the table in the community program planning process, but that the execution of these drop-in centers have peers throughout the entire process as an ongoing part of the program.

Pete Lafollette stated the importance of including measured outcomes as part of the contract and that the awards go to enriching human life and experience and not simply supplementing agency budgets.

Commissioner Discussion

Commissioner Bunch asked staff to answer Poshi Walker's question about how these kinds of centers would impact MHSA-funded LGBTQ funding for centers already in existence.

Mr. Orrock stated counties will be unable to supplant existing programs or to transfer funds to other programs. He stated this will be made clear in the RFA. He noted that there is a potential that these programs could be built on top of and strengthen existing programs.

Executive Director Ewing added that this is a challenging issue. The law is clear that a county cannot use this funding to replace their own dollars. He stated there is no guarantee of a scenario where there is no impact on the service array, but it is expected that those decisions within each county will be part of the community planning process.

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

- *The Commission approves the proposed outline of the Youth Drop-In Center Request for Applications.*
- *The Commission authorizes the Executive Director to initiate a competitive bid process for Youth Drop-In Center program grants.*

Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Brown, Bunch, Danovitch, Gordon, and Mitchell, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

Commissioner Berrick rejoined the Commissioners at the dais.

ACTION

3: <u>Overview of the Governor's 2020-21 Proposed Budget</u>

Presenter:

- John Connolly, Ph.D., Deputy Secretary, Behavioral Health, California Health and Human Services Agency

Chair Ashbeck stated the Commission will be presented with an overview of the California Health and Human Services Agency (CHHS) part of the Governor's Proposed Budget for Fiscal Year 2020-21.

John Connolly, Ph.D., Deputy Secretary, Behavioral Health, CHHS, provided an overview, with a slide presentation, of the three strategic priorities of building a healthy California for all, integrating health and human services, and improving the lives of California's most vulnerable, and the three focus areas of behavioral health of access, integration, and quality. He reviewed the major budget items for behavioral health in the Governor's Proposed Budget of Medi-Cal, the Community Care Collaborative Pilot Program, the Continuum of Care Reform, and the Adverse Childhood Experiences (ACEs) Aware initiative cross-sector trainings and screenings.

Commissioner Questions and Discussion

Commissioner Tamplen asked if the inclusion of billing for peer support services is being considered in the 2020 waiver.

Dr. Connolly stated he was not aware of anything specific to billing code for peer services in the waiver renewal discussions under Medi-Cal: Healthier California for All, although the Department of Health Care Services (DHCS) is in an ongoing conversation with counties about how to expand peer services. He noted that it is important to have the full continuum of professionals and peers available.

Commissioner Danovitch stated one of the priorities around access is reviewing strategies with the Department of Managed Health Care (DMHC) and the DHCS to increase the access to care through oversight. He asked for additional details and how this translates into an impact to consumers.

Dr. Connolly stated, within the commercial plan space, the DMHC currently enforces both federal parity law and the Knox-Keene requirements within the state of California. He stated parity speaks to how equivalent behavioral health coverage is to medical and surgical coverage. Knox-Keene goes further and speaks to the type of timely access that is being provided and the length of time that individuals wait for service.

Dr. Connolly stated there is an internal review initiated by the Governor to look at what can be done to be more assertive in that space. There is also an ongoing conversation with counties about network adequacy and how to get to the best way to assess how well timely access is being provided to individuals who need services.

Commissioner Mitchell asked for additional details on the DHCS Behavioral Health Quality Incentive Program (BHQIP).

Dr. Connolly stated the CHHS has asked the county behavioral health plans to be integrated, has proposed to revise the medical necessity criteria, and has asked for an enhancement of how counties report data to the CHHS to inform payment models in an effort to move to value-based frameworks. To do that, they have to reorient business processes. Dr. Connolly stated that adjustment requires work and has expense tied to it, so the CHHS is putting resources into this process to help counties meet the expectations of the goals.

Commissioner Berrick asked about the progress in thinking about a one-time transition plan to help relieve the counties to allow them to move forward.

Dr. Connolly stated everyone is anxious to move the payment reform pieces forward as quickly as possible, but it will require an adjustment of infrastructure and systems. He stated there have been discussions about a one-time relief plan but he was unaware of the conclusion to those discussions. He stated he would check into it and get back to staff on that.

Public Comment

Suzanne Edises, mental health advocate, was thrilled that the CHHS is working to increase access to health care and will work with the homeless and that the surgeon general will work on ACEs. The speaker encouraged including Striving for Zero: California's Strategic Plan for Suicide Prevention, put together by the Commission, in the Governor's Proposed Budget.

Poshi Walker echoed the comments of the previous speaker. The speaker stated the hope that the CHHS will continue to have stakeholder involvement to keep stakeholders informed and able to provide feedback. The speaker encouraged the CHHS and the Governor to seek consultation with the VA Homeless Program in California, especially with individuals with boots on the ground, while seeking how best to serve the homeless population. The speaker stated the VA Homeless Program has many lessons learned of what does and does not work. The speaker encouraged the CHHS to involve LGBTQ programming.

Joy Burkhard felt compelled as a professional in the health insurance industry to emphasize the key points that were mentioned in the presentation and to reinforce the need for peer support. The speaker loved that the CHHS is looking at whole person care. Until there is integration, things will not change. Payment parity is a big piece of mental health parity that has yet to be addressed. The speaker applauded the CHHS's effort to look at telepsychiatry in more detail.

Joy Burkhard stated peer support for mothers is critical. Low-income mothers in particular are often afraid to speak up to a medical professional for fear that their children will be taken away. Commissioner Beall has reintroduced Senate Bill (SB) 803. The speaker encouraged the Governor's Office to consider signing that bill. The speaker stated Moms 2020 strongly supports SB 803.

LUNCH BREAK

ACTION

4: <u>Overview of the Commission's 2020-21 Proposed Budget and the Commission's 2019-20 Expenditures</u>

Presenter:

- Norma Pate, Deputy Director, MHSOAC

Chair Ashbeck stated the Commission will be presented with an overview of the Commission's Proposed Budget for Fiscal Year 2020-21 and an update of the Commission's expenditures for 2019-20.

Norma Pate, Deputy Director, provided an overview, with a slide presentation, of the Commission Budget Adjustments for Fiscal Year 2019-20, the Commission budget update for Fiscal Year 2019-20, and the Commission's proposed budget for Fiscal Year 2020-21.

Deputy Director Pate stated the MHSOAC office is currently being expanded to take over the entire 17th floor. Construction will begin in February and is expected to take a year. She noted that the meeting room will be unavailable during construction; the intent is for all meetings to be held in different regions around the state in ways that fit with the agenda.

Commissioner Questions and Discussion

Chair Ashbeck suggested including the expenditure percentages in the mid-year report in the future.

Executive Director Ewing stated including percentages is difficult, since some of the percentages are monthly and others are not. Although he liked the idea of providing this report, it is difficult for staff and confusing for Commissioners and members of the public. He stated staff will try harder to find templates, but there is only one state agency that makes their internal operating budget public to this level.

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

- *The Commission approves Fiscal Year 2019-20 mid-year expenditures.*
- *The Commission authorizes the Executive Director to enter into a contract with a university for technical assistance to support Youth Drop-In Centers planning and implementation.*

Motion carried 8 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Berrick, Brown, Bunch, Danovitch, Gordon, and Tamplen, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

[Note: Agenda Item 5 was taken out of order and was heard after Agenda Item 8.]

ACTION

6: <u>Amendment to the MHSOAC Rules of Procedure</u>

Presenter:

- Filomena Yeroshek, Chief Counsel

Chair Ashbeck stated the Commission will consider adoption of the proposed amendments to the Commission's Rules of Procedure.

Filomena Yeroshek, Chief Counsel, provided an overview, with a slide presentation, of the background and high-level summary of the proposed changes.

Commissioner Questions

Commissioner Gordon referred to Rule 4.11 and asked why there are two requirements and not just a quorum.

Ms. Yeroshek stated the Attorney General's office released an opinion a few years ago that the majority of the quorum is needed in order to bind the body. The Commission can continue doing business without a quorum but it cannot take action if the quorum is lost.

Chair Ashbeck suggested clarifying the language of Rule 4.11A. The way it is currently written seems that the Commission can take a vote with five members instead of the nine-member quorum.

Commissioner Berrick asked if a recusal would alter the quorum for a vote.

Ms. Yeroshek stated a recusal would not eliminate the quorum.

Commissioner Gordon stated it puts pressure to put the items that require action in the morning.

Vice Chair Madrigal-Weiss asked if a call-in in the morning establishes a quorum.

Ms. Yeroshek stated it does if it is a teleconference, the address is posted on the agenda, and it is an open public meeting.

Commissioner Berrick stated he received an email that a stakeholder requested that this item be postponed.

Executive Director Ewing stated this agenda item was scheduled today as a first read. A second read is scheduled for the February meeting.

Commissioner Berrick suggested, where there is a vote when there is not a quorum present, taking that vote but then moving the item to the Consent Calendar of the following meeting for ratification so that there is a clear procedure. It can always be pulled off of the Consent Calendar if there is Commissioner or public disagreement.

Chair Ashbeck agreed and stated the practice of city government is, if the vote is not unanimous for the first reading, it cannot be put on the Consent Calendar for a future meeting.

Public Comment

Poshi Walker explained that they were knitting during the meeting for their mental health. Bilateral movement such as coloring, doodling, and knitting are helpful activities for anxiety and increase adult learning abilities. The speaker suggested adding a procedure rule to fund adult learning tools to Commissioners.

Poshi Walker spoke in support of updating the Rules of Procedure and continuing the item to the next meeting. The speaker suggested, if the contract authority for the Executive Director is increased, especially on funding, that contracts over $100,000 go to the Consent Calendar. Also, legislative items can go on the Consent Calendar for transparency and so stakeholders can see what is being advocated for to give them an opportunity to comment.

Tiffany Carter spoke in support of continuing this agenda item to the next meeting to give the public a chance to respond in depth. The speaker spoke in support of Rule 5.1. The speaker echoed Poshi Walker's comment about the Executive Director authority changes. The speaker requested additional language that items pertaining to Rule 2.4 about contracts and interagency agreements will be reported to the Commission.

Pete Lafollette stated giving more discretion power to the Executive Director weakens public participation. Contrary to the claim that the Commission has established a process for extensive community engagement, just the opposite is true. The speaker stated public comment has been minimalized and censored compared to earlier years of the Commission.

Chair Ashbeck asked Commissioners if there was a consensus that the feedback from Commissioners and the public be incorporated and that this agenda item be brought back for discussion for a second read at the February meeting, including procedures on how to manage second readings, clarity on the quorum, and clarity on reporting out on actions that have been taken.

Commissioners agreed.

ACTION

7: <u>Adopt MHSOAC Strategic Plan</u>

Presenters:

- Toby Ewing, Ph.D., Executive Director
- Susan Brutschy, President, Applied Survey Research
- Lisa Colvig, Vice President of Evaluation, Applied Survey Research

Chair Ashbeck stated Executive Director Ewing and Applied Survey Research will present the final draft of the MHSOAC Strategic Plan and the Executive Director will discuss the implementation of the Strategic Plan.

Executive Director Ewing reviewed the summary sheet provided in the meeting packet to remind Commissioners of the key priorities and the strategic planning process to date. He stated the main statement of the strategic plan is to point to opportunities that the Commission has to shape the impact that the MHSA has on systems. The strategic plan broadens the perspective of opportunity that the Commission has and, at the same time, creates a strategic framework to help the Commission decide how to allocate time and resources on the most effective opportunities, and to do that in conjunction with data and analytics and learning collaboratives so that the work being done shapes the

community mental health system around facilitation, technical assistance and support, and incentives.

Executive Director Ewing stated part of this is also how to brand and communicate who the Commission is and how this work is done. The strategic plan is a tool to shape discussions about the best opportunities.

Executive Director Ewing referred to page 7 of the document included in the meeting packet, titled “A Vision for Transformational Change in Mental Health,” and reviewed the priorities and objectives for 2020-2023, including Strategic Goal 1, advance a shared vision; Strategic Goal 2, advance data, analytics, and opportunities to improve results; and Strategic Goal 3, catalyze improvement in policy and practice.

Executive Director Ewing recognized the comments made around the Rules of Procedure and stated the Commission has been stepping away from some of its historical practices. He stated the comments from the members of the public are genuine, but the Commission needs to do a better job of highlighting the ways in which it does community engagement through subcommittee meetings and consumer, community, and youth engagement activities.

Executive Director Ewing stated staff would like the Commission’s guidance. The strategic plan is a nice blending of the work that Applied Survey Research walked through in terms of the Commission’s authorities, and its potential and ways to see that big picture with the things Commissioners have prioritized or that the Legislature has given the Commission to do in terms of budget authority. The plan aims to create a framework that synthesizes that information into strategic goals that can direct decisions made in the future without tying the Commission’s hands.

Executive Director Ewing stated he and the representatives from Applied Survey Research are here to answer questions about the process, the vision, what it means to move forward in terms of the results piece of the strategic plan, and how to operationalize it.

Commissioner Questions

Commissioner Danovitch commended Applied Survey Research and everyone that contributed in the strategic planning process. It is an exceptional deliverable that provides a coherent, clear, and articulatable framework that is understandable. The Theory of Change chart makes sense and is a way to understand the incredibly complex entity that is the Commission, how it functions, and its potential.

Commissioner Danovitch stated his appreciation for the Results Framework. Establishing the measures is imperfect but they can be added to, refined, and improved over time. It is a competency that needs to be integrated in all Commission functions so the Commission models what is expected of constituents.

Commissioner Danovitch stated he loved the summary document that was created, including the vision and objectives that are represented. There is an opportunity to crosswalk the objectives, which are qualitative processes, with what the measures are for them to help map them out.

Commissioner Danovitch stated the strategic plan will help make it much easier to talk both internally and externally to other individuals about the work of the Commission.

Commissioner Mitchell asked if something like this can be formalized or institutionalized for future generations.

Executive Director Ewing stated this is a plan; the Commission has work to do to improve the approach while spreading it into other fields. If the Commission adopts this as the official strategic plan, it will be posted on the website and filed with the Department of Finance. More than that, it is the desire that this approach will be adopted by partners in the system around data and analytics.

Executive Director Ewing stated the way in which to garner interest in this approach beyond the work of the Commission is for the Commission to become better at it and to invite partners in to give their input so the transformative process for mental health services can become a reality.

Executive Director Ewing stated continuing to push and be disruptive in the field, continuing to do this in a way that is collaborative and with lots of community engagement, bringing communities together to talk with them and empower them, partnering with entities, hosting webinars and surveys to capture the stakeholder voice is tempered by the quality of the engagement work that the Commission does. If the Commission is successful, the work will be picked up elsewhere and that is how it is solidified for future generations.

Commissioner Berrick echoed Commissioner Danovitch's comments and stated he was particularly excited about the emphasis on working with multi-county groups in collaboration. He stated the Commission's current focus is on data- and idea-sharing, but he hoped, as the Commission moves forward and the public gets more used to the Commission being more activist rather than oversight, that the Commission will be able to incentivize program development and support.

Heather Shumway referred to Objective 3c, support the youth-led efforts to advance and expand practices for consumer-led and consumer-centric services and expand access to youth-focused services, on page 9 of the strategic plan and asked for examples on how the Commission plans to implement the youth voice, such as holding meetings.

Executive Director Ewing stated everything the Commission is doing has not been articulated in the 9-page strategic plan document in the meeting packet. He stated the Commission has provided $2 million of funding for organizations to support youth voice statewide, has sponsored a multi-county idea lab on how to strengthen youth mental health services, has scheduled additional idea labs with the counties in the Sacramento Valley and Redding areas, is currently talking with counties about doing a youth mental health innovation summit in May in Los Angeles to coincide with the We Rise event, and will provide funding to incentivize counties to invest in the youth-driven drop-in centers.

Executive Director Ewing stated, on top of that, the Commission requires counties to provide information on who they serve, including information on age, tying that information into outcomes to learn if the systems currently in place are helping someone

with a behavioral health need get a job. School success for youth and employment success for others is often the best for recovery and wellbeing because it is about opportunity and hope.

Commissioner Gordon seconded Commissioner Danovitch's comments. He stated this is extraordinary work that will be extraordinarily helpful. Much of the challenge will be with the communication department. Much of the Commission's mission is to create cultures where youth can thrive and employees can thrive. He stated some entities do not know how to do that but, if the systems can work together, they can learn from each other. Keeping score with a dashboard is essential and will help enormously.

Chair Ashbeck asked when the scorecard will be available, even in its imperfect form.

Susan Brutschy, President, Applied Survey Research, stated the scorecard is a live document that will be continually updated.

Chair Ashbeck asked if the scorecard is online or if it should be brought to every meeting.

Ms. Brutschy stated it is in the link and is ready to be populated.

Executive Director Ewing noted that it has yet to be populated with data.

Chair Ashbeck asked when the scorecard will be populated with data.

Executive Director Ewing stated staff will begin to populate it after the strategic plan has been approved by the Commission. The first dashboard is the Innovation dashboard, which is live. The scorecard requires two things: a process needs to be developed to put the data into it and, at the same time, much of the work needs to be shifted into the conversation being held through the Research and Evaluation Committee, not necessarily on the internal metrics but on the external metrics. He stated it will take time, perhaps three years, but the Innovation metrics can begin to be populated.

Chair Ashbeck asked Ms. Brutschy to share one or two practical things to begin to change the strategic plan away from a completed project into the culture of the way the Commission thinks and operates.

Ms. Brutschy stated one way is by speaking with results language, which means following simple rules so that, when the Commission communicates what it does, why it does it, and how it knows it is successful, everyone is speaking in the same language.

Ms. Brutschy stated the second way is to keep exploring what is possible in terms of the world of communication because this is a communication function at its most basic.

Lisa Colvig, Vice President of Evaluation, Applied Survey Research, added a third way of periodically doing progress reports on the strategic plan to check things off and move toward the next items on the list. Without an update, it is difficult to see how the strategic plan is rolling out.

Public Comment

Poshi Walker stated they have been involved in and excited about the strategic planning process from the beginning and understands there have been technical difficulties. The speaker stated there was not enough time allowed for stakeholders to review and

provide comment on the strategic plan. The speaker made the same request they did for the Rules of Procedure earlier in the agenda – to hold the adoption of this item until it can be fully addressed at the February meeting to give time for written public comment.

Poshi Walker stated they had long conversations with Applied Survey Research regarding public engagement and operationalizing what that means. It is easy to engage a population; yet that population does not feel like they were engaged. The speaker highly recommended that cultural brokers be used, especially for special populations like LGBTQ or youth, to ensure that they really are met with at locations where they will show up, and that it not just be called “community engagement.”

Poshi Walker stated the need to ensure that this is operationalized somewhere so that the box is not just checked off. That is not the point. When communities are not meaningfully engaged, their voices are not represented within documents, committees, RFPs, and reports.

Steve Leoni, consumer and advocate, stated major changes will be occurring between the MHSA refresh and Medi-Cal update. The speaker stated it will potentially be a very different environment in a very short period of time. The speaker stated they thought at first that this may not be the right time to approve the strategic plan, but then thought, rather, this was the best time for the Commission to stake its claim and put its knowledge into that mix to help shape the changes to come.

Steve Leoni agreed with Poshi Walker to wait for adoption until the next meeting to allow stakeholders to voice their concerns. The speaker referred to Number 5, integrated service delivery, of the Commission’s Core Principles listed on page 1 of the document in the meeting packet and stated the term was originally “integrated service experience.” The speaker noted that the change in the wording is symptomatic of what has been discussed – the experience had to do with the core transformation. Nowhere in the MHSA is the word “transformation” mentioned.

Steve Leoni stated the group who had the most investment in transformation were the clients, followed by the family members. That transformation was about changing how individuals related to members of the mental health community, changing about voluntary engagement, changing about using strengths rather than weaknesses – that core central transformation was so much a part of why the client community supported this. The speaker stated the hope that the language could be adjusted somehow to bring that flavor out more than it is now.

Suzanne Edises stated they are pleased that the Commission is stepping back from the managing of the Innovation items and is looking at this from a vigorous systems perspective. The speaker loved the idea of looking at wellbeing, youth, data, and suicide prevention.

Pete Lafollette stated the main strategy of the MHSA is reducing disparities. The speaker questioned how individuals will be impacted, where and how individuals will be touched, and how individuals will be changed by the Commission’s work. The speaker stated it requires rendering an ethical health care model, not just simply passing on the most successful business model to each community. The work, recovery, history of the

MHSA, how individuals are impacted, and how individuals can learn to help themselves with the assistance rendered to them are overarching over anything else.

Commissioner Discussion

Executive Director Ewing stated the strategic plan was agendized at the October meeting and this is a second read. The part that is new is the summary piece to catalyze it. The framework, deliverables, and the material in the two PowerPoints have been publicly available and on the website. He stated he is happy if the Commission wants to bring it back for further discussion at the next Commission meeting.

Chair Ashbeck suggested using the strategic plan framework to organize future agendas. She asked Commissioners for their input.

Commissioner Gordon stated the strategic plan is not static but will change and evolve over time as the work is done and perfected. He stated the Commission should be open to comments and suggestions all along the way.

Commissioner Berrick stated he was confused by some of the comments because no substantive changes have been made to the strategic plan in several months. The additional document in the packet is a summary for convenience.

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

- *The Commission adopts the 2020-2023 Strategic Plan as presented.*

Motion carried 8 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Berrick, Bunch, Danovitch, Gordon, Mitchell, and Tamplen, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

Chair Ashbeck asked staff to provide laminated copies of the strategic plan at the table for every meeting for the next year.

ACTION

8: <u>Legislative Priorities for 2020</u>

Presenters:

- Toby Ewing, Ph.D., Executive Director
- Michelle Teran, Legislative Director for Assembly Member Sharon Quirk-Silva

Chair Ashbeck stated the Commission will consider legislative and budget priorities for the current legislative session including: SB 803 (Beall) Peer Certification; clarifying use of MHSA funding for services for individuals with potential co-occurring needs; expanding support for the Mental Health Student Services Act; and expanding the SMART/START initiative statewide.

Chair Ashbeck invited Michelle Teran to come to the presentation table to present a legislative proposal from Assembly Member Sharon Quirk-Silva.

Michelle Teran, Legislative Director for Assembly Member Quirk-Silva, presented a legislative proposal by Assembly Member Quirk-Silva that would strengthen mental health strategies to respond to persons with co-occurring mental health needs. She stated Assembly Member Quirk-Silva is preparing her legislative package for 2020 and wanted to meet with the Commission to look at legislation for providing mental health services to many Californians who need support services and addressing co-occurring issues with mental health and substance use disorders as they occur simultaneously.

Ms. Teran asked for the Commission's support and guidance on behalf of Assembly Member Quirk-Silva on how to better address co-occurring situations as these topics are explored.

Executive Director Ewing stated this gets at some of the language in the Rules of Procedure. This time of year, the Commission receives many inquiries from legislative offices that are interested in doing something related to mental health. He stated it is standard practice for departments to informally provide technical assistance. Staff has had several conversations with Assembly Member Quirk-Silva's office on the issue and challenges of co-occurring disorders. What staff has been discussing is that the MHSA is clear around mental health. Even though the field has moved towards behavioral health, there is ambiguity about when MHSA dollars can be used.

Executive Director Ewing stated providers have shared with staff that it quite often is unclear, when someone is presenting for services, if what is happening in that person's life at that moment is a mental health need or a drug-induced psychosis. If it is a co-occurring mental illness and substance use issue, quite often there is a freedom to use MHSA resources to support that, but individuals who need help often do not know if the need is a qualifying mental health or co-occurring disorder.

Executive Director Ewing stated Assembly Member Quirk-Silva's office asked the Commission to help them think about how to craft clarifying language to better align the rules with the realities in the service delivery system – not suggesting that MHSA funding is available to deal with substance use disorders in the absence of mental health, but the idea that it could take time to figure that out, so asking if there are provisions that would help a county or provider to begin to serve someone during that period of ambiguity.

Executive Director Ewing stated his hope that Commissioners would share their thoughts on this issue and perhaps work with the author to craft legislation that the Commission could support that would help address this in-between moment in time that may cause counties to be hesitant to provide services that might put them at audit risk.

Commissioner Questions

Chair Ashbeck asked for clarification that there is no document on this legislation yet, but the Assembly Member is looking for open feedback on if there was legislation regarding individuals with co-occurring disorders.

Ms. Teran stated it is still very early on in the process of trying to determine what legislation would look like.

Commissioner Danovitch spoke in support of the spirit behind this initiative. He stated it is important to achieve flexibility in the language. Substance use disorder is a mental health disorder. On one hand, the issue is not to let funds that are dedicated to one area be consumed by another area, but, on the other hand, the reality is the individuals who need to be touched often have both of these conditions together.

Commissioner Danovitch stated it is important not to let concern about funding lines interfere with the ability to screen, identify, and respond to the needs of individuals. He stated there is not a one-size-fits-all answer to how it is delineated, when something needs to be mental health versus substance use, but their separation is the exception and not the rule. The more flexibility there is in the language, the more that this can be resolved at the level of the issue of programming.

Commissioner Mitchell stated often those two disorders run in tandem. She asked if the language can be made flexible enough to include “and/or,” because sometimes there will not be a delineation simply because of what is going on with an individual at that time. The next episode could be more related to the other disorder. Often, the two are so closely tied together that there is no distinction.

Commissioner Berrick pointed out that there are times when the funding stream drives the assessment process so there is not a good diagnostic picture. This should be avoided.

Vice Chair Madrigal-Weiss stated she looked forward to having staff time on this and to having Commissioner Danovitch working towards this as well because it has been an ongoing concern. Co-occurring effects are also seen in schools. To spend time to do the research and to develop something around this to help inform practices and systems is worth the investment of time, energy, and resources.

Chair Ashbeck summarized the feedback from Commissioners that they would like to work with the author on language and would like an update at a future meeting. It is a long-overdue gap in the system of care in California.

Public Comment

Poshi Walker spoke in support of this legislation. The speaker stated, when the MHSA first came onboard, they kept hearing “no wrong door,” but there is a wrong door and entities are being audited. The speaker stated they interned at a substance abuse program and looked forward to doing therapy but were told they could not provide therapy because individuals had to be sober for a year to deal with their own mental health issues. Substance use was not seen as a mental health issue. The speaker stated they were removed from that program because their views did not agree with the program’s views.

Poshi Walker stated it is their personal and professional opinion that almost all individuals with substance use disorder have underlying mental health issues and that is what led them to the substances to begin with. Also, if this was not the case and an

individual got into a substance use addiction, that creates mental health problems anyway.

Poshi Walker stated Proposition 64, the Adult Use of Marijuana Act, does not mention mental health but is all about substance abuse. The speaker stated Cal Voices cannot apply because they would not be able to show that they do substance abuse work because Cal Voices' work is considered mental health work, even though many of the individuals and peers involved with Cal Voices also have co-occurring substance use disorder.

Steve Leoni stated the DHCS has been holding a series of two to three meetings per week over the past three months on behavioral health. One of those meetings is on payment reform. Another issue they are working on is not being required to have a diagnosis before services can be received. The speaker stated the idea is that individuals can seek services and the diagnosis will be figured out later.

Steve Leoni stated the meetings will conclude at the end of February and the DHCS will submit a report to the federal government in June. The speaker stated, if everything works well, many of these things are expected to be in operation by January of 2021. The speaker strongly advised checking in with the DHCS to see what they are doing because this legislation may not be needed.

Jeff Nagel, Ph.D., Director, Orange County Behavioral Health, stated Orange County has many co-occurring individuals but agreed that there is an ambiguity that occurs to determine if it is substance use disorder or a mental health issue when an individual presents. The speaker stated being patient-centered requires the opportunity to serve first and not be concerned about whether it was a substance use disorder primary diagnosis, in which case MHSA funds are not allowed. The speaker stated having a bill like this would provide the flexibility that would create a person-centered system and provide care first.

Jeff Nagel stated, if the diagnosis is substance use disorder primary, the county would be able to make that referral but not worry about going back and losing or giving up some of those funds. The speaker offered Orange County's support.

Senate Bill 803 (Beall): Peer Support Specialist Certification Act of 2020

Senate Bill 854 (Beall): Mental Health Parity: Access to SUD Treatment

Senate Bill 855 (Wiener): Mental Health as a Medical Necessity

Executive Director Ewing asked Commissioners to consider supporting SB 803, SB 854, and SB 855 and noted that the facts sheets for each are included in the meeting packet.

Proposed SMART/START Statewide Initiative

Executive Director Ewing stated there is an opportunity for the Commission to advocate for an innovation that was developed in two communities to go statewide. He suggested that the Commission support a statewide initiative to help schools put appropriate strategies in place for assessments such as the School Threat Assessment Response

Team (START) Program in Los Angeles and the System-wide Mental Health Assessment and Response (SMART) Program in Glenn County.

Executive Director Ewing suggested working with the Legislature and Los Angeles and Glenn Counties to begin to discuss how the state could support a statewide initiative rather than wait for every county to recognize the need and try something new. He asked Commissioners for their feedback.

Executive Director Ewing stated the SMART Program is innovation funding to strengthen a partnership between education and public safety to think about what to do when there is a threat and how to handle threats in an appropriate way. Counties use a variety of assessment strategies and schools have a differential approach to assessing suicide risk. A statewide initiative can address how to create uniformity in the approach that is more evidence-based, and how the state might support that conversation so that these issues would improve over time.

Commissioner Questions

Vice Chair Madrigal-Weiss stated other counties besides Los Angeles and Glenn Counties are beginning to react to concerns and, oftentimes, law enforcement is taking the lead. It is coming from a law enforcement perspective, not necessarily from a mental health perspective. It is important that this is a thoughtful process while engaging the Legislature about this issue.

Executive Director Ewing stated this will provide an opportunity for individuals to come together and learn, such as by a conference or by the development of a toolkit. He stated the Commission asked how to support individual innovations going to scale. The need is there, and this is one opportunity to help with that need. The part that is unknown is the path forward.

Executive Director Ewing stated Commissioners who are members of the Legislature could help the Commission figure out what that path forward is, which could be directing the Commission, the Department of Education, or the Department of Justice to do this work or in collaboration with all three.

Commissioner Gordon suggested that the Commission have a conversation about how to help counties take this type of innovation to scale before approaching a legislator with a bill for this purpose because sometimes it suggests a sense that this is a big priority for the Commission as compared to taking some other innovation to scale.

Commissioner Bunch asked why this would not be a priority for the Commission and across the country. It is not an issue of how different counties or school districts are responding, it is matter of if they are responding. She stated, in the absence of a mental health response, they are responding with law enforcement, which is why this is important.

Chair Ashbeck stated this is a chance to practice what the Commission has talked about – to take a project, see if it can be scaled, and see what that looks like. She suggested using this as a test case because it is important, and it is important to get it done. It has not been done in an intentional way; this can be a test example of what that looks like.

Commissioner Gordon further pointed out that, beyond this project, there are many places that do this work in many different ways around the state in both school districts and counties.

Executive Director Ewing stated the action item is about legislative and budget priorities. He stated the Commission is not ready to approach legislators with a possible bill. The budget and bill processes are starting up and Commissioners can give staff direction that this is something they want the Commission to invest in and figure it out in conversations with partners, the governor's office, and the Legislature, and return at a future Commission meeting with a proposal.

Commissioner Berrick stated he was less concerned with the specific idea and more concerned that the Commission coordinates it with the strategic goal. He stated he sometimes worries that violence prevention programs become a simplified method of doing integrated school-based mental health and school climate instead of being integrated into a broader approach. He stated he loved the idea of using this as a point of entry to begin the broader discussion, as long as the Commission is couching it as part of a broader strategy and goal to think about how this relates to mental health in schools.

Commissioner Tamplen echoed Commissioner Berrick's comments about further discussing this issue at a future meeting. She stated it is an important issue to address and discuss as a Commission, but there is also more that needs to be learned from other communities. There are many sensitivities with this subject that affect underserved and inappropriately served communities. It is important to recommend something that is not reactive but responsive. She stated it is important that the Commission does it right.

Chair Ashbeck thanked Commissioner Berrick for linking this item back to the strategic plan. She restated the need for staff to supply laminated copies of the strategic plan at the table at every future meeting for Commissioner reference.

Public Comment

Steve Leoni stated much of the problem with past peer certification bills has been because the DHCS has not been in support of funding peer certification; yet, the governor's veto on last year's peer certification bill mentioned how valuable peer support is and that he had his own ideas on this issue. The speaker stated sometimes there is tunnel vision in mental health. This is a bill inspired by peers with lived experience, but the peer movement is catching on in other areas.

Steve Leoni suggested that perhaps the governor thought the bill was too narrow and wanted to do something that covered all peer work. If that is the case, the mental health community needs to determine if they want to support a broader bill to include all peers. The speaker stated it might be helpful to explore what is out there with these things in mind.

Jeff Nagel stated Orange County has a program that has a model for the SMART teams. The speaker noted that the program is proactive in terms of the threat assessments being done. In fact, as children are identified in the school systems that

are viewed as at-risk or if there is a minor threat made, the schools include the sheriff's department as part of the team to do assessments and make referrals. The program also has the Active Shooter Simulation Drill for tabletop exercises that is part of this as well. The speaker asked that Orange County also be included in the models.

Joy Burkhard brought back the topic of maternal mental health as a potential legislative priority and a priority topic area for the Commission. The speaker shared ideas for potential legislation:

- AB 1676 introduced last year, called for a telepsychiatry consultation program to increase primary care provider capacity to treat basic depression and anxiety not just in mothers but in the pediatric population.
    - This is from a model developed out of Massachusetts Child Psychiatry Access Program, which has proliferated in many states. Massachusetts has since developed the Massachusetts Child Psychiatry Access Program for Moms model that was rolled out five years ago.
    - There is excellent evidence of successful outcomes in providing first-line providers with the support and lifeline that they need to do this work competently and confidently.
- 2020 Mom is interested in introducing a pilot budget ask this year to have three to five counties of various sizes participate in a pilot centralized at the state level. The speaker asked the Commission to support that work in contracting with state agencies that would oversee the pilot.
- 2020 Mom would like to hear from counties through a one-page report to the Commission reporting out what, if any, they are spending their MHSA dollars on relative to maternal mental health. 2020 Mom is interested in connecting more counties and supporting the implementation of best practices but needs to learn what the counties are doing.

Chair Ashbeck asked for a motion to support SB 803, 854, and 855, to work with Assembly Member Quirk-Silva to develop her proposal with guidance from Commissioner Danovitch, and to add an agenda item at a future meeting on the SMART/START initiative.

Commissioner Tamplen moved to take a formal support position on Senate Bills 803, 854, and 855, with direction to staff to update the Commission as these bills evolve, to work with Assembly Member Quirk-Silva to develop her proposal with guidance from Commissioner Danovitch, and to gauge interest and start to develop a proposal for the SMART/START initiative and a maternal mental health pilot project, and bring them back for a future meeting.

Commissioner Mitchell seconded.

Commissioner Gordon suggested sponsoring briefings for legislators and legislative staff on the strategic plan so they can get the idea of fitting some of their ideas into the strategic plan and the data platform that the Commission has created.

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

- *The Commission takes a support position on Senate Bills 803 (Beall), 854 (Beall), and 855 (Wiener), with direction to staff to update the Commission as these bills evolve.*
- *Staff is to work with Assembly Member Quirk-Silva to develop her proposal with guidance from Commissioner Danovitch and staff is to gauge interest and start to develop a proposal for the SMART/START initiative and a maternal mental health pilot project, and bring them back for a future meeting.*

Motion carried 8 yes, 0 no, and 0 abstain, per roll call vote as follows:

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

INFORMATION

5: <u>Executive Director Report Out</u>

Presenter:

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

Executive Director Ewing presented his report as follows:

<u>Partnerships</u>

The CHHS is in the process of forming the Governor's Behavioral Health Task Force to address the urgent mental health and substance use disorder needs across California. Executive Director Ewing has been asked to represent the Commission on the Task Force. Many meetings are anticipated. The CHHS has announced an application process for stakeholders and community members who would like to be considered for membership in the Task Force.

Staff has been meeting with the First 5 Association and the First 5 Sacramento Commission with Commissioners Alvarez and Berrick. It is recognized that more needs to be done in the early years.

Executive Director Ewing attended a meeting with the Commission on Aging and talked with them about Prevention and Early Intervention (PEI) programs. The Commission on Aging expressed frustration that much of the conversation around PEI is on children, when older adults also have first-episode mental health needs later in life.

Executive Director Ewing attended a meeting with the California Indian Health Service, which is a federal agency. They are interested in learning more about the work of the Commission and how to strengthen partnerships between the federal government and state agencies that are working on mental health issues for Tribal communities. The California Indian Health Service is planning to host a site visit to a facility that they are building, as well as to connect with Tribal health centers in the northern part of the state.

Project Updates

The Commission is supporting projects to reduce the number of individuals who are at risk of an incompetent-to-stand-trial declaration. There are three projects underway. Staff will provide an update at the February meeting.

Statewide Suicide Prevention Plan

A hard copy of the Suicide Prevention Plan that the Commission adopted at the end of last year was distributed at the meeting and included in the meeting packet. Staff will work to implement the plan in coordination with the Governor's Office and the Legislature.

Workplace Mental Health

Executive Director Ewing attended a meeting with the DMHC to discuss the Commission's work on mental health in the workplace. Periodically, staff receives phone calls from individuals who are unable to access care even though they have insurance. Staff is hoping to partner with the DMHC to develop information products to point individuals in the right direction.

Executive Director Ewing is in discussion with the DHCS and the Department of Human Resources (CalHR) about the Commission's work on mental health in the workplace.

Youth Innovation Project

The first Youth Innovation Idea Lab was held in Santa Barbara where there was a lot of excitement and staff learned a lot. It was helpful to have this youth-driven event. Staff is interested in the extent that the counties that participated use that energy to drive decisions that they are making in terms of how they design programs to support young people. Staff is also interested in whether that activity counts towards the community planning process requirement because it may not in the minds of local advocates. Staff is testing that by giving counties the opportunity to get ideas and seeing how that works with their local stakeholder groups and with their boards of supervisors as they move program proposals forward.

Solano County has offered to host a second Youth Innovation Idea Lab.

Past Projects

Fiscal Reversion

When the Commission identified unspent funds, the state reset the clock for those funds, particularly on Innovation funds. Staff continues to work closely with the DHCS to understand what the updated numbers are in terms of revenues, expenditures, and unspent funds. Under the AB 114 reset language, the DHCS is interpreting the law that counties have until June 30th of this year to spend their Innovation funds that otherwise would have reverted if the reset not happened. The DHCS interpretation of the law is, if those funds are in a dedicated Innovation plan that has been authorized by the Commission, then they are protected from

reversion. If the funds are not spent or authorized by the Commission, they are subject to reversion.

Executive Director Ewing asked Commissioners to let staff know if they are interested in participating in upcoming Commission activities.

ADJOURNMENT

There being no further business, the meeting was adjourned at 3:16 p.m.

AGENDA ITEM 2

Action

February 27, 2020 Commission Meeting

Early Psychosis Intervention Plus (EPI Plus) Outline for Request for Applications

Summary: The Commission will consider approval of an outline for the Request for Application (RFA) to support high-quality, evidence-based early psychosis intervention services in the state. The RFA is a competitive bid process that would distribute $15,562,000 to support Early Psychosis Intervention programs. The proposed outline includes a set aside of $3,890,000 for evaluation, training and technical assistance efforts.

Background: Assembly Bill 1315 (Mullin) established the Early Psychosis Intervention Plus (EPI Plus) Program and the EPI Plus Advisory Committee to advise the Commission regarding the allocation of funds for a competitive selection process to expand the provision of high-quality, evidence-based early psychosis and mood disorder detection and intervention services in the state. The Commission's 2019-2020 budget includes $19,452,000 to expand and improve the fidelity of existing early psychosis and mood disorder detection and intervention services in California. These funds can support the goal of moving California from a stage 4 crisis response system to a stage 1 early intervention system of care. Individuals who have experienced a first episode of psychosis benefit from early intervention, which can reduce the negative outcomes of untreated mental illness.

Advisory Committee Engagement: To inform this proposed outline, the Commission formed the EPI Plus Advisory Committee in March of 2019. The Committee held four meetings to identify priorities for the use of these funds and related work.

The EPI Plus Advisory Committee heard presentations on the components of AB 1315, a description of the current landscape of early intervention, and what will be required to increase access for people experiencing a first episode of psychosis. The Committee discussed opportunities to expand a learning collaborative and strengthen early psychosis intervention programs in the state through technical assistance and monitoring for full fidelity to the Coordinated Specialty Care model, an evidence-based approach to early psychosis care.

In November 2019 the Commission convened a symposium on this work, the *Statewide Implementation of Early Psychosis Care in California: Increasing Access to High Quality Care for all Californians.* At that event, state and national leaders presented on work underway around the country.

In January 2020, the EPI Plus Advisory Committee discussed strategies for the allocation of EPI Plus funding, including scaling up successful programs which endeavor to implement the core components of the Coordinated Specialty Care model with fidelity and providing technical assistance and training to support the successful adoption of the model.

In brief, the Coordinated Specialty Care model is a recovery-oriented treatment program which promotes shared decision making and uses a team of specialists who work with clients to create individualized treatment plans. Programs include the following components to assist individuals to stay engaged in school or work, make stronger connections to relationship supports and achieve higher levels of health and wellness:

1. Recovery-oriented psychotherapy
2. Family psychoeducation and peer support
3. Supported education and employment
4. Pharmacotherapy and primary care coordination
5. Intensive case management

Presenter:

- Tom Orrock, Chief of Stakeholder Engagement and Grants

Enclosures (1) Proposed Outline of Request for Application (RFA) for Early Psychosis Intervention Services; (2) The Rise of Early Psychosis Care in California; (3) RAISE: Evidence-Based Treatments for First Episode Psychosis; (4) California's Early Psychosis Opportunities and Challenges (Map)

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

Mental Health Services
Oversight & Accountability Commission

Outline for the
Early Psychosis Intervention Plus (EPI Plus)
Request for Applications

Background

The Mental Health Services Act provides a clear emphasis on transforming the mental health system from a "fail-first" service delivery model to focus on pathways for prevention and early intervention. In recognition of this perspective, the Commission has identified the opportunity to provide early intervention support for people who are developing signs of early psychosis. Psychotic symptoms, such as hallucinations and delusions, often emerge between the ages of 15 and 25. It is estimated that 32,000 young people will experience a first episode of psychosis by 2024. Approximately 3 in every 100 young adults experience psychotic symptoms each year.

A significant body of literature documents evidence-based strategies and models to identify and treat young adults with early signs of psychosis. A key strategy for improving outcomes is to reduce the duration of time spent without treatment. As such, an early intervention system of care is essential in order to reach the goal to improve outcomes for individuals who experience episodes of psychosis or mood disorder.

In California, there are approximately 30 Early Psychosis Programs across 24 counties. However, there is little uniformity in treatment models, how programs operate, data collection strategies, and fidelity to a particular model of care.

Assembly Bill 1315 (Mullin) established the Early Psychosis Intervention Plus (EPI Plus) Program and the EPI Plus Advisory Committee to advise the Commission regarding the allocation of funds for a competitive selection process to expand the provision of high-quality, evidence-based early psychosis and mood disorder detection and intervention services in the state.

To support a more coordinated effort to decrease the duration of untreated psychosis and mood disorder, the Commission was provided $19,452,000 through the Budget Act of 2019 to ensure that programs operate with fidelity to an evidence-based model and expand service capacity for early psychosis and mood disorder detection and intervention services in California.

Advisory Committee Activities

In March 2019 then Commission Chair, Khatera Tamplen, appointed the members of the Advisory Committee as prescribed in AB 1315. Per the statutes, the Commission Chair leads the Advisory Committee. The Committee is made up of subject matter experts with knowledge related to mental health care including consumers, behavioral health directors, clinicians, researchers, a private health plan representative, a parent, and an expert in medical technologies. The Advisory Committee gathered for four full-day meetings between June 2019 and January 2020.

Through these four meetings, along with consultations with other experts and interested parties, the Advisory Committee highlighted areas of need which should be addressed to meet the core objectives and create a statewide strategy for early intervention of psychosis and mood disorders.

Advisory Committee Recommendations

The EPI Plus Advisory Committee has recommended that available funds establish and support a network of Coordinated Specialty Care (CSC) providers through training, technical assistance, and fidelity monitoring.

1. Allocate 80 percent of available funding to strengthen programs which are currently operating early psychosis clinics by supporting their efforts to reach full fidelity to the Coordinated Specialty Care (CSC) model.
2. Allocate 20 percent of available funding to provide technical assistance to grantees through a learning collaborative, train the workforce in the CSC model, monitor programs for fidelity, and begin the formation of regional centers of excellence by assessing for needs where services currently are not offered.
3. Incentivize matching funds through Medi-Cal, private donations, or other mental health resources.
4. Support tailored approaches to meeting unique community needs within the CSC model to enhance client engagement and how the core components are delivered to diverse populations, communities or regions.
5. Ensure that all grantees include a shared decision-making approach.
6. Incentivize multi-county collaborative efforts.

Coordinated Specialty Care Clinics (CSC)

In 2008, the National Institute of Mental Health (NIMH) launched the Recovery After an Initial Schizophrenia Episode (RAISE) project. RAISE is a large-scale research initiative that began examining different aspects of coordinated specialty care (CSC) treatments for people who were experiencing first episode psychosis. Coordinated specialty care

(CSC) is a recovery-oriented treatment program for people with first episode psychosis (FEP). CSC promotes shared decision making and uses a team of specialists who work with the client to create an individualized treatment plan. The RAISE project produced strong outcomes and created an evidence-base to support the expansion of the CSC model.

This funding opportunity will promote the expansion of Coordinated Specialty Care Clinics as the primary method for delivering high-quality, integrated care to individuals experiencing a first episode of psychosis. These programs will use evidence-based approaches which will help identify and address participant needs through a shared decision-making approach. Individuals and their families will be supported through a team-based structure of support which provides a full continuum of services to assist in their recovery. Programs will include the following components to assist individuals to stay engaged in school or work, make stronger connections to relationship supports and achieve higher levels of health and wellness:

1. Recovery-oriented psychotherapy
2. Family psychoeducation and peer support
3. Supported education and employment
4. Pharmacotherapy and primary care coordination
5. Intensive case management

Funding Allocation:

The proposed funding for this Request for Application (RFA) is $19,452,000 to support the expansion and capacity building of CSCs across California. Funds allocated by the Commission shall be made available to selected counties or counties acting jointly.

The Committee recommended that the Commission apportion funds in two categories.

A. **Program Support:** $15,562,000 (80 percent of available funds) to support program grants to individual counties or counties acting jointly that will expand the capacity and bring to full fidelity the current early intervention of psychosis and mood disorder services within their communities. Grants would not exceed $2 million and would be provided over a four-year grant term, with an incentive for matching funds.

B. **Training and Technical Assistance:** $3,890,000 (20 percent of available funds) set aside for a training and technical assistance contractor who will provide support and guidance to grantees, ensure program quality, and strengthen the statewide network of CSC providers. This contract would be provided over a four-year term.

A. Program Support

One-time funding of $15,562,000 to strengthen the Coordinated Specialty Care (CSC) statewide network of providers by supporting current early psychosis intervention programs toward full fidelity to the CSC model. The Request for Application outline includes:

I. Eligibility

County, city, or multi-county mental health or behavioral health departments acting jointly.

II. Minimum Qualifications

Applicants must meet the minimum qualifications below in order to be eligible for this funding opportunity. The purpose of establishing these minimum qualifications is to ensure that the entities applying for funding are adequately experienced and have the capacity to perform the duties as outlined.

1. Applicants must be county, city, or multi-county mental health or behavioral health departments.
2. Applicants must identify a contribution of local funds which will support the programs.
3. Applicants must have demonstrated knowledge and experience operating a Coordinated Specialty Care clinic within their county.

III. Program Grant Funding and Term

$15,562,000 will be made available for program grants and approved for a grant term of up to four years with funds allocated annually, in quarterly installments, contingent on fulfilling reporting requirements.

IV. Key Action Dates

RFA Release	March 13, 2020
Application Due Date	April 24, 2020
Intent to Award	May 28, 2020

V. Allowable Costs

Grant funds must be used as stated in the application submitted by the awardee and approved by the Commission, as follows:

1) Allowable costs include personnel, administration and program costs.

a. A budget worksheet shall be submitted with the applications which outlines all planned expenditures, amounts, and time frames for personnel hire dates, administrative cost expenditures, and program costs including training, technology, transportation and facilities.

2) Grant funds may be used to supplement existing programs but may not be used to supplant existing funds for early intervention of psychosis or mood disorder programs.

3) Grant funds cannot be used for purposes other than the stated purpose of this grant.

VI. EPI Plus Program Plan

The Program Plan must demonstrate the Applicant's ability to meet all specified qualifications, requirements, and standards set forth in the RFA as required by Welfare and Institutions Code Section 5835.3. The Program Plan will include but not be limited to:

1) A description of need, including, at a minimum, a comprehensive description of the early psychosis and mood disorder detection and intervention services and supports to be established or expanded, community need, target population to be served, linkage with other public systems of health and mental health care, linkage with schools and community social services, and related assistance as applicable, and a description of the request for funding.

2) A description of all programmatic components, including outreach and clinical aspects, of the local early psychosis and mood disorder detection and intervention services and supports.

3) A description of any contractual relationships with contracting providers as applicable, including any memorandum of understanding between project partners.

4) A description of local funds, including the total amounts, that would be contributed toward the services and supports.

5) The project timeline.

6) The ability of the awardee to effectively and efficiently expand an evidence-based program.

7) A description of the applicant's capacity to collect core data for evaluating outcomes.

8) A description of the sustainability of program services and supports in future years.

VII. Full Fidelity Plan

The Commission will require the applicants to submit a Full Fidelity Plan as a part of the application. The Full Fidelity Plan outlines the CSC components which will be added or brought to full fidelity and the steps which will be taken by the applicant to accomplish the goals of the Plan.

VIII. Program Communications Plan

Applicants must include a description of the communication plan which will increase awareness of the services in the community or region where they exist. The plan will outline how youth, families, providers, educational entities and other community-based organizations will be made aware of the program services. As a result, the Commission will require that the CSCs maintain up to date information on their website(s).

IX. Budget Requirements

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

X. Program Evaluation

In order to determine program success, awardees are required to collect and provide data on the specific measures as outlined by the Commission.

B. Training and Technical Assistance

One-time funding for training and technical assistance available through a sole-source contract with UC Davis or another comparable provider to support the work of CSC providers to include:

- Research
- Evaluation
- Technical assistance
- Data support and other purposes

The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services

Tara A. Niendam, Ph.D., Angela Sardo, B.A., Mark Savill, Ph.D., Pooja Patel, B.S., Guibo Xing, Ph.D., Rachel L. Loewy, Ph.D., Carolyn S. Dewa, M.P.H., Ph.D., Joy Melnikow, M.D., M.P.H.

Objective: California's Mental Health Services Act Prevention and Early Intervention funds provide a unique opportunity for counties to initiate programs focused on early intervention in mental health, including early psychosis. To explain the configuration of early psychosis programs and plan for a statewide evaluation, this report provides an overview of California's early psychosis programming, including service composition, funding sources, inclusion criteria, and data collection practices.

Methods: Following a comprehensive identification process, early psychosis program representatives were contacted to complete the California Early Psychosis Assessment Survey (CEPAS).

Results: The response rate to the CEPAS was excellent (97%, 29 of 30 active programs across 24 of 58 counties). Most programs (N=27, 93%) serve individuals with first-episode psychosis between the ages of 12 and 25. Twenty-two programs (79%) provide more than half of the standard components of early psychosis care outlined in the First-Episode Psychosis Service Fidelity Scale. Sixty-four percent of programs collect client-level data at intake and follow up on five or more relevant outcome domains; however, these varied significantly across sites.

Conclusions: Substantial variability in services, inclusion criteria, and data recorded was evident across programs. Prior to conducting any large-scale evaluation, these findings highlight the significant challenges in retrospectively evaluating program effectiveness, need to harmonize program data collection methods, and importance of assessing the impact of program variability on outcomes.

Psychiatric Services in Advance (doi: 10.1176/appi.ps.201800394)

Across multiple countries, programs serving individuals with early psychosis have been found effective (1). Some countries (e.g., United Kingdom) have adopted top-down standardized models, whereas in the United States, several states have allowed for a bottom-up approach. In 2004, California passed the Mental Health Services Act (MHSA), which established specific mental health services funding, including Prevention and Early Intervention services. Funds are distributed at the county level with autonomy in how they are allocated. Many counties used these resources to develop early psychosis programs. Rather than implementing one treatment model across the state, California counties are permitted to adopt different evidence-based early psychosis care models, with the ability to modify some program details to appropriately address local needs. In 2014, state mental health block grant funds were allocated across the United States for early psychosis services, leading to the development of early psychosis programs using a variety of evidence-based treatment models that were executed at a state or local level. Although California has served as a precursor to the national expansion of early psychosis programs in the United States, its county-driven mental health system led to implementation of diverse programs with little top-down coordination.

HIGHLIGHTS

- Over half of California's counties have developed (41%) or are developing (21%) early psychosis programs, with the majority serving both individuals with first-episode psychosis and at clinical high risk of psychosis.
- Significant variability was reported in clinical populations, data collection practices, and outcomes collected between programs, precluding statewide evaluation using retrospective data.
- Reported variability among programs in components of coordinated specialty care highlights the need for careful evaluation of service delivery at program level to understand the impact of such variation on client-level outcomes.

For U.S. programs, evidence-based treatment components include broad community-based outreach with rapid referral to reduce duration of untreated psychosis (2), comprehensive assessment to determine eligibility, and team-based coordinated specialty care (CSC) (3). Treatment includes case management, ongoing psychiatric or medical assessments and treatment, client and family psychoeducation and psychotherapy, educational and vocational support, and relapse prevention. Most programs provide services to individuals who recently developed a psychotic disorder or those at clinical high risk of psychosis to reduce the likelihood of developing full psychosis.

EARLY PSYCHOSIS PROGRAMMING IN CALIFORNIA

Though founded on existing evidence-based treatment models, California counties have discretion in how they implement their individual early psychosis programs. This approach allows counties to tailor services to the needs of the local population and the resources available (4). Although such customization may be practical for individual programs, this lack of consistency could dilute the measurable impact of these programs on client outcomes (5–10). A similar issue exists at a national level, given that individual states or local jurisdictions have chosen to implement early psychosis programming out of a variety of potential models (4). CSC is effective in improving outcomes in early psychosis (11, 12). However, it is not clear which particular components are key to improving outcomes. Additionally, although recent studies suggest that it is feasible to implement CSC in clinical practice (13), it is unclear how effective the intervention is when delivered in this setting, as opposed to within the more structured environment of a clinical trial. Evaluating the effectiveness of CSC across a range of existing heterogeneous community programs for early psychosis represents an important step toward determining the effectiveness of the model in standard clinical practice. Exploring the impact of program-level differences across these services may help to identify which particular components of care are key to improving specific outcomes. However, before an evaluation can be conducted, it is critical to understand the composition of the programs that may be included, their data collection practices, and the nature of the heterogeneity between programs.

This article provides a descriptive summary of California's early psychosis programs, including the com position of program services, funding sources, data collection practices, inclusion criteria, and use of data collection system (e.g., electronic health records). Given recent interest in harmonized data collection and coordination for early psychosis programs nationally (14), this represents a necessary first step in developing an evaluation approach for the state's complex landscape of early psychosis programs.

METHODS

Design

From May to October 2016, active early psychosis programs were identified through a multiphase process that included review of mental health and county program Web sites, MHSA plans, Substance Abuse and Mental Health Services Administration (SAMHSA) mental health block grant applications, and stakeholder feedback. The MHSA coordinator in each county was contacted to confirm the existence of an early psychosis program and identify a program or county representative.

In October 2016, early psychosis program representatives were contacted via e-mail with a project overview and participation request, followed by a link to the California Early Psychosis Assessment Survey (CEPAS). In counties with more than one program, representatives were asked to complete separate surveys to capture the nuances between programs. If the representative failed to respond after 2 weeks, three courtesy calls were administered and additional reminder e-mails were sent to encourage survey completion. Once the surveys were completed, representatives were contacted to clarify vague responses, resolve discrepancies in the data, or resubmit missing data through May 2017. This evaluation was reviewed and approved by the University of California, Davis Institutional Review Board.

CEPAS

The CEPAS is a structured online survey designed to gather information about early psychosis program characteristics and the nature of the data collected (see Appendix 1, which is available as an online supplement to this article). The First-Episode Psychosis Services Fidelity Scale (FEPS-FS 1.0) (10, 15, 16), a standardized measure of fidelity to program best practices (see Supplemental Methods in the online supplement), was integrated into the CEPAS to assess both the presence and the absence of treatment model components. Additionally, the CEPAS includes multiple-choice and open-ended questions on the following areas: client age, diagnoses served, outcomes data collection methods, program funding sources, program outreach methods and family involvement, program treatment components, pharmacotherapy options offered, administrative program components (e.g., staff-to-client ratio, types of staff employed), use of Early Psychosis Clinical Services PhenX toolkit measures (17), challenges or barriers to program implementation, and opinions on each component of early psychosis care described within the FEP-FS.

Prior to CEPAS distribution, local stakeholders including early psychosis program managers, MHSA staff, and clients with lived experience reviewed the scale to confirm that items were understandable and captured the necessary data. Results of the presence or absence of treatment components are reported here, whereas program ratings of the importance of these components are reported elsewhere (18).

TABLE 1. Characteristics of 30 county programs for treatment of early psychosis in California[a]

Name	County	Start of program[b]	Age (years)		DUP (months)[c]	Treatment model	Duration of care (years)	Intakes per month	Clinical populations[d]
			Minimum	Maximum					
Prevention and Recovery in Early Psychosis (PREP) Alameda	Alameda	2010	16	24	24	PREP	2	3–5	SZ
First Hope	Contra Costa	2013	12	25	na[e]	Other	2	8	CHR
First Episode Psychosis Clinic	El Dorado	2016	14	25	6	Recovery After an Initial Schizophrenia Episode (RAISE)	3	0–1	SZ, mood, OPSD
First Onset Team	Fresno	2010	18	28	24	Uncertain	3	37	SZ, mood, CHR, OPSD
Imperial Portland Identification and Early Referral (PIER)	Imperial	2015	12	25	12	PIER	2	3–4	Mood, CHR, OPSD
Early Psychosis Intervention	Los Angeles	2014	14	25	12	CAPPS	1	30	SZ, CHR, OPSD
University of California (UC), Los Angeles (UCLA) Aftercare Research Program[f]	Los Angeles	2014	18	45	24	Other	3	15	SZ
UCLA Center for the Assessment and Prevention of Prodromal States (CAPPS) Program[f]	Los Angeles	2001	12	30	nr[g]	Other	2	8	Mood, CHR, OPSD
First-Episode Psychosis Peer Support	Madera	2015	16	30	nr[g]	Other	1	4	SZ, mood, OPSD
First Episode Psychosis Program	Merced	2015	15	30	6	Uncertain	1	30	SZ, mood, CHR, OPSD
PREP Monterey	Monterey	2013	14	35	60	PREP	2	3–4	SZ
Napa Supportive Outreach and Access to Resources (SOAR)	Napa	2014	8	30	24	EDAPT	2	3	SZ, mood, CHR, OPSD
Orange County Center for Resiliency, Education, and Wellness	Orange	2011	12	25	24	EASA	4	9	SZ, OPSD
UC, Davis, Early Diagnosis and Preventative Treatment (EDAPT) Clinic[f]	Sacramento	2004	12	40	24	EDAPT	2	6–8	SZ, mood, CHR, OPSD
UC, Davis, Sacramento EDAPT Clinic	Sacramento	2011	12	30	24	EDAPT	2	6–8	SZ, mood, CHR, OPSD
Pathways–Kickstart	San Diego	2010	10	25	6	PIER	2	34	SZ, mood, CHR, OPSD
Cognitive Assessment and Risk Evaluation Early Psychosis[f]	San Diego	2012	12	30	24	PIER	2	8	SZ, mood, CHR, OPSD
PREP San Francisco	San Francisco	2009	12	35	60	PREP	2	10–20	SZ, mood, CHR, OPSD[h]
UC, San Francisco, Early Psychosis Clinic[f]	San Francisco	2008	No limit	No limit	60	PREP	No limit	5–6	CHR
Telecare Early Intervention Recovery Services[i]	San Joaquin	2015	16	25	12	PIER	2	3	SZ, mood, CHR, OPSD
Campus Residential Crisis Program	San Luis Obispo	2015	17	25	36	RAISE	1	15	SZ, mood, CHR, OPSD
PREP San Mateo	San Mateo	2012	14	35	24	PREP	2	5	SZ, mood, CHR, OPSD
Behavioral Wellness Transition Age Youth Program	Santa Barbara	2010	16	25	12	EDAPT	2	40	SZ, mood, CHR, OPSD
Raising Awareness and Creating Early Hope Program	Santa Clara	2011	10	25	12	PIER	1	3	SZ, mood, CHR, OPSD
Inspire Clinic–Stanford University[f]	Santa Clara	2014	No limit	No limit	nr[g]	Other	No limit	8	SZ, mood, CHR, OPSD
Prevention and Early Intervention Early Onset of Psychosis	Shasta	2012	15	25	12	Other	No limit	1–2	SZ, mood, CHR, OPSD

continued

TABLE 1. *continued*

Name	County	Start of program[b]	Age (years)		DUP (months)[c]	Treatment model	Duration of care (years)	Intakes per month	Clinical populations[d]
			Minimum	Maximum					
Solano SOAR	Solano	2015	14	25	24	EDAPT	2	6	SZ, mood, CHR, OPSD
Lasting Independence and Family Empowerment (LIFE) Path	Stanislaus	2011	14	25	12	Early Assessment and Support Alliance	2	Varies greatly	SZ, mood, CHR, OPSD
Ventura Early Intervention Prevention Services	Ventura	2011	16	25	18	PIER	3	7	Mood, CHR, OPSD
First-episode psychosis[j]	Lake	nr[g]	nr[g]	nr[g]	nr[g]	nr[g]	nr[g]	nr[g]	nr[g]

[a] Results are from the California Early Psychosis Assessment Survey, completed by each program between October 2016 and May 2017.
[b] Fiscal year.
[c] Maximum allowed duration of untreated psychosis (DUP).
[d] *DSM-IV* diagnostic groups: SZ, schizophrenia spectrum disorders (e.g., schizophrenia, schizoaffective disorder, schizophreniform disorder); mood, mood disorders (e.g., major depressive disorder, bipolar disorder) with or without psychotic features; CHR, clinical high risk of psychosis; OPSD, other psychotic spectrum disorders (e.g., psychotic disorder not otherwise specified, brief psychotic disorder, delusional disorder).
[e] na, not applicable.
[f] Not publicly funded.
[g] nr, not reported.
[h] Mood disorders included bipolar I disorder only.
[i] Only partial data received.
[j] The program did not respond to the survey and was excluded from the analysis.

FEPS-FS items were scored in a present or absent manner for 23 of the 30 items assessed. The exceptions were items 21–27, in which a FEPS-FS score of 3 or higher was scored as endorsing the item (see Table 1 in the online supplement for a description of the endorsement criteria for each item).

RESULTS:

Across 58 California counties, 24 (41%) reported having at least one active program for treatment of early psychosis, with five counties reporting multiple programs. Twelve counties (21%) reported having programs in development, and 22 counties (38%) reported no early psychosis program. Of the 30 active programs identified (Table 1), 28 programs (93%) provided complete data on the CEPAS, one county provided partial data, and one county did not provide data. The final analysis includes the 29 programs that provided complete or partial data on the CEPAS (Figure 1 in the online supplement).

Client Population Characteristics

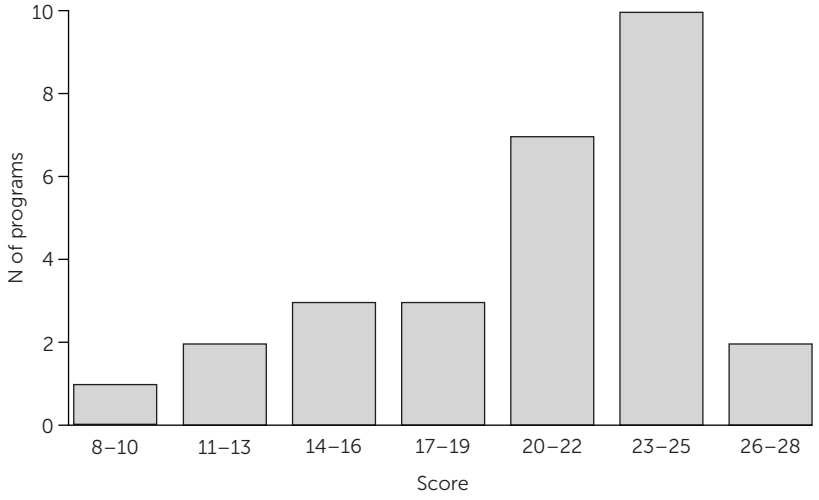
Program-level details are reported in Table 1. Of the 29 programs, 22 (76%) serve both clients with first-episode psychosis (FEP) and clients at clinical high risk of psychosis, five (17%) serve FEP clients only, and two (7%) serve CHR clients only. Twenty-five programs (86%) reported serving clients diagnosed as having a *DSM-IV* schizophrenia spectrum disorder, whereas 86% serve those having any psychotic spectrum disorder. Twenty-one programs (72%) serve clients diagnosed as having mood disorders with psychotic features (e.g., major depressive disorder with psychotic features, bipolar disorder with psychotic features), and six programs (21%) serve clients with a diagnosis of mood disorders without psychotic features. One program reported that it provides services to clients diagnosed as having mood disorders only if they meet criteria for bipolar disorder I, with or without psychotic features.

The most common reason for ineligibility for services was intellectual disability (N=22 programs, 76%), followed by a diagnosis of a substance-induced psychotic disorder (N=19, 66%). Eighteen programs (62%) excluded individuals if they are not county residents, and 13 programs (45%) exclude individuals because of substance dependence. Almost all programs provide services to uninsured clients (N=25, 86%) or undocumented clients (N=23, 79%). Twenty-two programs (76%) provide services to privately insured clients, whereas only two programs (7%) do not serve any of these types of clients.

Characteristics of Program Services and Model Elements

Twenty-eight programs provided data regarding number of eligibility evaluations, with a median of seven individuals per program receiving evaluations per month (mean± SD=11.45±11.54, interquartile range [IQR]=4–15, range

FIGURE 1. Distribution of preliminary scores on the First-Episode Psychosis Services Fidelity Scale (FEPS-FE) among 28 county programs for treatment of early psychosis[a]



[a] Score was based on the number of FEPS-FE components endorsed by the program.

0–40), yielding approximately 84 clients per program per year. All 29 programs provided data regarding number of individuals engaged in ongoing treatment services per month, with a median of 35 individuals per program receiving services per month (mean=50±62.10, IQR=18–50, range 2–300). Sixteen programs (55%) reported the target duration of services was up to 2 years. Five programs (17%) reported a target treatment duration of 1 year or less, four programs (14%) reported a target duration of 3 years, and one program reported a target duration of up to 4 years (3%). Three programs (10%) reported treatment was available indefinitely based on need.

The most frequently adopted CSC model was Maine's Portland Identification and Early Referral (PIER) model (N=6, 17%) (19, 20), followed by the Felton Institute Prevention and Recovery in Early Psychosis model (N=5, 17%); the University of California, Davis, Early Diagnosis and Preventative Treatment model (N=5, 17%); the Recovery After an Initial Schizophrenia Episode model (N=2, 7%); and the Oregon-based Early Assessment and Support Alliance model (N=2, 7%) (4). Eight programs reported using other models that include various CSC components. For example, Los Angeles reported using the University of California, Los Angeles, Center for the Assessment and Prevention of Prodromal States model; Contra Costa County reported using the PIER model with some adaptations; and Madera County reported using a "peer supportive service" within a full-service partnership to support linkage to medications and therapy. Two programs (7%) were "uncertain" about their model.

Twenty-eight of 29 programs provided sufficient data to evaluate the number of FEPS-FS components offered (Table 2). The most commonly reported components of early psychosis programs included explicit admission criteria, targeted outreach and education across community for referrals, assignment of a case manager to each client, individualized treatment plans, and client and family involvement in initial assessment. Twenty-two programs reported providing at least half of the FEPS-FS components of evidence-based FEP care. These data and programs' reported CSC models suggest that many California early psychosis programs are providing a reasonable level of evidence-based care, although fidelity levels required for good outcomes is unclear.

Program Funding Sources

Twenty-eight programs reported funding data, with 15 programs (54%) receiving MHSA funding. Twelve programs (43%) reported receiving Medi-Cal or Early and Periodic Screening, Diagnosis and Treatment funding for children under age 21, 10 (36%) receive SAMHSA mental health block grant funding, six (21%) receive funds from private insurance, six (21%) receive self-pay funds, five (18%) receive research grants funding, five (18%) receive philanthropic funding, and one program reported county-specific funding for early bipolar disorder treatment. Based on responses from 22 programs, 14 programs (64%) reported that they are reimbursed per unit of service, four (18%) programs reported reimbursement from the SAMHSA mental health block grant, one program (5%) reported monthly reimbursement, and one program did not provide data.

Methods for Collection of Outcome Data

Programs were asked to report the types of data they collect and collection time points (Table 3). Of the 28 programs that provided data, 18 programs (64%) reported collecting data on at least five relevant outcome domains at both intake and at least one follow-up point. All 28 programs reported collecting basic demographic data at intake. The most commonly reported types of information collected at both intake and follow-up were substance use information (21 programs, 75%), risk assessment data (19 programs, 68%), psychosocial data (18 programs, 64%), medication data (17 programs, 61%), hospitalization data (16 programs, 57%), and emergency room or crisis services use (15 programs, 54%). Notably, only four programs collected data at intake and follow-up on a maximum of 15 of the 20 domains assessed, with only 9 domains in common. This suggests a significant lack of overlap between programs in the longitudinal outcome data collection.

Of the 29 programs, 17 (59%) reported using a mix of paper and electronic records, five programs (17%) reported using a paper-only system, and seven programs (24%) reported using a solely electronic system. Eight programs (28%) began prior to electronic record implementation, with

TABLE 2. Components of care offered by 28 programs for treatment of early psychosis in California[a]

Item	Component	Programs (N)
1	Patient is seen within 2 weeks of referral	23
2	Patient and family involved in initial assessment	27
3	Comprehensive initial/intake assessment	12
4	Psychosocial needs incorporated into treatment plan	16
5	Individualized clinical treatment plan developed after initial assessment	27
6	Antipsychotic medications prescribed (considering patient preference)	25
7	Antipsychotic medication dosing is within government-approved guidelines	13
8	Guided antipsychotic dose reduction if patient achieves remission after 1 year	10
9	Clozapine offered for medication-resistant symptoms	12
10	Patient is provided psychoeducation on illness management by clinician (individual or group format)	25
11	Family members are provided education and support (individual or group format)	24
12	Individual or group cognitive-behavioral therapy (CBT)	23
13	Individual or group treatment to address weight gain	1
14	Annual comprehensive reassessment	4
15	Psychiatrist assigned to each patient	18
16	Case manager assigned to each patient	27
17	Motivational enhancement or CBT provided to address comorbid substance use disorders	14
18	Supported employment and/or supported education provided	17
19	Proactive outreach with community visits to maintain engagement	20
20	Community living skills addressed	19
21	Crisis intervention services delivered by program and program links clients to appropriate crisis services	20
22	Patient-to-provider ratio less than 30:1	25
23	Master's-level team lead oversees program	22
24	Psychiatrist as active team member who participates in team meetings	19
25	Multidisciplinary team provides case management and specific service elements (e.g., medication, therapy, etc.)	24
26	Treatment provided for 2 or more years	7
27	All team members attend weekly meetings to review cases	23
28	Targeted outreach and education across community for referrals	27
29	Coordination of care with inpatient to support discharge planning	25
30	Program has explicit admission criteria	28

[a] Results are from the 30-item First-Episode Psychosis Services Fidelity Scale. Only programs that provided completed data are included.

2 to 4 years of early records remaining in a paper-only format.

DISCUSSION

This report provides a descriptive summary of California early psychosis programs funded through a variety of entities, the individuals served and services provided, the types of data they collect, and the data collection systems they use. In terms of populations served, 22 of the 29 programs included provide care for both FEP and CHR clients, five programs serve FEP only, and two serve CHR only. A variety of funding streams, from federal, state, and donor sources, is used to support services. The majority of programs serve individuals between the ages of 12 and 25 years, include clients who have experienced psychosis for up to 24 months, and provide services for up to 2 years. Twenty-two programs reported providing at least half of the FEPS-FS components of evidence-based FEP care. Of the 28 programs that provided sufficient data, 18 programs collect data on five or more relevant outcome domains at intake and follow-up, although which outcomes were collected and when varied substantially between programs. Finally, 24 programs have at least some data stored in an electronic format.

Strengths and Limitations

To our knowledge, this is the first report on the landscape of California early psychosis programs and provides a previously unrecorded insight into the similarities and differences between these programs and the types of data being collected throughout the state. This descriptive summary could inform large-scale evaluations and provides a clear methodology for gathering data across a wide array of programs at the state or national level. Because of the extensive follow-up procedure, the response rate to the CEPAS was exceptional, with 97% of active early psychosis programs providing data as well as clarifications or additional information as needed, significantly improving data reliability.

Regarding limitations, this descriptive assessment was based on survey data reported by staff associated with the early psychosis programs and counties; thus, the findings are contingent on the accuracy and completeness of the self-reported information. For some data (e.g., sources of funding), missing data precluded analysis or reporting. Importantly, the FEPS-FS data were not collected by an external evaluator as would be standard practice (10, 15). Consequently, FEPS-FS program components are only reported at the group level because of the preliminary nature of this approach. Future evaluations examining the impact of

TABLE 3. Types of data collected by 28 programs for treatment of early psychosis, by time of collection[a]

	Intake		Follow-up		Intake and follow-up	
Type of data	N	%	N	%	N	%
Client characteristics	28	100	7	25	7	25
Diagnosis	25	89	16	57	14	50
Symptom severity	19	68	15	54	15	54
Physical health	26	93	10	36	10	36
Metabolic parameters	13	46	18	64	11	39
Vital signs	17	61	18	64	13	46
Family history of mental health conditions	27	96	5	18	5	18
Cognitive functioning	14	50	5	18	5	18
Psychosocial data	24	86	18	64	18	64
Premorbid functioning	15	54	3	11	3	11
Medication data	26	93	17	61	17	61
Medication side effects	20	71	14	50	13	46
Substance use data	27	96	21	75	21	75
Hospitalizations	27	96	16	57	16	57
Crisis utilization	27	96	15	54	15	54
Legal involvement	27	96	14	50	14	50
Risk assessment data	27	96	19	68	19	68
Impact of care received	7	25	17	61	4	14
Treatment satisfaction	5	18	16	57	4	14
Other	4	14	6	21	4	14

[a] Only programs that provided completed data are included.

fidelity on client outcomes should include a comprehensive evaluation of program treatment components to determine the actual type and amount of care received by program participants. California's MHSA funding allows substantial flexibility in how funds can be used to support mental health services, which may not be available in other states. However, these study procedures could be replicated within or across other states to identify common program features and outcome data elements as a first step in developing a nationwide evaluation of early psychosis services, which is of growing interest at the federal level (14).

Implications

With early psychosis programs expanding nationwide, states are increasingly looking to evaluate the impact of these programs. However, lack of consistency between programs may dilute the measurable impact of these programs on client outcomes (5–10). For example, 83% of California early psychosis programs serve individuals at clinical high risk of psychosis; the impact of CSC care among patients at clinical high risk has not been evaluated and the inclusion of these individuals in broad outcomes evaluation of early psychosis programming will affect findings. The reported variations in clinical populations, service structure, data collection practices, and outcomes collected between programs found in this study highlight the need to first accurately survey the programs under evaluation to determine what potential impact variations between sites may have. Additionally, this study also highlights the significant challenges of using retrospective data to evaluate program effectiveness.

This study identified large variations in maximum duration of psychosis used in the inclusion criteria. This is important, given that recent findings suggest that CSC is more effective than usual care only when treatment is initiated early (i.e., within 74 weeks) (12). In addition, large variations in the length of treatment provided—ranging from 1 year to indefinite—were also noted. This is inconsistent with current national recommendations for treatment to be available for at least 2 years (3) and evidence that treatments over an even longer period may be necessary for a subset of individuals to maintain long-term significant improvements (21, 22). As a result, treatment of such relatively short duration may reduce both the short- and long-term effectiveness of early psychosis services.

Programs reported significant variations in the com ponents of care delivered across the various services according to the FEPS-FS checklist. One site reported delivering 27 of the 30 FEPS-FS components assessed, whereas another program reported delivering only nine (Figure 1). Although there is evidence to suggest that CSC is effective (11, 12), it is still unclear which specific components of care affect client outcomes and whether variations in components offered affect treatment effectiveness. As a result, any large-scale evaluation of existing services requires careful examination of care components delivered by each service, both to aid interpretation of heterogeneity of treatment outcomes across services and to understand what components of the CSC may be key to improving outcomes.

CONCLUSIONS

This study indicates that there is considerable variability between early psychosis programs across California, including the components of care provided, inclusion criteria for service users, and data programs routinely collected. As a result, it is important to evaluate what impact these variations may have on treatment outcomes. In addition, this study highlights the significant challenges to conducting a retrospective statewide evaluation of early psychosis services, instead suggesting that prospective evaluation with synchronized data collection would be necessary for statewide or nationwide evaluation. Currently, multiple California counties are embarking on a collaborative effort to harmonize data collection across their early psychosis programs. Results of this project were used to identify the approaches and data elements that these programs already have in common, as well as areas in which additional standardization will be needed. Comprehensive fidelity evaluations of program components will enable evaluation of program-level differences on client outcomes. The collaboration hopes that evaluation results will inform the development and funding of future early psychosis programs across the United States and suggest the minimum standards necessary for programs to yield positive outcomes.

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RAISE
Recovery After an Initial Schizophrenia Episode

Evidence-Based Treatments for First Episode Psychosis:

Components of Coordinated Specialty Care

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1. Background

On January 17, 2014, President Barack Obama signed into law H.R. 3547, the "Consolidated Appropriations Act, 2014." Recognizing that the majority of individuals with serious mental illness, such as schizophrenia, bipolar disorder, and major depression, experience the first signs of illness during adolescence or early adulthood, and that there are often long delays between symptom onset and the receipt of evidence-based interventions, the legislation provides funds to the Substance Abuse and Mental Health Services Administration (SAMHSA) to support the development of early psychosis treatment programs across the United States. A 5% set-aside (approximately $25M) has been allocated to SAMHSA's Mental Health Block Grant program to support the work. Senate Report 113-71, which accompanies the legislation, notes that multicomponent first episode psychosis (FEP) treatment programs already implemented in Australia, Canada, and the United Kingdom represent viable treatment models for improving symptoms, reducing relapse episodes, and preventing deterioration and disability among individuals suffering from psychotic illness. In order to ensure that programs with a demonstrated evidence base are established in the United States, the National Institute of Mental Health (NIMH) has been directed to assist SAMHSA in developing input for states regarding promising FEP treatment models. In response to that directive, this document provides an overview of the evidence-based components of coordinated specialty care programs for the treatment of FEP.

2. First Episode Psychosis

Approximately 100,000 adolescents and young adults in the United States experience FEP each year (calculated from McGrath, Saha, Chant, et al., 2008). With a peak onset occurring between 15-25 years of age, psychotic disorders such as schizophrenia can derail a young person's social, academic, and vocational development and initiate a trajectory of accumulating disability. Youth who are experiencing FEP are often frightened and confused, and struggle to understand what is happening to them. They also present unique challenges to family members and clinical providers, including irrational behavior, aggression against self or others, difficulties communicating and relating, and conflicts with authority figures. Impaired awareness of illness may be an additional complicating factor. Despite these complexities, early intervention with evidence-based therapies offers real hope for clinical and functional recovery. Both meta-analytic and narrative reviews of randomized and quasi-experimental treatment studies conclude that early intervention services for psychosis can improve symptoms and restore adaptive functioning in a manner superior to standard care (Bird et al., 2010; Penn et al., 2005).

3. Evidence Supporting Early Intervention

An abundance of data accumulated over the past two decades supports the value of early intervention following the first episode of psychosis. Clinical research conducted world-wide supports a variety of interventions for ameliorating psychotic symptoms and promoting functional recovery in FEP, including low doses of atypical antipsychotic medications (Robinson et al., 2005; Sanger et al., 1999); cognitive and behavioral psychotherapy (Jackson et al., 2005; Lecomte et al., 2009; Lewis et al., 2005; Wang et al., 2003); family education and support (Goldstein et al., 1978; Leavey et al., 2004; Zhang et al., 1994); and

educational and vocational rehabilitation (Killackey et al., 2008; Nuechterlein et al., 2008; Nuechterlein et al., 2013). These evidence-based components often come together in specialized early intervention programs that emphasize prompt detection of psychosis, acute care during or following periods of crisis, and recovery-oriented services offered over a 2-3 year period following psychosis onset. Recent studies emphasize continuity of specialized care for up to five years post-psychosis onset in order to consolidate gains achieved through initial treatment (Norman et al., 2011). Randomized controlled trials (Craig et al, 2004; Petersen et al., 2005), historical control investigations (Fowler et al., 2009; McGorry et al., 1996; Mihalopoulos et al., 2009), and naturalistic effectiveness studies (Uzenoff et al., 2012) indicate that coordinated specialized services offered during or shortly after FEP are effective for improving clinical and functional outcomes among youth and young adults at risk for serious mental illness.

In 2009, NIMH launched the *Recovery After an Initial Schizophrenia Episode (RAISE)* research initiative to explore methods for establishing coordinated specialty care programs for FEP in the United States. Two research investigations–the RAISE Early Treatment Program and the RAISE Connection Program–were funded to develop, test, and implement coordinated specialty care programs in non-academic treatment settings. Initial results from the RAISE projects suggest that mental health providers across multiple disciplines can learn the principles of coordinated specialty care for FEP, and apply these skills to engage and treat persons in the early stages of psychotic illness. These early findings, combined with the already reviewed evidence supporting early intervention in psychosis, are so compelling that the question to ask is not whether early intervention works for FEP, but how specialty care programs can be implemented in community settings throughout the United States.

4. Coordinated Specialty Care

Coordinated Specialty Care (CSC) is a team-based, multi-element approach to treating FEP that has been broadly implemented in Australia, the United Kingdom, Scandinavia, and Canada. Component interventions include assertive case management, individual or group psychotherapy, supported employment and education services, family education and support, and low doses of select antipsychotic agents. In clinical trials, CSC has been restricted to persons with non-organic, non-affective psychotic disorders who have been ill for five years or less; empirical evidence regarding the effectiveness of CSC is greatest for persons who meet these criteria. CSC is intended primarily for youth, adolescents, and young adults ages 15-25, although some programs extend eligibility to age 30. Early intervention programs are designed to bridge existing services for these groups and eliminate gaps between child, adolescent, and adult mental health programs.

At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. CSC emphasizes shared decision making as a means for addressing the unique needs, preferences, and recovery goals of individuals with FEP. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. CSC services are also highly coordinated with primary medical care, with a focus on optimizing a client's overall mental and physical health.

4.1 Team-Based Approach

In some regards, the CSC framework for FEP resembles the widely disseminated Assertive Community Treatment (ACT) model of community-based psychiatric care. Shared aspects include reliance on multi-disciplinary treatment teams, a small client to staff ratio, and a menu of services directed at supporting adaptive functioning in the community (e.g., case management, psychiatric treatment, housing and vocational assistance, substance abuse services, family education and support, and 24/7 accessibility). There are important differences between ACT and CSC models, however, including the clients served and the goals of treatment. In contrast to ACT, CSC teams serve a younger population without established disability, have the capacity for out-of-office visits but do not require them as the modal practice, and set expectations for a time-limited treatment experience of 2-3 years. If treatment is required beyond 3 years, most clients can step down to a lower level of specialized care, with eventual transition to regular services at the mental health center.

CSC is typically delivered by 4-6 clinicians who are trained in the principles of phase-specific care for FEP and maintain a shared caseload of 30-35 clients; providers' individual caseloads vary depending on how the CSC program is organized, as explained in Section 5, *Configuring and Staffing CSC Programs*. Allied health professionals—i.e., psychologists, social workers, mental health counselors, and rehabilitation counselors— generally provide case management, individual and family therapy, and supportive employment and education services; psychiatrists and nurse practitioners are primarily responsible for pharmacotherapy and coordination with primary healthcare. Weekly team meetings and frequent communication among team members bolsters fidelity to the early intervention model, focuses treatment on each client's recovery goals and needs, and builds interdisciplinary team morale that sustains high-quality service provision over time.

A developing program should consider including individuals with lived experience of psychosis as team members, particularly peers who can help ensure the "youth friendliness" of the CSC program (Stavely et al., 2013). Recent studies illustrate that persons with lived experience can effectively deliver CSC interventions such as supported employment services, and add unique value to recovery-oriented programs (Kern et al., 2013). Any of the key functions described below can be filled by persons with lived experience, provided that the individual meets credentialing and/or licensing requirements associated with the CSC role and has successfully completed training in all aspects of phase-specific care for FEP.

Although an individual with FEP may work with multiple members of the CSC team, one provider is always identified as the client's principal care manager. This person is responsible for coordinating all aspects of the client's care, and serves as the client's link to the rest of the treatment team, as well as outside social service agencies and emergency treatment facilities.

4.2 Key Roles on CSC Teams

Successful implementation of CSC depends more on assuring adequate coverage of key roles rather than achieving 1:1 correspondence between the number of providers and CSC service components. Table 1 summarizes critical roles and clinical services provided in CSC programs. Essential functions include (1) overall team leadership and management and (2) competent delivery of core clinical services, including case management, psychotherapy, supported employment and education, family education and support, and pharmacotherapy/primary care coordination. The number of providers necessary to fill key roles may vary from site to site depending on the size of the FEP cohort served, the number of providers available, and the level of effort each provider devotes to the CSC program. In programs with smaller caseloads, key roles may be combined so long as the provider has achieved competency in each assigned CSC function. For example, the Team Leader may deliver clinical interventions such as primary care management or family education and support while also providing overall administrative and supervisory oversight to the team. Alternately, the roles of individual psychotherapist and care manager might be combined. The only exception to this practice is the supported employment/education role, which involves highly specialized skills and the majority of work time spent in the community assisting job seekers with locating employment. Section 5, *Configuring and Staffing CSC Programs,* provides several examples of staffing models and role configurations implemented in the RAISE Early Treatment and Connection Programs.

Table 1. Key CSC Roles and Clinical Services.

CSC Role	Description	Rationale
Team Leadership	The CSC Team Leader is an experienced clinician with a clear commitment to recovery-oriented care and strong communication, management, and program development skills. The Leader provides ongoing consultation to team members regarding the principles of early psychosis intervention and coordinates key services such as screening potential clients for admission into the program, leading weekly team meetings, overseeing treatment planning and case review conferences, and cultivating referral pathways to and from the CSC program.	**Building and sustaining an effective mental health team requires committed leadership that provides clarity of purpose, a shared vision, coordination of services, and frequent review of team operations to maintain high quality care.** Strong leadership results in greater collaboration and coordination within multidisciplinary teams; solid teamwork translates into improved patient care and superior clinical outcomes for persons with first episode psychosis.
Case Management	Case management assists clients with problem solving, offering solutions to address practical problems, and coordinating social services across multiple areas of need. Case management involves frequent in-person contact between the clinician and the young person and their family, with sessions occurring in clinic, community, and home settings, as required.	**Successful treatment of individuals with FEP often requires a high degree of coordinated care which is effectively delivered using a case management model.** Individuals who experience FEP frequently need assistance with practical problems such as obtaining medical care, managing money, securing transportation, navigating the criminal justice system, and procuring stable housing.

Supported Employment and Education (SEE)	SEE services facilitate the recovering person's return to work or school, as well as attainment of expected vocational and educational milestones. SEE emphasizes rapid placement in the individual's desired work or school setting and provides active and sustained coaching and support to ensure the individual's success. The SEE Specialist strives to integrate vocational and mental health services, is the CSC team liaison with outside educators and employers, and frequently works with the client in the community to enhance school or job performance.	**For younger clients, the experience of FEP can disrupt school attendance and academic performance. For young adults, FEP can impede attempts to obtain or maintain employment.** Young clients with FEP are often in school or are establishing their initial work career. Resumption of normal educational or vocational activity is a common goal for clients and family members. SEE services are highly valued by many clients, and often provide a motivation for adhering to other aspects of the CSC program.
Psychotherapy	Psychotherapy for FEP is based upon cognitive and behavioral treatment principles and emphasizes resilience training, illness and wellness management, and general coping skills. Treatment consists of core and supplemental modules and is tailored to each client's needs. Clients and psychotherapists work one-on-one or in groups, meeting weekly or bi-weekly, with the duration and frequency of sessions personalized for each individual.	**Psychological interventions are essential for symptomatic and functional recovery, and may aide in the prevention of comorbidities, such as nicotine addiction and substance abuse.** The experience of FEP disrupts the person's sense of wellness and often derails confidence and pursuit of pre-illness life goals. Psychotherapy—individual or group—aims to restore the person's feelings of personal wellness, reinforce coping and resilience, and lessen the likelihood of subsequent psychotic episodes and prevent or treat co-morbidities.
Family Education and Support	Family education and support teaches relatives or other individuals providing support about psychosis and its treatment and strengthens their capacity to aide in the client's recovery. To the greatest extent possible, and consistent with the client's preferences, supportive individuals are included in all phases of treatment planning and decision making. For individuals less than 18 years of age, participation of a family or guardian is generally required. Depending on the number of clients served at any given time, family therapy may be offered on an individual basis, or through multi-family workshops and support groups.	**A first episode of psychosis can have a devastating impact on the ill person's relatives and other support persons, who struggle to adjust to changed circumstances and new demands.** Education about psychosis and its treatment is recommended for all families during the initial phase of FEP care. Increasing relatives' understanding of psychotic symptoms, treatment options, and the likelihood of recovery can lessen family members' distress and feelings of helplessness. In addition, an alliance between the CSC team and family members often helps to maintain contact with the client in the event that psychotic symptoms reoccur.
Pharmacotherapy and Primary Care Coordination	Evidence-based pharmacologic approaches guide medication selection and dosing for persons with FEP. Pharmacotherapy typically begins with a low dose of a single antipsychotic medication and involves monitoring for psychopathology, side effects, and attitudes towards medication at every visit. Special emphasis should be given to cardiometabolic risk factors such as smoking, weight gain, hypertension, dyslipidemia, and pre-diabetes. Prescribers maintain close contact with primary care providers to assure optimal medical treatment for risk factors related to cardiovascular disease and diabetes.	**Guideline-based use of medication optimizes the speed and extent of recovery, as well as acceptance of pharmacologic interventions.** The medical care of young people during the early stages of mental illness is considerably different in style and content compared to approaches used in older individuals with established illness.

Licensed clinicians—i.e., psychologists, social workers, mental health counselors, and rehabilitation counselors—typically possess the education and training required for the CSC team leader, case manager, psychotherapist, and family therapist roles. Supported employment and education specialists should be selected on the basis of (1) an undergraduate degree in mental health, social services, or business; (2) experience working with people with serious mental illnesses; and (3) experience providing employment services within the Individual Placement and Support (IPS) model (Drake et al., 2012). Licensed physicians and nurses are required to fill CSC medical roles.

4.3 Core Functions of Coordinated Specialty Care

In addition to the clinical services noted above, CSC provides six critical functions for young people experiencing a first episode of psychosis: (1) access to clinical providers with specialized training in FEP care; (2) easy entrée to the FEP specialty program through active outreach and engagement; (3) provision of services in home, community, and clinic settings, as needed; (4) acute care during or following a psychiatric crisis; (5) transition to step-down services with the CSC team or discharge to regular care after 2-3 years, depending on the client's level of symptomatic and functional recovery; and (6) assurance of program quality through continuous monitoring of treatment fidelity.

Specialized Training in FEP Care

Training in evidence-based treatment for FEP occurs at two levels: (1) the overall philosophy of team-based care for FEP, and (2) specialized services that support the client's recovery. Each team member must master the overall theoretical framework of CSC treatment, including the recovery potential for FEP persons, developmental issues specific to adolescents and young adults experiencing a first episode of psychosis, the concepts of shared decision making and person-centered care, and the importance of maintaining an optimistic therapeutic perspective at all times. In addition, CSC staff members must understand common problems that cut across all service categories, such as difficulties in engaging the client and their family members, clients' vulnerability for developing substance use problems, and heightened risk of suicide during the early years of treatment.

Both the RAISE Early Treatment Program and the RAISE Connection Program have developed training materials that (1) present the rationale for early intervention in first episode psychosis; (2) introduce the principles of team-based coordinated specialty care; (3) orient providers to the key roles and clinical services provided in the CSC program; and (4) detail core competencies related to specific treatment modalities. These materials—manuals, instructional videos, educational handouts, and worksheets—are listed in Section 8, *CSC Program Development Resources,* and are available on-line.

In order to enhance fidelity to the CSC model, workforce development also involves ongoing supervision and continuing education for all staff involved in the treatment program. Supervision may occur at multiple levels, including in-person sessions with the CSC Team Leader for case managers and supported employment specialists, or consultation with FEP subject matter experts via conference calls, webinars, or distance learning programs for medical professionals, psychotherapists, and family therapists. Case review during weekly team meetings is also an effective means for reinforcing CSC

treatment principles and ensuring competent FEP clinical care. Soliciting input from current and former clients is an excellent method to ensure the "youth friendliness" of the CSC program and increase its relevance to young people recovering from FEP (Stavely et al., 2013).

Community Outreach

Early intervention programs aim to reduce the duration of untreated psychosis by improving early detection of FEP in the community and facilitating rapid access to CSC services. As was the case in the two RAISE studies, a single provider must be responsible for community outreach, with a charge to remove barriers to CSC access and to speed entrée to FEP services. The outreach specialist is given dedicated time to develop referral pathways with inpatient facilities, emergency departments, crisis intervention services, and the criminal justice system, cultivating relationships with admission and discharge personnel at these agencies through frequent visits, phone calls, email communication and timely evaluation of potential FEP cases. The outreach specialist also communicates regularly with administrators of child and youth mental health programs to identify clients in those systems who might benefit from CSC treatment. Similarly, the outreach specialist monitors referrals and intakes to the parent agency, facilitating connection of likely candidates to the CSC program.

For programs newly established under the fiscal year (FY) 2014 budgetary set-aside funds, it is recommended that CSC staff emulate the strategy of engaging proximal referral sources first, as noted above, and to defer outreach to other potential referrers—e.g., schools, primary care physicians, and social services agencies—until the CSC program is firmly established.

Client and Family Engagement

Persons experiencing FEP, and their family members, are often difficult to engage in treatment, requiring a thoughtful approach to presenting the CSC program from the moment of initial contact. Assertive outreach, efficient enrollment, and hopeful messages are critical at the time of intake. Descriptive materials should be free of stigmatizing and clinical language, and emphasize the program's focus on helping individuals address and accomplish their own goals. Examples of descriptive brochures and flyers developed in the RAISE Connection Program for prospective clients and their family members can be found in Section 8, *CSC Program Development Resources*.

First contacts with clients and family members should be supportive and reassuring, with emphasis placed on learning about how the individual experiences symptoms, how such experiences impact their daily lives, and how changes related to FEP have affected family members or other significant others. The CSC team uses this information as a starting point for describing the CSC program, emphasizing specific services that may be most helpful to the individual and family members. Initial ambivalence is common among clients and relatives, so effective engagement requires ongoing education and support and a willingness on the part of providers to negotiate changes in treatment goals and strategies. Engagement is also facilitated by establishing a "youth friendly" atmosphere in the clinic setting and instilling such a mindset among providers. Such efforts will require locating the CSC program in a space distinct from the larger clinic, ideally with a separate entrance and waiting room. Receptionists and

office personnel—who may be accustomed to serving adults with long-standing psychotic disorders—may require additional training on the recovery model and needs of transition age youth with FEP.

The CSC care manager should contact the referred individual as soon as possible, ideally within 24 hours, to describe the CSC service and screen for program eligibility. Offering appointments on evenings and/or weekends is essential to meet the needs of youth and family members with school or work commitments, and allows for more rapid evaluation. If referred individuals are in the hospital, 'in reach' to the inpatient unit is optimal. The CSC care manager should gather information relevant to establishing eligibility including age, time since onset of psychosis, previous treatment, response to treatment, degree of established disability, and history of medical problems, substance use, and affective symptoms. Consistent with the overall program orientation, the process of gathering information should be supportive, person-centered, and youth friendly. Individuals meeting eligibility criteria should be offered an admission interview with the CSC team quickly, ideally within seven days of the screening interview.

Individuals ineligible for the CSC program (e.g., who do not meet FEP diagnostic criteria, or who have been ill for more than 5 years) should be referred to other mental health services. For those admitted to CSC, collaborative treatment planning (Heinssen et al., 1995) and shared decision-making (Deegan and Drake, 2006) regarding medical, psychological, and rehabilitative interventions will serve to build mutual respect between clients with FEP and providers, and enhance ongoing cooperation. Personalized, recovery-oriented goals that focus on normal developmental milestones (e.g., returning to school or work, re-engaging with peers) are most likely to sustain motivation for treatment beyond the initial phase of care.

Mobile Outreach and Crisis Intervention Services

Mobile outreach is provided to young people who have difficulty engaging with clinic-based services, or those who have complex needs requiring intensive support, such as legal issues, homelessness, or obtaining medical care for comorbid physical conditions. The CSC team employs a multi-disciplinary approach to mobile case management, with supportive interventions occurring in clinic, community, and home settings as required. For example, case managers may escort clients to appointments in the community, and facilitate engagement with needed social services. Likewise, supported employment and education specialists provide active coaching and support school and work settings. Similarly, family clinicians may offer support in the FEP client's home, including practical assistance to clients and relatives during periods of turmoil or instability.

The RAISE Connection Program found that 24-hour telephone coverage was sufficient for managing most crisis situations and, in many instances, averted the need for acute services such as emergency department visits or inpatient hospitalization. In instances where an emergency could not be managed remotely, the on-call person facilitated rapid and effective use of crisis services available outside the CSC program. In the event of hospitalization, the on-call person alerted the client's primary care manager, who contacted the inpatient team to coordinate discharge planning and transfer back to the CSC program for follow-up care.

Transition of Care

CSC treatment programs in the RAISE initiative did not mandate a specific intensity or duration of services, but developed treatment plans based on the individual client's specific needs, goals, and pace of recovery. CSC programs developed abroad often offer services for no more than 24 months, but evidence suggests that abrupt transfer to usual care after two years compromises the immediate benefits of early intervention (Bertelsen et al., 2008; Gafoor et al., 2010). These data have been cited as evidence that the short-term benefits of early psychosis intervention do not automatically translate into longer term gains (Bosanac et al., 2010), and argue for continuity of care for up to five years after psychosis begins. A recent Canadian study supports the notion of continuity of care, with reported maintenance of early treatment gains at five-year follow-up for clients who transitioned to a lower intensity of specialized intervention after two years (Norman et al., 2011). This step down in care involved ongoing connection with one member of the CSC team (e.g., case manager or psychiatrist) for an additional 1-3 years, with eventual transition to regular services at the mental health center.

Determining when a client is ready for transition to a less intensive level of care should be a collaborative process involving the client, their relatives and important others, and members of the CSC team. Together, there should be an assessment of the client's progress in achieving treatment goals in key domains (e.g., school and work functioning, quality of peer and family relationships, relief from symptoms, abstinence from substances, effective management of health issues) and identification of areas that require additional work. An important consideration in planning the transition from CSC is the client's personal vision of stability, success in community functioning, and personal autonomy. Focusing on these issues enable the CSC team to work effectively with the client to achieve an optimal balance between professionally delivered treatment, therapeutic activities and supports available in the community, and self-directed recovery goals. Transition planning guides and worksheets can be found in the supplemental resource list found in Section 8, *CSC Program Development Resources.*

Assuring Fidelity to the Early Intervention Treatment Model

Fidelity and outcome measures allow program planners and administrators to answer key questions around CSC program implementation such as:

1. Are CSC team members implementing interventions as intended?
2. Are providers delivering what was promised in the service contract?
3. Have CSC services achieved desired clinical and functional outcomes for clients with FEP?

Fidelity monitoring also addresses the needs of clients and family members who seek assurance that services offered are of satisfactory quality, and will lead to desired school, work, social, and health outcomes.

Efficiency calls for a very practical approach to fidelity monitoring, with measures drawn from information readily available from routine clinical operations. The best fidelity measures are those that are acceptable proxies for key components of CSC. For example, a core expectation of FEP specialty care is that antipsychotic medications are a central part of treatment for almost everyone, with careful

monitoring for effectiveness, side effects, and metabolic changes over time. Medication records and associated laboratory orders provide information necessary to assess the quality of psychopharmacology interventions, including medication type and dose, and whether metabolic parameters were assessed. The fidelity of a CSC clinic to pharmacotherapy guidelines (e.g., Buchanan et al., 2010) can be assessed by computing the proportion of clients (1) who were prescribed a recommended antipsychotic medication; (2) who had at least one trial of a recommended medication, within the recommended dosage range, for at least four continuous weeks; and (3) who received the recommended metabolic monitoring. The RAISE Early Treatment Program has developed a decision support system for prescribers which can enhance the implementation of evidence-based pharmacotherapy, while also providing a seamless framework to monitor quality and fidelity of medical interventions. Information about this medication decision support system can be found in Section 8, *CSC Program Development Resources*.

Many clinics or hospitals with CSC teams will document service contacts and clinical data via an electronic health record (EHR), allowing fidelity and outcome information to be obtained from electronic claims data or other automated reports. In the absence of an EHR, routine service logs may be used to inform many fidelity measures so long as they note the client and staff member involved, whether family members were present, and the location of the service (i.e., office versus community). When abstraction from electronic claims data is not an option, implementing a chart abstraction system is a feasible approach. Finally, the Supported Employment Fidelity Scale, part of SAMHSA's Supported Employment toolkit (SAMHSA, 2009), provides a means for measuring the quality and impact of supported employment services. Illustration of how key CSC components–i.e., team structure and functioning, psychopharmacology, individual psychotherapy, family intervention, supported employment/education–were operationalized in the RAISE Connection Program, with benchmarks that indicate fidelity to the CSC intervention model can be found in Section 8, *CSC Program Development Resources.*

5. Configuring and Staffing CSC Programs

In collaboration with the New York State Office of Mental Health, RAISE researchers have developed a publicly available decision support tool to determine the number of CSC teams needed to provide services in a given region, as well as the approximate cost of providing services (Humensky et al., 2013). The tool accounts for several variables, such as estimated incidence of FEP for a given catchment area, the percentage of eligible individuals who will actually enroll in the program, and the average duration of time an individual with FEP will receive services. The tool can help states select the CSC program configurations that best match local circumstances.

CSC team members should be selected on the basis of credentials, clinical experience, affinity for recovery oriented care, and respect for clients' independence and self-determination. Seasoned clinicians are the preferred candidates for CSC roles, with emphasis on those clinicians who embrace the challenges of working with adolescents and young adults experiencing psychosis, are flexible regarding intervention approaches to engage clients and family members, and can tolerate uncertainty regarding

clients' preferred recovery strategies. Peers and those with lived experience have also been shown to be important resources for these programs given their ability to engage and support young people struggling with a psychotic disorder (Stavely et al., 2013).

In staffing the programs, agency administrators may select the majority of CSC team members from existing personnel and fill gaps in expertise by hiring professionals with needed skills. Alternatively, a clinic may opt to hire additional staff for this new service. Personnel selected would then be formed into integrated teams to serve the FEP population through (1) extended training in the principles of team-based, stage-specific care for early psychosis and (2) protected time for fulfilling the key CSC roles and core functions described in Sections 4.2 and 4.3 of this document.

The case studies that follow illustrate variations in how the CSC model has been implemented in the two NIMH RAISE investigations. In each instance the CSC team was embedded within the parent health care organization to capitalize on synergies with existing clinical programs and administrative resources. While CSC team members' primary clinical responsibilities were for FEP clients, certain clinicians may have fulfilled other roles within the agency, and provided services to both FEP and non-FEP clients. This arrangement provided the parent agency with maximum flexibility for allocating clinical resources to multiple areas of need. The examples below reflect acceptable models for how new programs might implement the CSC model.

5.1 RAISE Connection Program

The RAISE Connection Program created CSC programs in New York City, New York and Baltimore, Maryland; each team consisted of four staff members (2.7 full-time equivalent [FTE] employees) for a target caseload of 25 clients. A licensed clinician served as full-time team leader. The team leader provided administrative oversight of the program and supervised other team members to assure fidelity to the CSC model. The team leader also served as the primary care manager for most clients. A full-time supported employment/education specialist provided services based on the IPS model. A half-time recovery coach provided individual and group cognitive and behavioral psychotherapy interventions for clients with FEP and psychoeducation sessions for clients' family members. Finally, the total FTE for the program psychiatrist was 0.2. It was helpful if the psychiatrist was otherwise employed in the agency so that he/she would be available in the case of a crisis. Of note, the team members were not responsible for conducting evaluations for program eligibility; this was done by a separate outreach and enrollment specialist who worked with the team.

In June 2013 the New York State Office of Mental Health announced *OnTrackNY*, an initiative designed to implement CSC programs in the downstate region. For this project, the RAISE Connection program model was modified to increase flexibility and to allow for staff time to do CSC outreach and evaluations for eligibility. In the *OnTrackNY* approach, CSC teams serve between 30 and 35 clients and require two FTE licensed staff members who cover four roles: team leader; recovery coach; primary care manager; and outreach and recruitment coordinator. The team leader must be full-time. The other clinician FTE can be a full-time staff member or divided among two part-time staff. Additional staff members include

a full-time supported employment/education specialist, a psychiatrist who is 0.3 FTE, and a 0.2 FTE nurse who assists with medication and health related issues.

In this approach to CSC, individual providers assume more than one role on the treatment team. In practice, each clinician serves as primary care manager for a group of patients and then assumes at least one other clinical responsibility in the program. This creates optimal flexibility and allows for staff members with appropriate training to assume various roles as needed. The team leader oversees role and client assignment. Depending on the preferences of the team and staff backgrounds, several permutations of the *OnTrackNY* model will work.

Example 1: The team leader is full-time and the other two clinician staff members are half-time. In addition to serving as team leader, the team leader could be in charge of outreach and recruitment and have a small caseload. One of the half-time staff members could serve as recovery coach and primary clinician. The third half-time staff member could serve as primary care manager only.

Example 2: Both the team leader and second clinician are full-time. The team leader serves as primary care manager as well as team leader with a larger caseload. The second clinician could serve as recovery coach and do outreach and recruitment with a smaller caseload.

5.2 RAISE Early Treatment Program

The RAISE Early Treatment Program established CSC programs in 17 community clinics located in urban, suburban, and rural settings across the United States. The embedded team model worked well in a variety of agency contexts, as illustrated in the following examples.

Example 3 (urban setting): One CSC program was developed in a mental health center that served a small urban area. With a catchment area covering ~160,000 individuals, agency administrators anticipated an FEP caseload of 25-30 clients. An existing team-based treatment program for outpatients at high risk for hospitalization (HRH) was leveraged in order to form a team of CSC providers. A subset of six HRH team members were selected for the roles of CSC team leader (0.3 FTE), family therapist (0.25 FTE), supported employment/education specialist (0.5 FTE) and psychiatrist (0.2 FTE). Two additional clinicians (0.5 FTE each) filled the role of psychotherapist/case manager. While the primary function of the CSC subgroup was to care for FEP clients, team members also provided services in the HRH program. Each provider's HRH caseload was adjusted downward based on the number of CSC clients enrolled in the program.

Example 4 (suburban setting): One CSC program was formed within a suburban mental health center that anticipated a caseload of 20-25 clients with FEP. Four agency personnel were selected for new clinical positions on the FEP treatment team. The CSC team leader and family therapist roles were combined into a single full-time position. Likewise, psychotherapist and case manager roles were performed by one full-time provider. The psychiatrist and supported education/employment specialist were full-time employees of the mental health center, but devoted 0.2 FTE and 0.5 FTE level of effort to the CSC program, respectively. The psychiatrist and supported employment specialist worked with all CSC

participants, but also served clients from other agency programs. The non-CSC caseloads of the employment specialist and the psychiatrist were reduced to accommodate the needs of clients in the FEP treatment program.

Example 5 (rural setting): One CSC program was developed in a rural mental health center that had no prior experience with team-based care. With a sparsely populated catchment area, program planners predicted an FEP caseload of 12-15 clients. Agency administrators selected five clinicians from four separate departments to create a cross-agency CSC team consisting of a team leader/family therapist (0.3 FTE), a case manager (0.2 FTE), a psychotherapist (0.25 FTE), a supported employment/education specialist (0.25 FTE), and a medication prescriber (0.1 FTE). As in the previous examples, all team members maintained separate caseloads outside of the CSC team, with non-CSC caseloads adjusted downward based on the number of FEP clients. The challenge of this model is the degree of coordination required between the CSC team leader and departmental chiefs to meet the staffing needs of the respective clinical programs.

6. Financing Services

Table 2 lists the key elements of CSC, along with information on whether/how each element is typically covered under fee-for-service insurance. We note that our focus here is on some vs. no coverage, i.e., we do not consider the amount of reimbursement for services if they are covered; nor do we consider possible benefit limits, except as noted. The effects of the latter may be partially mitigated by the Mental Health Parity and Addiction Equity Act of 2008.

Table 2. Coverage of CSC Components under Public and Private Fee-for-Service Programs

CSC Role	Services	Coverage Status
Team Leadership	Cultivate referral networks; facilitate access to care; outreach to patients and family members; coordinate clinical services among team members; provide ongoing clinician supervision	Not covered
Psychotherapy	Provide individual and group psychotherapy sessions, including integrated substance abuse sessions when needed	Billable via CPT 90832; 90834; 90853
Case Management	Perform assertive case management functions in clinic and community settings	Inconsistently covered*
Family Education and Support	Provide psychoeducation, relapse prevention counseling, and crisis intervention services	Billable via CPT 90846; 90847; 90849
Supported Employment/ Education	Implement IPS model of supported employment and supported education; provide ongoing client support following job or school placement	Inconsistently covered*
Pharmacotherapy and Primary Care Coordination	Medication management; coordination with primary medical care	Billable via CPT 99214

CSC Team-Level Activity	Team meetings, coordination of services among team members, CSC training, clinical supervision, 24-hour phone coverage for managing crisis situations	Not covered

*if covered, coverage is almost only provided by Medicaid

As illustrated in Table 2, Current Procedural Terminology (CPT) codes exist for some of the major components of CSC for FEP. The availability of CPT codes generally indicates that providers can bill the service under public insurance, particularly Medicaid, as well as under private insurance. CSC services with corresponding CPT codes include individual and group psychotherapy, family therapy, and medication management. Pharmacotherapy, particularly the antipsychotic medications themselves, is also generally covered under private and public health insurance.

In terms of the CSC components that involve direct provision of care, the principal exceptions to current coverage are supported employment/education and assertive case management services. Supported employment/education services have no corresponding CPT code. While private insurance seldom covers supported employment, some states' public health insurance provides some coverage via separate programs (Latimer et al., 2004). Medicaid programs—but not private insurance—typically cover some case management services for persons with serious and persistent mental illness. However, in many states, eligibility for such coverage is limited to individuals with established illness and disability; by definition, individuals with FEP typically do not meet such chronicity criteria, and may therefore be ineligible for coverage of case management services.

In general, neither public nor private insurance programs cover most CSC team leadership and team-level activities listed in Table 2 that are essential for: (1) assertive outreach to referral networks; (2) facilitating patients' access to FEP care; (3) engaging and retaining patients in treatment; (4) coordinating services in team meetings; (5) clinical supervision; or (6) assuring the quality of services through fidelity monitoring. The absence of specific coverage for these activities is a barrier to providing them; evidence gathered from the RAISE Early Treatment Program suggests that this coverage gap limits the ability to provide effective, coordinated treatment for FEP in many community clinics, and that the gap in coverage may undermine the effectiveness of treatment components that are currently covered.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) within the U.S. Department of Health and Human Services recently examined a range of policy questions related to early intervention in mental disorders. This included a report (Goldman et al., 2012) and associated journal article (Goldman et al., 2013) that focused on understanding the financing of CSC for FEP in the context of the RAISE Early Treatment Program. The investigators visited several community clinics participating in the Early Treatment Program and described how the respective sites addressed issues of financing various CSC components. As the reports describe, strategies included implicit cost-shifting from CSC program participants with relatively comprehensive coverage to those with limited or no insurance; capitated payment arrangements that were sufficient to cover otherwise non-covered components of CSC for FEP; and non-patient-specific funding from state mental health authorities that individual sites applied to CSC for FEP. Further details are available in the cited reports.

The assessment of financing issues in the RAISE Early Treatment Program predated full implementation of the Patient Protection and Affordable Care Act of 2010 (ACA). The reports mention several aspects of the ACA that may help address some financing gaps. These include several ways in which the ACA is likely to increase the fraction of individuals experiencing FEP who have health insurance, which would reduce the extent to which a CSC for FEP program would need to find funding to serve individuals who lacked any insurance. The reports also describe several ways that the ACA would likely make it easier for states to cover CSC components like case management, supported employment/education, team-leadership, and team-level activities through section 1915(i) of the Social Security Act, the Home and Community-Based Services State Plan Option. Since relevant provisions of the ACA are being implemented at the time of this writing, the extent to which they may mitigate or even resolve some of the coverage gaps identified in this section is not known.

The coverage gaps identified here need to be addressed in order to achieve robust implementation of CSC for FEP. At minimum, states' mental health authorities should work with CSC programs to utilize the kind of funding mechanisms described in the ASPE reports to whatever extent is feasible and appropriate. "At minimum" is written because it is likely to strengthen CSC programs – and thus benefit individuals experiencing FEP – for there to be specific funding mechanism in place to cover all the components of CSC for FEP in a systematic and ongoing fashion. For the services listed in Table 2 with corresponding CPT codes, as well as for supported education and employment services, such funding could be implemented via fee-for-service or capitated payment mechanisms, as long as reimbursement levels adequately cover program costs and Summary Plan Descriptions are explicit about eligibility and coverage rules. For care management and the program support activities in Table 2 that do not involve direct provision of care, it may be more effective to finance these on a case-rate basis than via fee-for service, or also include them explicitly within the scope of a capitated payment mechanism.

7. How to Begin Planning Implementation of the FY2014 Set Aside

CSC programs associated with the RAISE initiative are currently operating in 20 states (CA, CO, FL, GA, IA, KS, LA, MD, MI, MN, MO, NE, NH, NJ, NY, NM, OH, OR, RI, and VT). Based on publically available information, at least 5 additional states with community programs for FEP that appear to be consistent with the CSC model have been identified (AZ, CT, MA, NC, and PA). States with existing CSC resources could use the FY2014 set aside funds to increase capacity for offering specialty care services, including (1) expanding the number of CSC programs throughout the state; (2) extending community outreach beyond emergency care settings for existing programs to include public education and developing new referral relationships with schools, primary care physicians, and child welfare agencies; and (3) instituting an in-state training and consultation program to broaden resident expertise in FEP care.

In states without CSC programs, FY 2014 set-aside funds should be used to develop initial capacity for FEP specialty care. Any state implementing a CSC program for the first time is encouraged to focus on starting a single program that adheres closely to the CSC principles described in this document. As a first step, the state could leverage existing clinical and administrative resources that might serve as a platform for developing an integrated CSC program for youth with FEP. For example, is there an agency with experience in offering team-based treatment, like ACT Teams? Are there clinicians with expertise in

adolescent and youth mental health? Are core CSC services, i.e., case management, individual or group psychotherapy, supported employment and education, family education and support, pharmacotherapy and primary care coordination, already available? The agency may deliver some or most of these services, but will need to fill gaps and tailor interventions to meet the needs of youth and young adults with FEP.

New hires, or creative partnerships between agencies, may be necessary to acquire needed expertise, such as clinicians with supported employment and supported education skills. In addition, organizational restructuring, staff training, and ongoing consultation with FEP experts may be necessary to repurpose existing services and providers into an integrated, team-based CSC treatment program. Administrative changes may be needed to facilitate the integrated delivery of services, like protecting staff members' time for team meetings and providing ongoing supervision to assure fidelity to CSC principles. Finally, a variety of community outreach activities are necessary to stimulate and maintain referral pathways to the CSC program. One CSC team member must be designated as responsible for cultivating and maintaining these contacts, with protected time for outreach functions.

8. CSC Program Development Resources

A variety of CSC program development and training materials—manuals, videos, educational handouts, and worksheets—are available to assist states' efforts to initiate or expand CSC services for youth and young adults with FEP. Resources developed under the RAISE initiative are listed below, with hyperlinks. Other training resources will be developed over time via the SAMHSA MHBG Technical Assistance Center, such as distance learning for continuing education, webinars for group supervision, consultation time with FEP subject matter experts, etc.

A. RAISE Coordinated Specialty Care for First Episode Psychosis Manuals:

1. Coordinated Specialty Care for First Episode Psychosis Manual I: Outreach and Recruitment
   - Summarizes key concepts, principles and processes involved in community outreach and developing and maintaining referral networks
   - Includes examples of person-centered language to use when presenting the program
   - Includes sample brochures, contact forms and screening packets
   - Provides an overview of how to establish outreach and referral tracking systems
   - Offers sample emails and articles to use when informing others about the CSC program
2. Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation
   - This manual provides a concise overview of administrative, training and supervision activities needed to start a first episode psychosis treatment program.
   - Resources provided include a 'Getting Started' Checklist, example program inclusion/exclusion criteria, and sample job descriptions for team hires
   - Provides training materials, including vignettes for team training, scripts for training role plays, and slides to use for team training
   - Includes resources for maintaining program fidelity

B. RAISE Connection Program Manuals and Resources:

1. *Voices of Recovery Videos Series*
   - A series of 24 vignettes of consumer and family members, the videos share inspirational and informative recovery stories focusing on a variety of topics.
   - A manual is available to help integrate the videos into treatment and training.

2. Performance, Quality, and Fidelity Indicators
   - Overview Table summarizes quality and fidelity indicators and overall measurement approach used for the RAISE Connection Program study.
   - Available in the *Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation*

C. RAISE Early Treatment Program Manuals and Program Resources:

1. CSC (Navigate) Team Members Guide
   - Gives an overview of the CSC-Navigate Program and describes how it works
   - Provides information that all team members need to know, including background on schizophrenia and the special needs of persons with FEP
   - Covers logistics of staffing
   - Should be read by all CSC-Navigate team members

2. CSC (Navigate) Team Leader Manual
   - Details the CSC-Navigate Team Leader's role and responsibilities
   - Includes chapters on logistics; outreach; developing referrals; forming, leading and supervising the team; engaging the client and family members; and more
   - Includes worksheets and checklists
   - Should be read by Team Leaders

3. Individual Psychotherapy (Resiliency Training) Manual
   - Details how to provide Individual Resiliency Training (IRT) which is aimed at helping clients set and work towards personal goals, enhancing wellness and personal resiliency, teaching about psychosis and treatment, and improving illness management
   - Includes client handouts
   - May be used in conjunction with IRT videos
   - Should be read by IRT Clinicians

4. Individual Psychotherapy (Resiliency Training) Demonstration Videos
   - Hosted by the developers of Individual Resiliency Training (IRT), the video set consists of 15 short training videos, most 5-13 minutes in length
   - Each training video demonstrates one of the IRT modules with a mock-client.
   - Intended to accompany the IRT Manual
   - Should be viewed by IRT Clinicians

5. CSC (Navigate) Family Intervention Manual
   - Details how to conduct the CSC-Navigate Family Intervention, which aims to help relatives support the recovery of a loved one who has experienced a first episode of psychosis.
   - Topics align with Individual Resilience Training
   - Contains educational handouts for family members
   - Should be read by Family Clinicians and Team Leaders
6. Supported Employment and Education Manual
   - Details how to provide Supported Employment and Education (SEE), which aims to help clients achieve their work and/or school goals.
   - Includes forms and worksheets
   - Should be read by SEE Specialists and Team Leaders
7. Psychopharmacological Treatment Manual
   - Details how to provide pharmacological treatment to clients with early phase psychosis within a shared decision making framework
   - Covered topics include recommended medications, management of side effects, enhancing adherence, and medical management of cardiovascular and metabolic abnormalities
   - Describes a medication decision support system to inform pharmacological treatment options
   - Includes tables of medication dose ranges and side effect profiles for early phase clients
   - Includes client and prescriber forms
   - Should be read by CSC-Navigate Prescribers (nurse practitioners or physicians)

D. Additional FEP Training Tools and Resources:

Resources, such as intervention manuals from other CSC programs and training materials (webinars, power point presentations, etc.) may be available through the RAISE initiative investigators and their collaborators. Some of these materials are available at no cost; others may have fees associated with their use.

1. *OnTrackNY* Manuals and Program Resources*:*

   The RAISE Connection Program clinical manuals were revised and adapted for use in the implementation of a statewide CSC program, '*OnTrackNY.'* These materials will be available for download at http://practiceinnovations.org/OnTrackUSA/tabid/253/Default.aspx.

   a. Outreach and Recruitment Manual
      - Represents an adaptation of the *Coordinated Specialty Care for First Episode Psychosis Manual I: Outreach and Recruitment,* and details how outreach and recruitment is being conducted in NY FEP program.
      - Includes forms for screening and evaluation, including those used to determine pathways to care and duration of untreated psychosis.

- Provides tools for tracking outreach/referral activities, template for resource lists for individuals not eligible for the program, and sample promotional materials using non-stigmatizing language.

b. Team Manual
   - Provides an overview of rationale and principles of FEP treatment.
   - Includes a series of shared decision making tools to be used in treatment.
   - Lists readings and resources relevant to the treatment of early psychosis.

c. Supported Employment/Education (SEE) Manual
   - Describes principles and activities for SEE specialist according to IPS model.
   - Includes examples of career profiles, plans for approaching employers and receiving assistance with school.
   - Resources include employer/school contact logs, job/education support plans and an SEE supervision log.
   - Lists readings and resources relevant to the treatment of early psychosis.

d. Primary Clinician Manual
   - Provides overview and description of primary clinician role including family support.
   - Includes an overview of the *OnTrackNY* treatment program and team functioning/roles.
   - Details core treatment sessions and themes.
   - Offers handouts to be used in treatment.
   - Includes forms for needs assessments, safety plans, wellness management and transition planning, as well as cognitive behavioral therapy treatment tools.
   - Includes materials relevant for the family intervention component of treatment.
   - Offers a list of readings and resources relevant to early psychosis treatment.

e. Recovery Coach Manual
   - Provides overview and description of recovery coach role including skills training, skills based substance abuse treatment and family psychoeducation.
   - Includes tools to be used in the treatment process.
   - Notes and checklists to track work and progress.
   - Includes monthly family psychoeducation group materials.

f. Psychopharmacology Manual
   - Provides evidence-based approach to prescribing and monitoring antipsychotic medications.
   - Includes an overview of core treatment sessions.
   - Provides a copy of the *OnTrackNY* Side Effects Checklist.
   - Lists readings and resources relevant to the treatment of early psychosis.

E. Performance, Quality, and Fidelity Materials:

1. *OnTrackNY* forms and indicators
   - Summarizes indicators selected by the *OnTrackNY* program to track outcomes and fidelity.
   - Provides an example of how an existing program is tracking 'real-time' outcomes through program implementation and existing resources.

F. Employment Resource Book:

- Provides tools and exercises to help individuals with FEP with obtaining employment

G. Interactive Early Psychosis Program Planning Tool:

- Estimates number of teams needed to serve a given population; a spreadsheet version of the tool can be made available for interested users.

Acknowledgements

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California's Early Psychosis opportunities & challenges

- <u>Strengths</u> = WIDE dissemination! 30 programs across 24 counties, serving diverse clients and families
- <u>Challenges</u> = No uniformity across state in implementation of EP services – treatment models differ county by county, and some counties do not have access
- No standard measurement of outcomes using valid and appropriate measures for EP populations
- Need to establish methods for implementing measurement-based care in community practice
- California EP programs are currently isolated from each other, and struggle to find training, resources or reduce staff turnover
- State and national initiatives are pushing for more collaboration and data sharing – and we need to respond.

AGENDA ITEM 3

Action
February 27, 2020 Commission Meeting
Awarding Stakeholder Contracts

Summary: The Mental Health Services Oversight and Accountability Commission will consider awarding six stakeholder contracts in the amount of $2,010,000 each to the highest scoring applicants in response to the Request for Proposals for mental health advocacy on behalf of Clients and Consumers, Diverse Racial and Ethnic Communities, Families of Clients and Consumers, LGBTQ Communities, Parents and Caregivers and Veterans, and authorizing the Executive Director to act in accordance with the Commission's decision.

At its November of 2019 meeting the Commission approved the scope of work and minimum qualifications for the RFP and authorized the Executive Director to initiate a competitive bid process to make one award available in each of the six stakeholder populations listed above for a total of approximately $12,060,000 for three years. The goal of this RFP is to ensure that individuals from each population have a voice in the development and implementation of local level mental health policies and programs, as well as access to quality services.

The RFPs were released on December 5, 2019. They were posted on Cal eProcure, the MHSOAC website, and were advertised through an email notification to the MHSOAC listserv.

Scope of Work
Proposers were asked to develop deliverables in response to the scope of work as outlined in the Request for Proposals in the following three priority areas:

- Advocacy
- Training and Education
- Outreach and Engagement

RFP Timeline

- December 5, 2019: RFP released to the public
- January 24, 2020: Deadline to submit proposals for Clients and Consumers, Families of Clients and Consumers and Veterans communities
- January 31, 2020: Deadline to submit proposals for Diverse Racial and Ethnic Communities, Parents and Caregivers and LGBTQ communities
- February 27, 2020: Results presented to the Commission

RFP Evaluation Process

The entire scoring process from receipt of proposals to posting of the Notice of Intent to Award is confidential. In accordance with the State of California standard competitive selection process, all proposals were evaluated in a multiple stage process.

- **Stage 1: Administrative Submission Review**
  Verify all required documents are included in the proposal. Pass/Fail evaluation.

- **Stage 2: Background Review**
  Verify responses provided to the requirements and evaluate the responses. Combination of Pass/Fail and scored requirements.

  The maximum points possible for this stage was 600 points.

- **Stage 3: Workplan Review**
  Evaluate the Local and State-level engagement plan, tasks and activities. Scored requirements

  The maximum points possible for this stage was 9,160 points.

- **Stage 4: References**
  Validate desirable qualifications. Scored requirements.

  The maximum points possible for this stage was 2,000 points.

Final selection is determined on the basis of the highest overall point score. The recommended awards are to be made to the proposers receiving the highest overall point score for each of the six stakeholder populations.

In the event that there are no compliant bidders for the RFP the Commission will have option to consider amending the RFP or closing the solicitation and re-issuing a new Request for Proposal.

RFP Award and Protest Process

Within five working days of the Commission's vote to award the contracts, unsuccessful proposers, wishing to protest the decision, must submit to the Commission an Intent to Protest letter. Within five working days after the Commission receives the Intent to Protest letter, the protesting proposer must submit a Letter of Protest detailing the grounds for protest. The Letter of Protest must describe the factors that support the protesting Proposer's claim that:

1. The protesting proposer would have been awarded the contract had the Commission correctly applied the prescribed evaluation rating standards in the RFP; or

2. The protesting proposer would have been awarded the contract had the Commission followed the evaluation and scoring methods in the RFP.

As outlined in the RFP, the MHSOAC Executive Director reviews the grounds for protest and renders a final decision.

Presenter:

- Tom Orrock, Chief of Stakeholder Engagement and Grants, MHSOAC

Enclosures: None

Handout: A Power Point presentation will be made available at the Commission meeting.

AGENDA ITEM 4

Action

February 27, 2020 Commission Meeting

El Dorado County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will consider approval of El Dorado County's Extension request to expend up to $2,158,704 in MHSA Innovation funds over an additional nine months in support of the Community Based Engagement and Support Services (aka HUBS) innovation project**.**

- **This innovation project from El Dorado County was removed from the Consent Calendar on January 23, 2020 due to stakeholder opposition (NAMI El Dorado County), requiring the County to come forward to present in front of the Commissioners.**

- **Subsequent to the Commission Meeting, an updated letter that revisits NAMI El Dorado County's opposition letter, dated August 12, 2019, now shows support for the continued funding of the HUBS project.**

This project was originally approved by the Commission on August 25, 2016 for up to $2,760,021 in innovation spending authority. The original project intended to promote interagency collaboration and partnered with County Public Health, the First 5 Commission and the County's Health and Human Services Agency by developing and placing five community hubs in local libraries within the County with the goal of increasing physical and mental health care access for families, pregnant women, and children from birth through 18 years of age.

The County is requesting an additional amount of $2,158.704 in innovation spending authority along with a nine-month time extension to address challenges the County experienced in relation to staffing, technology, and the analysis of data and reporting. To address these challenges, the County would like to incorporate additional personnel and upgrade the technological needs for project staff which would allow for continued learning in this project. The County wishes to address these barriers in order to adequately meet their original learning objectives.

Presenters for El Dorado County's Innovation Project:

- Jamie Samboceti, MFT, Deputy Director, El Dorado Behavioral Health
- Sabrina Owen, MFT, Mental Health Programs Manager, El Dorado Behavioral Health
- Ren Strong, MHSA Program Manager, El Dorado County Behavioral Health
- Heather Longo, Senior Analyst and MHSA Coordinator, El Dorado County Behavioral Health

Enclosures (5): (1) Biographies for El Dorado County's Innovation Presenters; (2) HUBS Staff Analysis; (3) HUBS Project Brief; (4) Letters of Support; (5) Letters of Opposition

Handout (1): PowerPoint will be presented at the meeting.

Additional Materials (1): A link to the County's Innovation Plan is available on the Commission website at the following URL:

https://mhsoac.ca.gov/news-events/events/commission-meeting-february-27-2020/el-dorado-inn-plan-feb-2020

Proposed Motion: The Commission approves El Dorado County's Innovation Project Extension, as follows:

Name:	**Community Based Engagement and Support Services (aka HUBS)**
Additional Amount:	**Up to $2,158,704 in MHSA Innovation funds for a total of $4,918,725**
Additional Project Length:	**Nine months for a total length of four years and nine months**

El Dorado County
Community-Based Engagement and Support Services ("Community Hubs")

Speaker Biographies

Jamie Samboceti is a licensed MFT and is the Behavioral Health Deputy Director for El Dorado County. Jamie has been licensed for 11 years and has worked in El Dorado County Mental Health during that time as a Clinician, Quality Assurance/Utilization Review Manager, and Deputy Director over all mental health and substance use disorder programs. Jamie additionally serves as a behavioral health representative on Marshall Hospital Strategic Plan, El Dorado County Office of Education Threat Assessment and Bellweather Projects, and Stepping Up and Pre-Trial Diversion initiatives in El Dorado County.

Sabrina Owen is a licensed MFT and is the manager of mental health programs for El Dorado County Health and Human Services Agency, Behavioral Health - South Lake Clinic. Sabrina has been licensed for over 20 years and specializes in the treatment of complex trauma. She additionally serves as the representative of South Lake Tahoe on the El Dorado County ACES Collaborative, as a commission member for First5 El Dorado, and is a founding member of the South Lake Tahoe Behavioral Health Network.

Ren Strong is a Program Manager with the El Dorado County Health and Human Services Agency in the Behavioral Health Division, Mental Health Plan. Ren has been the Mental Health Services Act (MHSA) manager since January 2013, and she splits her time between MHSA and the Mental Health Plan compliance, Quality Improvement. Quality Assurance, data evaluation, reporting and budget functions.

Heather Longo is a Senior Department Analyst with the El Dorado County Health and Human Services, Behavioral Health and is the Mental Health Services Act (MHSA) Coordinator. Heather has served in this capacity for the past two and a half years.

STAFF ANALYSIS – EL DORADO COUNTY EXTENSION

Revised 2/14/2020 (see italicized information under Review History)

Innovative (INN) Project Name:	**Community Based Engagement and Support Services (aka HUBS)**
Extension Funding Requested for Project:	**$2,158,704**
Time Extension Requested for Project:	**9 months**

Review History:

MHSOAC Original Approval Date:	**August 25, 2016**
Original Amount Requested:	**$2,760,021**
Duration of Innovation (INN) Project:	**Four (4) Years**

- ***This innovation project from El Dorado County was removed from the Consent Calendar on January 23, 2020 due to stakeholder opposition (NAMI El Dorado County), requiring the County to come forward to present in front of the Commissioners.***

- ***Subsequent to the Commission Meeting, an updated letter that revisits NAMI El Dorado County's opposition letter, dated August 12, 2019, now shows support for the continued funding of the HUBS project.***

Current Request:

County Submitted Final INN Extension:	**November 4, 2019**
Approved by BOS:	**June 25, 2019**
MHSOAC Consideration of INN Project:	**January 23, 2020-Consent**

Project Introduction

This project from El Dorado County was originally approved by the Commission on August 25, 2016 for up to $2,760,021 in innovation spending authority. The original project intended to promote interagency collaboration and partnered with County Public Health, the First 5 Commission and the County's Health and Human Services Agency by developing and placing five community hubs in local libraries within the County with the goal of increasing physical and mental health care access for families, pregnant women, and children from birth through 18 years of age. The hubs were developed to offer mental

and physical health prevention activities such as support groups, education classes, engagement opportunities, screenings for mental health, alcohol, and drug and referrals were offered as needed.

Although the project was approved in August 2016, the project did not start until May 1, 2017. The County indicates this nine-month delay occurred due to normal County processes. Subsequent to Commission approval, the County's Board of Supervisors had to create and approve the positions that were needed to implement the project. County Human Resources then had to create duty statements for all the required positions and then County Behavioral Health interviewed, selected candidates and completed required background checks and pre-employment screening.

The County is requesting an additional amount of $2,158.704 in innovation spending authority along with a nine-month time extension to address challenges, explained in detail below, the County experienced in relation to staffing, technology, and the analysis of data and reporting. To address these challenges, the County would like to incorporate additional personnel and upgrade the technological needs for project staff which would allow for continued learning in this project. The County wishes to address these barriers in order to adequately meet their original learning objectives.

Reason for Extension The original project was developed as a result of a Maternal, Child, and Adolescent Needs Assessment and Action Plan which revealed that El Dorado County residents had a high rate of mood disorder and substance use hospitalizations in pregnant women and youth between the ages of 15-24 years of age. Community hubs were developed and placed in five libraries within the County with the goal of engaging isolated pregnant women, families and children and providing health navigation and referrals to community based mental health services as needed.

Following the implementation of the project, the County began to experience challenges that if not addressed, would interfere with the overall learning objectives that were established. The four identified challenges were in the following areas:

1. Staffing
2. Limited Family Engagement Staff
3. Technology and infrastructure
4. Analysis of data and reporting

Staffing:

El Dorado County originally hired five Public Health Nurses as limited term positions, as opposed to full-time positions, and as a result experienced a high rate of staff turnover. The County had a difficult time retaining Public Health Nurses in these positions as most employees in that position desired a full-time position and would vacate the limited term positions once a more permanent position was available.

Proposed Solution:

As a result, the County restructured those limited term, full time positions to permanent, full time positions which helped to lessen staff turnover. This change highlighted the need

for a full time Public Health Nurse Supervisor. As part of the original project, the County onboarded a part time (0.20 FTE) Public Health Nurse Supervisor; however, the County realized this position that in order to allow for adequate program oversight, supervision and interagency collaboration, this position should also be full time. **Additional funding for a full time Public Health Nurse Supervisor is being requested as part of this extension**.

Limited Family Engagement Staff:

The current project has a part-time Family Engagement Staff located at each of the five hubs. The primary purpose of the Family Engagement Staff was to work with families and community agencies to support the developmental needs of children age birth to five years old. Research indicates the quality of relationships early on is important for lifelong mental health and affect in the first few months of life is linked with the effects of the primary caregiver (Klitzing, K, et al, 2015).

The part time Family Engagement Staff were able to provide developmental screenings for 300 children and engage 797 adults in developmental activities during the last fiscal year which resulted in a decrease in social isolation and positive interaction within families; however, the part time Family Engagement staff could only provide screenings for children up to five years of age. The County states that increasing Family Engagement Staff to full time positions would allow an additional 150 developmental screens annually and would permit Family Engagement Staff to work with children and young adults up to the age of 18.

Proposed Solution:

The County states that increasing the Family Engagement Staff to full time positions within each hub would increase the amount of developmental screenings offered with special focus on school engagement and would also allow Family Engagement staff to work with individuals and families with children up to up to 18 years of age. The County states the expansion and availability of Family Engagement Staff would allow greater partnerships with the schools and facilitate working with the families of children who may be experiencing challenges in school that may negatively affect and/or impact a child's wellbeing and resilience later in life. In order to provide supervision and review of the Family Engagement Staff, the County would like to onboard a part time (0.10 FTE) Family Support Coordinator who will observe and provide support for the five full time Family Engagement Staff. **Additional funding is being requesting to convert the current part time Family Engagement Staff, located in each hub, to full time positions along with the onboarding of a part time (0.10 FTE) supervising Quality Improvement and Family Support Coordinator.**

Infrastructure and technology:

Some of the community hubs have unreliable internet connectivity, or may even have non-existent internet connectivity, making the entry of data cumbersome and may result in the loss of data. Currently, the Public Health Nurses utilize a tablet which is not efficient

in terms data storage. Additionally, the Public Health Division within El Dorado County maintains patient and client electronic health records utilizing Patagonia Health; however, the Public Health Nurses store data in a software program other than Patagonia so data is captured through a separate software program which does not allow the consolidation and accessibility of patient data for case management and referral for various services within the community.

Proposed Solution:

The County would like to upgrade to laptops which are capable of much larger data storage capacity and will also allow data entry into appropriate software programs until data can be successfully uploaded with strong network connectivity.

The County would also like the Public Health Nurses to store data within the Patagonia software program which would allow more effective case management and running of reports for program success without the possible duplication of data entry and data error. **Additional funding is being requested to upgrade from tablets to laptops to minimize loss of patient data due to inconsistent internet connectivity along with additional licenses to utilize Patagonia software to allow proper maintenance and security of electronic health records.**

Data Analysis and Reporting:

This project involves the collaboration and partnering of various community partners providing assessments, linkages, and services to individuals which results in the collection of data, analysis, and outcome reporting. Historically with this project, each of the collaborating partners have captured data relative to their specific funding stream which has led to variations in the way data has been collected and analyzed, along with the analysis of the data which has been completed by the Public Health Nurses. Inconsistent data has been a concern expressed by stakeholders as a barrier in terms of the final evaluation of this project.

Proposed Solution:

The County proposes to acknowledge the concerns expressed by stakeholders by onboarding a Senior Analyst who will be charged with the evaluation of the data. The County indicates a single point of contact to evaluate the data would increase the reliability, including the possibility of increasing collaboration with all partners to explore requirements consistent to gathering data. **The County is seeking additional funding to bring in a Senior Analyst who will be responsible for the evaluation component of this project and coordinating a more cohesive partnership.**

The Community Program Planning (CPP) Process

The original project was created out of stakeholder input provided during the Fiscal Year 2016/2017 Annual Update which yielded feedback to proceed with development of the original innovation project. For this extension, El Dorado County held their 30-day public

comment period beginning April 19, 2019 followed by their Mental Health Board public hearing on May 22, 2019. Board of Supervisor approval was received on June 25, 2019.

The County sought input from their stakeholders via several community meetings held during the day and evening to solicit robust feedback. The meetings were attended by 121 individuals who provided input regarding the County's innovation projects. The County also distributed surveys to solicit stakeholder feedback for the Fiscal Year 2019/2020 Annual Update, including this innovation project. A total of 302 surveys were received in response. Additionally, the County's Mental Health Services Act (MHSA) Division attended the County's Health and Human Services Open House and obtained a booth where approximately 250 members of the community stopped and inquired about various MHSA programs and innovation proposals.

The Community Hubs project leads were invited to update the Behavioral Health Commission at their April 2018 and April 2019 meetings. The community was also updated on the status of the Hubs project and the challenges the County had encountered during its implementation.

Commission staff originally shared this project with stakeholders on May 14, 2019 while the County was in their 30-day public comment period and comments were to be directed to the County. The final version of this project was again shared with stakeholders on November 8, 2019. No letters of support or opposition were received by Commission staff as a direct result of the sharing of this project with stakeholders on the two dates referenced above; **however**, there were three letters of opposition that were submitted (two of those three letters were from same individual), along with 27 letters of support submitted by community partners in the County. One letter of opposition was received on May 9, 2019, the second letter of opposition was received on July 29, 2019, and the final letter of opposition was dated August 12, 2019. (*Note: letters of opposition and support will be included as part of the Commissioners packets. Permission has been granted from those who wrote letters of opposition to be included and they have waived their desire to remain anonymous*).

The letters of opposition reflected concern surrounding the possibility of reverted funds being returned to the County and the need for these funds to support other behavioral health concerns in the county.

As part of MHSA General Standards, El Dorado County will depend upon community collaborations and stakeholder feedback during all phases of this project. The County intends to utilize culturally and linguistically appropriate staff to engage individuals within the community hubs. This project is client and family driven where individuals and families can engage in programs of their choice and seek services as needed with emphasis based on recovery, wellness, and resilience.

Learning Objectives and Evaluation

The learning goals, questions, and methods that will be used to evaluate the HUBS program remain unchanged. Additionally, the El Dorado County will continue to target individuals of all ages in the County, with attention given to geographically isolated

families and pregnant women. Overall, the County hopes to learn if the impact of the HUBS approach can lead to increased access to services. Additional expected learnings revolve around the project's impact on reducing mental health costs, increasing client screenings and treatment for MH services, and whether the trauma-informed approach can assist in reaching clients deemed to be "hardest" to serve.

While the limitations noted in the extension request have delayed the project overall, early learnings from the project indicate that there has been an overall increase in referrals received and client contacts, suggesting that clients are willing to access community hubs within libraries. The County also notes that the true impact this has on mental health services overall is yet to be determined as they continue gathering data and evaluating the program and is seeking an extension of time and funding to allow for the thorough analysis of the learning objectives with the increase in staffing and improved technology support.

The overall evaluation plan remains the same, however, it is laid out more methodically with more thought given to measurements that will be used to explore each learning objectives. Data will continue to be collected by tracking referrals and client contacts, linkages made, as well as through various tools administered by public health nurses, such as the Family Strengthening Protective Factors Survey and various other screening tools (**see pgs15-16 of County plan**). One consideration missing from the evaluation plan is **how a baseline will be established upon which data will be compared, and how often surveys will be administered** to better understand client satisfaction and increased knowledge among staff. At the conclusion of the program, the County will share lessons learned and findings at various local meetings, as well as via the county's Health and Human Services Agency Facebook pages and other webpages.

Keywords: Community Hubs; mental health screening in libraries; community health advocates in libraries; adverse childhood experience study; community hubs; mental health screening in rural communities.

Budget

The original project was approved for $2,760,021 in innovation funding in August 2016 for a duration of four years. This extension request is seeking an additional $2,158,704 in innovation funding with an extension of time of nine months, not to exceed the five-year innovation project regulatory timeframe. Personnel costs total $1,234,882 to cover the additional position of a supervising public health nurse (1.0 FTE), a senior analyst (1.0), contracted family engagement staff (2.50 FTE), and a supervising family support coordinator (0.10 FTE). Operating costs (which include indirect and direct costs) total $171,989 and will cover items associated with travel expenses, network fees, communications and rent. Non-recurring costs in the amount of $120,000 (5% of extension request) includes technology needs such as laptops, docking stations, wireless cards and other technology-related needs which will assist in addressing the challenges relative to data gathering. The County will be contracting with the County Office of Education in the amount of $611,033 for the provision of personnel serving as Family Engagement Specialists. Evaluation for this extension project totals $18,300 and administrative costs will cost $2,500.

The County is leveraging a total of $1,139,710 from in-kind funds and other funding sources (Public Health MCAH Funds, First 5, El Dorado County Office of Education). The total cost of this project is $3,298,414 which includes innovation funding and various other funding sources (see page 29 of project plan for listed funding sources).

Pursuant to AB114, the County states they will utilize funds subject to reversion first until no reversion funds are available. Regarding sustainability, the County may continue with this entire project or components of this project, including personnel, with either Community Services and Supports funds or Prevention and Early Intervention funding.

Additional Regulatory Requirements

The proposed project (extension) appears to meet the minimum requirements listed under MHSA Innovation regulations**.**

References

Klitzing, K., Dohnert, M., Kroll, M., Grube, M. Mental Disorders in Early Childhood, May 2015; 112(21-22): 375–386. Retrieved on December 20, 2019 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4496484/

https://www.thewholechild.org/parent-resources/age-0-5/normal-development-stages-ages-0-5/

El Dorado County
Community-based Engagement and Support (Community Hubs)
Innovation Project Modification Request

Summary of the Innovation Modification Request

The Community-based Engagement and Support (more commonly referred to as "Community Hubs" or "Hubs") project was originally approved by the MHSOAC on August 25, 2016. This Modification Request extends the project term from an ending date of September 18, 2020 to June 30, 2021 and increases Innovation funding by $2,158,704 for a total Innovation funding of $4,918,725.

Since implementation and service delivery began, the Community Hubs have been embraced by our small rural county and the data continues to show the tremendous positive impact of the Hubs on our community's mental health and building resiliency. The Hubs have evolved from being an access point for providing information about services, into being a central part of our rural fabric and a way of providing cohesive services and collaboration across agencies. Public Health Nurses meet individuals in places where the individuals feel most comfortable. That may be the library, a park, a school, or the person's home. Moreover, within their scope of licensure, Public Health Nurses are skilled at performing validated mental health screenings, such as the Edinburgh Postnatal Depression Scale Screening, the Adverse Childhood Experience (ACE) Questionnaire and the PHQ-9. As the State and the MHSOAC place more emphasis on ACEs, it is important to realize that the ACE Study is one of the foundations of this project. Public Health Nurses coordinate care for patients, including connections to County Behavioral Health and other local behavioral health and substance use disorder providers. They also communicate with patient primary care providers. The Hub teams provide primary prevention strategies and they offer referrals and linkages to services. They provide clients with reassurance and warm hand-offs to community partners. Further, with the stigma around talking about mental health and accessing mental health services, the Public Health Nurses and the rest of the Hub team play an integral role in developing rapport with the clients by helping to break the barriers erected from the stigma. The Community Hub teams not only promote mental and physical health services, but they also provide education on resiliency and mental health awareness. There is a very clear nexus between the Community Hubs and mental health. In short, the Hub teams are immersed in our communities and they play an important role both in helping our communities address mental health needs and build resiliency through prevention.

Since the implementation of the Community Hubs, the team has discovered emergent challenges related to staffing issues and data analysis and reporting. This Modification Request seeks to address those emergent challenges. With regards to staffing challenges, the Public Health Nurse position allocations were "limited-term" allocations, meaning a position was filled to accomplish a specific project that was limited in duration, was not of a recurring nature, and would continue for a period of six months or more. It was difficult to attract, recruit, hire, train, and retain limited-term employees when most qualified individuals were seeking full-time employment. The County restructured the Public Health Nursing staffing to accommodate regular status positions, which has helped to somewhat stabilize this challenge. Unfortunately, statewide there is a shortage of Public Health Nurses. Additionally, there is still a need for a full-time Public Health Nurse Supervisor to provide program oversight and supervision of the Public Health Nurses. The current allocation is 0.20 full-time equivalent (FTE). This allocation is not adequate to perform all the functions of this role, as well as to oversee the outcome reporting for this program. The Modification Request includes changing this allocation to a 1.0 FTE.

Another staffing challenge exists with the Family Engagement allocation. The Family Engagement Specialist staff administers developmental screenings. Most children cannot verbalize mental health challenges. However, the developmental screenings may provide the Family Engagement Specialist with insight into something that may have a mental health element. Therefore, the Family Engagement staff is a crucial piece of the Community Hub team. They help to bring resiliency to families by connecting them to services and establishing supportive community relationships before a potential crisis impacts the family. The current Family Engagement allocation is 0.5 FTE at each Community Hub. This Modification Request includes changing this allocation to 1.0 FTE at each Community Hub and adding 0.10 FTE supervising Quality Improvement and Family Support Coordinator to provide monthly observation of the Family Specialists and to review programming strategy and performance as it relates to the Family Engagement.

Funding for an Analyst also is requested through this Modification Request. The Analyst would be responsible for data analysis, which currently falls to the Public Health Nurses and Public Health Nurse Supervisor, neither of which have a background in data analysis. As an interagency collaboration program, the Community Hubs requires capturing and reporting a significant amount of data and reporting outcomes. There are inconsistencies in the way in which data is

collected and/or interpreted, so adding an Analyst who is familiar with data collection and evaluation will greatly improve data reporting.

There also have been infrastructure and technology issues. The Community Hub employees currently use tablets, which connect to Wi-Fi, to access cloud-based applications. The internet connectivity in various locations within the county can be spotty at best, non-existent in other areas. This issue has caused data to not be entered and data to be lost. Purchasing laptops for the Community Hub employees to use will eliminate the need to connect to the internet to access cloud-based applications, and instead Microsoft Office products can be used. Additionally, expanding use of Public Health's electronic health record also will enable greater data collection and reporting capabilities, as well as enable more case management. Migration to the sole use of Public Health's electronic health record will require result in additional maintenance costs.

Finally, this Modification Request includes extending the project by nine (9) months to address these emergent issues so that the funding partners can better assess the success of the project based on the learning objectives.

Data

During Fiscal Year 2018/19, the Community Hub teams made 122 referrals[1] to behavioral health services (compared to 48 referrals in Fiscal Year 2017/18); with the most common resource connection being early-intervention focused counseling services for clients. Of the 122 referrals, 54 were confirmed to have received services.

Moreover, the Community Hub teams made 700 referrals to other community-based resources to help individuals and families gain the services and supports they need for basic needs and building resiliency. These referrals include, but are not limited to: Primary care doctors, mild-to-moderate mental health providers, Heat and Energy Assistance Program (HEAP), local food banks or distributions, CalFresh food program, CalWORKs, Women, Infant and Children (WIC), Head Start, Lifeline Cell Phone program, transportation, housing programs, parent classes, support groups, library programming, one-time grant-funded financial support applications (e.g., Women's Fund, Lighthouse, Aspire Kids, etc.), and childcare resources. All of these resources and services help families gain the services and supports they need for basic needs and building resiliency. If basic needs are not met, many individuals will exhibit health-related (including mental health-related) symptoms.

Historically, it has been very difficult to engage El Dorado County's Latino population in services. However, the Community Hub teams interacted with 412 individuals who self-identified as Latino during Fiscal Year 2018/19.

The total number of referrals in Fiscal Year 2018/19 is 1,861 (compared to 824 referrals in Fiscal Year 2017/18). This is an increase of 1,037 referrals (44% increase) in one year.

Approval Background

On May 25, 2016, the Behavioral Health Commission approved the original Community Hubs project and on June 13, 2016, the El Dorado County Board of Supervisors approved the project. On August 25, 2016, the MHSOAC approved the initial project for a duration of four-years and funding of $2,760,021. The project was implemented on September 19, 2016 with direct client services beginning on May 1, 2017.

This project modification seeks to extend the duration of the project by nine months (for an end date of June 30, 2021) and an additional $2,158,704 in funding for a total funding of $4,918,725. Of the additional funding request, it is estimated that up to $1,783,832 is funding subject to reversion if not spent by June 30, 2020.

Through analysis and evaluation of the learning objectives in Fiscal Year (FY) 2016/17 and 2017/18, and engagement of stakeholders during the FY 2018/19 and FY 2019/20 Mental Health Services Act (MHSA) Annual Update Community Program Planning Process (CPPP) meetings, it was determined that it was necessary to seek a modification of the original project in order to more fully learn from this project.

At the June 4, 2018 Public Hearing meeting, the Behavioral Health Commission approved the Fiscal Year 2018/19 MHSA Annual Update, including the Community Hubs modification, by a vote of 8 ayes and 1 no. The County Board of Supervisors unanimously approved the modification request at their June 26, 2018 meeting.

[1] It is estimated that this number is underreported due to issues with data collection and reporting methods.

Upon Board of Supervisor approval of the project, El Dorado County was advised by the MHSOAC staff that the modification request was more of a "concept" and they encouraged use of the recently released MHSOAC Innovation template and returning for stakeholder feedback through the CPPP for the FY 2019/20 MHSA Annual Update.

Again, throughout the 2018/19 CPPP, stakeholders supported modification of the Community Hubs project. At the May 22, 2019 Public Hearing, the majority of speakers supported the Community Hubs modification. However, the Behavioral Health Commission members appointed to an Ad Hoc Committee charged with reviewing the MHSA Annual Update, did not come to a unanimous conclusion and requested that the item be continued at the June 12, 2019 Behavioral Health Commission meeting.

At the June 12, 2019 Behavioral Health Commission meeting, six Commissioners voted in support of the FY 2019/20 MHSA Annual Update, including the Community Hubs modification proposal. One Commissioner voted against approval of the MHSA Annual Update, one Commissioner abstained, and one Commissioner was absent.

The El Dorado County Board of Supervisors unanimously adopted the FY 2019/20 MHSA Annual Update, inclusive of the Community Hubs modification request at their June 25, 2019 meeting. Upon Board approval, the County's MHSA staff began working with the MHSOAC Staff as they prepared their staff analysis. At the Commission's request, El Dorado County is grateful for the opportunity to present the project at the February 27, 2020 meeting.

Budget

The Community Hubs is funded by County of El Dorado/Behavioral Health/MHSA (53.12%)[2], County of El Dorado Public Health (30.72%), First 5 El Dorado Children and Families Commission (10.27%), and El Dorado County Office of Education (5.89%).

The budget for the Innovation Modification Request is as follows (***Innovation Funds only***):

Cost Category	FY 19/20	FY 20/21	TOTAL
Personnel	$241,569	$993,313	$1,234,882
Operating Costs	$49,686	$122,303	$171,989
Non-Recurring Costs	$120,000	--	$120,000
Contracts	$289,148	$321,885	$611,033
Evaluation	$8,300	$10,000	$18,300
Administration	--	$2,500	$2,500
Total	$708,703	$1,450,001	$2,158,704

This modification includes items to address the above-referenced challenges, including:

- Increased personnel:
  - 0.80 FTE Supervising Public Health Nurse
  - 1.00 FTE Sr. Analyst (equivalent or lower classification)
  - 2.50 FTE Family Engagement Staff (contracted)
  - 0.10 FTE Supervising Quality Improvement and Family Support Coordinator
- Technology Upgrades
- Revised project end date to 6/30/2021 from 9/18/2020.

NOTE: Actual expenditures have fallen short of the initial approved budget in the first two years of operations by nearly $750,000, which is largely due to implementation delays and low staffing levels.

MHSOAC Staff Analysis

The MHSOAC Staff Analysis notes that when the Commission staff shared the project with stakeholders on May 14, 2019 and November 8, 2019, no letters of support or opposition were received as a result of sharing the project with stakeholders on those dates. However, outside of these dates, the Commission staff did receive three letters of opposition

[2] Percentages include funds and in-kind funds; and are reflective only of the modification request (Fiscal Year 2019/20 and 2020/21).

– two letters from the Behavioral Health Commission Chair and one letter signed by a then current NAMI president and co-signed by a former NAMI president.

County response to the letters of opposition: The letters from the Behavioral Health Commission Chair note that he represents the minority of Commissioners who did not support the Hub Modification Request. In fact, he is the only Commissioner who voted against the Fiscal Year 2019/20 MHSA Annual Update, inclusive of the Hubs modification (and he is the only Commissioner who voted "no" on approving the Fiscal Year 2018/19 Annual Update and the Community Hubs modification.) Further, his letters cites data from 2017/18, rather than the most recent data from 2018/19, which shows increases in the number of mental health referrals and overall referrals, as discussed above. He also states that his substantive comments were not incorporated into the final Fiscal Year 2019/20 MHSA Annual Update. This is incorrect. All comments were included. The entire Community Program Planning Process, Public Comment, and Public Hearing processes were completed with integrity.

Both of the Behavioral Health Commission Chair's letters and the NAMI letter question the use of Innovation funds for a prevention and early intervention project. The letters of opposition also assert that Innovation is not for learning and that Innovation funds should only be used on projects that address serious mental illness. Both of these assertions are categorically false. The MHSA General Standard upon which this project is based on is that of "Introduces a new practice or approach to the overall mental health system, including, but not limited to, *prevention and early intervention"*. Further, the opinions stated by authors of the letters are not reflective of the entire NAMI Board or NAMI members, nor are the letters reflective of the entire Behavioral Health Commission. El Dorado County provided the MHSOAC with 27 letters of support. One support letter submitted by the County was from a NAMI member and one support letter was authored by a Behavioral Health Commission member. It also bears repeating that ultimately, the Behavioral Health Commission approved the Fiscal Year 2019/20 MHSA Annual Update – including the Community Hubs Modification. Essentially, the opposition letters question the MHSOAC's approval of the initial project, of which the modification also is built upon, and assert that Innovation funds can only be used to address serious mental illness.

The NAMI letter also calls the learning objectives into question, often citing "serious mental illness". Again, this is not an Innovation project directed toward serious mental illness. For learning objectives that rely on data, the MHSA and Community Hub teams have acknowledged that there have been issues with data reporting. This modification seeks supports to address the data reporting issues. There also are assertions that the Public Health Nurses are "not provisioned" at the library, and "are not necessarily skilled in Mental Health assessments". Community Hub employees, including Public Health Nurses, are at the libraries, but they also are out in the community, meeting individuals where they feel more comfortable. They also are out ensuring warm handoffs and service connections are made. Further, as previously mentioned, mental health screenings are within the Public Health Nurse scope of licensure and service. If mental health issues are noted, referrals for appropriate agencies are made. The NAMI letter also states that the "Public Health Nurses promised as part of the Hub program have not been delivered on." While it historically has been easier to fill the paraprofessional Community Health Advocate positions, as stated in this modification, there is a statewide shortage of Public Health Nurses. The County continues to recruit, interview, and train new nurses. The Public Health Nurses play a vital role in this project.

Since learning of these opposition letters, Behavioral Health has offered additional education and information to the current NAMI co-presidents, the NAMI Board, and the NAMI support group members. Behavioral Health has received verbal confirmation from some NAMI representatives, that they support the Hubs Modification.

El Dorado County's MHSA Team and our Community Hub partners remain excited about this Innovation project. The Community Hubs have become a recognized and trusted entity in our small rural county and their presence has positively impacted the resiliency of our residents.

Letters of Support

WELLNESS • RECOVERY • RESILIENCE

NAMI El Dorado County

National Alliance on Mental Illness

February 12, 2020

Mental Health Services Oversight and Accountability Commission
1325 J Street
Sacramento, CA 95814

RE: NAMI El Dorado County Comments on Community HUBS Project; Sent via Email

Dear MHSOAC Chair and Members:

The following revisits the August 12, 2019 letter directed to MHSOAC from NAMI El Dorado County (NAMI EDC). The letter drafted by NAMI EDC's then-President, Jeanne Nelson, expressed concerns about the Community HUBS Program (HUBS) funded by MHSA revenues. The letter went on to suggest that MHSA funds related to HUBS be re-distributed.

NAMI EDC invited El Dorado County's Health and Human Services Agency (HHSA) Director, Don Semon, along with EDC's Deputy Director of Behavioral Health Services and MHSA Program Coordinator to discuss HUBS at its recent Board of Directors meeting. El Dorado County's Behavioral Health Commission Chairperson, Dr. Stephen Clavere, also participated.

The HHSA team provided important information regarding HUBS including: 1) HUBS as an innovation project; 2) HUBS related community resource referrals; 3) MHSA requirements for HUBS funding. Additionally, HHSA's Behavioral Health Division agreed to work together with NAMI EDC on matters related to HUBS and better address concerns raised by NAMI going forward.

The issue of whether to oppose or support continued HUBS funding with MHSA revenues was put to a vote of NAMI EDC's Board of Directors. The Board voted to **SUPPORT CONTINUED HUBS FUNDING**. As such, NAMI EDC **OPPOSES RE-DISTRIBUTION**.

NAMI EDC is pleased that El Dorado County HHSA/Behavioral Health is engaged in a cooperative discussion of HUBS. NAMI EDC looks forward to more collaboration on this and other issues affecting the mental/behavioral health community in El Dorado County.

Sincerely,

Karis Holman
Co-President

Fred Hjerpe, OD
Co-President

Shared Vision/Bringing the Library to You Grants

The 2019-20 California state budget contains $8 million for the State Library to provide grants to local public library jurisdictions to implement early learning and after school programs, and to support mobile library solutions. These new grant programs, which are currently under development, will increase Californians' access to health, educational, workforce and other services, while also increasing the mobility and accessibility of public libraries.

Shared Vision Community Partnership Grants for Early Learning and Out-of-School Time Programs - $5 Million

- **Early Learning** – Early Learning grants will aim to connect children, youth, families and caregivers with the services they need to thrive. As trusted, stigma-free community hubs, libraries offer a unique setting to strengthen at-risk families, promote wellness and deliver a range of important early learning opportunities. Grants will help libraries create and strengthen partnerships with other critical community services and institutions, from local elementary schools, to health clinics, to First 5 organizations, to apprenticeship programs, to mental health services agencies to better deliver these services. By further integrating the work of libraries and other community service providers, Californians will have easier access to the resources they need where and when they need them.
- **Out-of-School Time** – A California child spends six hours a day in a classroom and 10 waking hours outside of one. The average school year lasts 180 days. These grants will focus on supporting and expanding the critical role libraries play for children and teens during the 60 percent of their lives they aren't in school. Libraries provide free and welcoming spaces, STEAM programming, health and wellness activities and help develop leadership skills and social-emotional and workforce readiness in youths. Like the Early Learning grants, the involvement of other community partners will broaden the impact of the services provided.

Bringing the Library to You: Mobile Library Solutions Grants - $3 Million

- Bringing the Library to You grants will help libraries implement new ways to bring literacy, technology and other services to those who face challenges visiting their local library. When Californians lack transportation, live far from their library, or work long hours, mobile library solutions make it possible to access library services and programs.

More information about these grants will be available soon! Three one-hour online meetings have been scheduled, one for each program area (see registration links below)

We invite you to join us, hear about what's being planned, and give your feedback and input.

- **Bringing the Library to You: Mobile Library Solutions Grants (July 25, 2019, archived version)**
- **Shared Vision: Early Learning Grants (July 30, 2019, archived version)**
- **Shared Vision: Out-of-School Time Grants (August 6, 2019, 11 AM)**

Questions? Contact:

- Mobile Libraries Solutions Grants: **Beverly Schwartzberg**
- Shared Vision Early Learning Grants: **Carolyn Brooks**
- Shared Vision Out-of-School Time Grants: **Natalie Cole**
- **Library Development Services**

June 12, 2019

To: Behavioral Health Commission
From: Norma Santiago, Behavioral Health Commission, Member
RE: Community-Based Engagement and Support Services – Existing Project and Proposed Expansion

Since our meeting on May 22nd, I have compiled some points to help clarify my understanding as to the objections raised regarding the Community Hubs and their effectiveness as it relates to mental health.

Generally, there was agreement that the community hubs model is a good model; however, the main objection was that given the amount of money invested in this program, specifically with MHSA innovation dollars, there wasn't enough data to substantiate the investment. In other words, the community hub model appears not to work in the case of identifying and treating individuals in need of mental health services. This conclusion is based upon the low number of referrals to Behavioral Health in relation to the number of MHSA dollars invested.
With this in mind, I looked at the following documents to help me ascertain the effectiveness of this investment:

1) EDC Community Hub 1 – Linkage Process, DRAFT August 15 2017
2) Interagency referral form – specifically looking at the PHN Referral Criteria and what MHSA covers in that context. MHSA innovation dollars pay for the referral criteria listed under 'At-Risk Families' which include early indication of possible mental health concerns.
3) Intake check list – Here under the 'Public Health Nurse Referral' is a check box indicating "mental health concerns for a child, parent or family member".

From this, I was able to gain a further understanding of the primary objectives of the program:

1) How can the best connection be achieved between services and those needing these services.
2) Building strong relationships with families
3) Build upon existing services to maximize dollars

It is important to remember that this program is an intervention and prevention program and the structure of the Community Hubs has been recognized as being innovative.
Through the efforts of Family Engagement Specialists, Community Health Advocates, and Public Health Nurses, we can assist the communities find the help they need. However, when evaluating the limited data before us, it is difficult to assess the success of the program. For example, at the May 22nd meeting, Lynnanne reported the for the first three quarters of 2018/19 there were 2157 Client Contacts, 98 Mental Health referrals, and 31 Direct Services.

If one looks simply at the referrals, one could, understandably, draw the conclusion that we are not getting a significant return on these MHSA innovation dollars. However, I would argue that the Client Contacts which, in many instances, are handled by the Family Engagement Specialists (FES) provide an opportunity to connect community members to needed services including mental health. The FES is part of the first line of defense in preventing early indicators into morphing into more serious problems that can lead to the need for more costly services. This is the major objective of a prevention program. Unfortunately, there is no data available to ascertain the effectiveness of this component of the Community Hub. It is my understanding that as this innovation program continues, there will be ways to capture many data points to

better ascertain program success than just referrals. As this is a system change, there is no doubt that some tweaking is going to be needed as the program evolves.

After extensive review of the annual update, evaluation of the plan to extend capacity, and speaking with agencies that provide these important services, I, strongly, support the recommendations provided in annual update for this program and suggested funding. To that end, I am prepared to make a motion stating such at the appropriate time.

Respectfully submitted,

Norma Santiago

Barton Health

2170 South Avenue
South Lake Tahoe
CA 96150

530.541.3420 TEL
bartonhealth.org

April 3, 2019

To whom it may concern,

The pediatricians of South Lake Tahoe would like to send our appreciation for the funds that have supported the additional resources to our community through the First 5 program. These programs have been essential to our pediatric patients and we have no other fail-safe to step into their place should this program not be renewed.

Besides the amazing resources for our families, it has provided a framework for our hospital and other local resources to collaborate, including El Dorado County Public Health Nursing. We have been able to establish lines of communication and pathways for referrals to these resources that otherwise would never have occurred.

Thank you for your continued support of the health of our children, which is the future of the health of our community.

With sincerity,

Matthew Wonnacott MD
Chief Medical Officer
Barton Health System

BAYSIDE
CHURCH OF PLACERVILLE

April 18, 2019

EDC Behavioral Health Commission

Greetings,

I am writing in support of funding for Community Hubs as part of the Mental Health Services Act Innovations Act. Community Hubs are a valuable resource to our county. They provide physical and mental health resources and services to at-risk families in our county. In the fiscal year 2017 – 2018 they served 1482 children and families and hope to serve more in the upcoming year.

As a pastor and chaplain I see families at some of their most difficult moments in life. Community Hubs are a valuable recourse offering services to families who may otherwise not have access to care. Early intervention is a small investment that pays large dividends by improving the quality of life for some of our most important residents, our children, and can decrease their needs for greater services later in childhood, by providing preventative services and education to parents early in their parenting experience.

I highly encourage you to consider and support this funding.

Sincerely,

Betsy Vanderpool

Betsy Vanderpool
Care & Connection Pastor

4602 Missouri Flat Road, Placerville, CA 95667 • 530-626-7288 • baysideplacerville.com

BUCKEYE UNION SCHOOL DISTRICT
5049 Robert J. Mathews Parkway
El Dorado Hills CA 95762

April 10, 2019

First Five, El Dorado County
2776 Ray Lawyer Drive
Placerville CA 95667

ATTN: Kathi Guerrero, Executive Director

To whom it may concern:

We are honored to write on behalf of our El Dorado County Community Hubs as part of the Mental Health Services Act and Innovations Grant as considered by the El Dorado County Behavioral Health Commission. We have heard that they are seeking additional funding through MHSA to augment their project and increase the Family Engagement staff as they are currently part-time. To do so will help them plan for sustainability.

Our professional interactions with the Community Hub nurses and their support staff come from direct contact as a district level nurse with Buckeye Union School District, serving the needs of over 4,700 children in our community. The Community HUB staff members serve to assist and support our role in public health at times when assistance has been required to help meet the needs of the children in our county. In fact during 2017-2018 they were able to reach 1,482 children in the county, but I am guessing that we can improve on this with additional support.

Our Community Hubs have a great deal of positive influence, and although restricted in hours, they always seem to make time for a student, parent, or other community member. If they say they will research an area of concern, they will certainly come back to us with timely answers. They are dedicated to connecting our children and their families with medical services. They have a genuine interest in bettering outcomes for our students and providing materials on prevention to stop a problem in its tracks. Being connected at the library, where public transportation makes it possible for many families to connect with the Community Hub staff make it much simpler for them to offer early screening and identification for areas of concern with regard to both mental and medical health outcomes alike.

We feel that our Community Hub staff members have the desire to find a better way to reach the members of our community who need assistance and intervention, even if the way in the past was considered satisfactory. This is really the essence of what we all need to harness in order to move into a brighter future. We would recommend your support for the Community Hubs without reservation. Please feel free to contact either of us should you have any questions.

Sincerely,
Tristan Kleinknight, RN MSN PHN & Sandy Chavez, RN MSNc PHN
Tristan Kleinknight, RN MSN PHN & Sandy Chavez, RN MSNc PHN

April 17, 2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2766 Ray Lawyer Drive
Placerville, CA 95667

Dear Commissioners,

The California State Library Early Learning with Families Initiative supports the innovative Community Hubs in El Dorado County where young families and their young children naturally gather. When looking to build Community Hubs, First 5 El Dorado built upon the strong foundation of the County Library System.

Libraries are safe, accessible, and stigma-free gathering place for families with young children. They provide needed infrastructure and are cost-effective with a countywide network already established in population centers. Community Hubs are a partnership that connect families with the supports they need to thrive because we know that hungry children can't learn, sick children can't grow, and toxic stress damages children and their families. The California State Library will continue to support the El Dorado County Community Hubs in their local libraries as they play a key role in reinventing service delivery and are used as essential model that is being replicated across the state.

In El Dorado County, one in four families with children under the age of five visit libraries making it the most accessible public service for children. Libraries offer services for all families and are not limited by eligibility requirements required by other agencies, for example, an entitlement or result from a negative experience such as involvement with child protective services. Libraries are essential partners for ensuring children are ready for school. The Community Hub services build upon resiliency and are free of cost are not provided through Plexiglas.

The goal of Community Hubs is to build family resiliency using the Family Strengthening Protective Factors. In 2017-18, a total of 4,678 (duplicated across Hub programs) individuals were provided with First 5 funded services, resulting in the following accomplishments:

- Families are using positive strategies to guide and teach their children. Seventy-eight percent (78%) of parents reported that they or another family member reads with their child each day.
- Children are receiving preventive health care. Eighty-nine percent (89%) of parents reported that their children birth through 5 had received timely well child visits.
- Children are being screened for developmental delays. A total of 612 children received either an ASQ or ASQ:SE developmental screening.

One in four families completing the First 5 Family Survey experienced growth in each of the Family Strengthening Protective Factors.

In supporting Community Hubs, the California State Library Early Learning with Families Initiative is confident they are addressing their goals of providing prevention and early intervention services to families and their children. In El Dorado County libraries have leveraged over a million dollars in the last decade to enhance base services and extend their reach in the community. They are a leader and exemplary model for delivering early learning services in the state.

Sincerely,

Carolyn Brooks

Carolyn Brooks
Library Programs Consultant
Early Learning with Families Initiative
California State Library

April 22, 2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Dear El Dorado County Behavioral Health Commission,

The El Dorado County Child Abuse Prevention Council strongly supports the continuation and expansion of the Community Hub Project that ensures children and families get connect to services throughout the county. This project is critical to ensure that the children and families of El Dorado County are healthy and thriving.

The Child Abuse Prevention Council serves children and families throughout the county as well as provides local leadership for prevention and education on abuse. We work closely with our county Health and Human Services Agency and understand the need for the resources that the Hub offers particularly to our most vulnerable families. Our fifteen-member council is a public private partnership whose membership is composed of early care community agencies, community members, faith based organizations, health and mental health services, parents and advocates, and law enforcement.

Our council is excited about the work the Hubs have already developed. The Hub staff support families gain access to essential mental health services in our county. These services are imperative to strengthening families and preventing child abuse. When a child and family are doing well and have access to supports and resources, they are significantly less likely to be in situations of abuse. By connecting families to services, the Community Hubs strengthen the entire family's health. For families who are isolated, the Hubs are an essential resource for health and mental health education and access. Health specialist at each Hub individually support families and provide continuity of care for those needing help.

Expanding the Community Hub Project will have a lifelong positive impact on the families of El Dorado County. Proactively investing in children and families ensures countywide improvement and strengthening. For these reasons, the El Dorado Child Abuse Prevention Council respectfully asks for your continued support and expansion of the Hubs.

Sincerely,

Commander Kim Nida, Chair
Placerville Police Department

Jenna Knight, Council Coordinator
El Dorado Early Care & Education Planning Council

Choices for Children

www.choices4children.org

Resource & Referral Program
Child Care Subsidy Program
Child Care Food Program
Training & Resource Development

April 17, 2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Dear Behavioral Health Commission,

For the past three years Choices for Children has developed a successful partnership with the Community Hubs. Our relationship is based on the foundational goal of strengthening family's lives. Collaboration with the Community Hubs is essential to supporting families and building resilience. The Hubs refer families to Choices for Children to receive Child Care Referrals, information about Subsidized Childcare options, and Parent and Provider Education services. Choices for Children refers parents and providers to the Hubs for services related to early literacy, public health, Play & Learn Activities and Ages and Stages services. We value the continued collaboration and support from the Community Hubs during our Annual Kids' Expo and Day of the Young Child events.

Choices for Children looks forward to continuing our partnership with the Community Hubs Maternal Child Adolescent Health services. According to the El Dorado County Community Hubs Report, last year 1,482 families were reached through the Hubs. Prevention and early intervention and mental health access for pregnant women, families and children ages birth through 18 years is greatly needed. The HUBS provide an innovative approach to families receiving these vital services.

The result of Hubs services will be a greater number of our county's most vulnerable residents receiving high quality support, resources that improve their health, functioning and effectiveness later in life. I confidently recommend El Dorado County Hubs for the Mental Health Services Innovation Grant. I am certain that the Hubs will effectively meet and exceed all necessary MHSI funding requirements. Should you require any additional information please do not hesitate to contact me at 530-676-0707 or JLawrence@choicesforchildren.org.

In Partnership,

Jennifer Lawrence

Jennifer Lawrence
Director Resource & Referral, Choices for Children

South Lake Tahoe Office
1029 Takela Drive, Suite 1
South Lake Tahoe, CA 96150
Phone: 530-541-5848
Fax: 530-541-1376

Cameron Park Office
3161 Cameron Park Drive, Suite 101
Cameron Park, CA 95682
Phone: 530-676-0707
Fax: 530-676-8416

Markleeville Office
100 Foothill Rd., D-6, P.O. Box 215
Markleville, CA 96120
Phone: 530-694-2129
Fax: 530-694-1889

Children will be Healthy and Ready for School by Age 5

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

April 18, 2019

Dear Commissioners of the El Dorado County Behavioral Health Commission:

I am writing in support of Community Hubs as part of the Mental Health Services Act Innovations Grant under your consideration. As the Chair of Divide Ready by 5, (a grassroots community group that works to provide connections to services and information to families regarding school readiness, health, child development, literacy and parenting), I have worked directly with the Hub 4 team from the beginning. The Hub 4 team has become integral into all that we do as an organization on the Divide.

Divide Ready by 5 has been a presence in the community for over 10 years, and the Hub 4 team worked with us to quickly develop a strong foothold in the community. Divide Ready by 5 was welcomed by the Hub team as a community resource and we welcomed the Hub team! We gathered materials to help create a friendly space for families to meet with Hub team personnel at the Georgetown Branch library, and we have seen the library grow as the go-to place for community resources. We regularly refer families to the Hub 4 team for Storytime, health insurance, dental services, counseling services, health issues, child development and parenting help. The Hub 4 team has made a deep impact on our mission and has made it possible for us to connect more families to the services they need. We work hard to promote every Hub activity, group, support or class, as we know that this is how we can best serve our families.

We have partnered with the Hub team at all local events (where we have an active, child and family-centered activity booth) and now the Hub 4 team has booths at community events and engages in outreach to those hard to reach families. Hub 4 rapidly worked with us to connect to our social media and website – sending us information to post--and they continue to come to our monthly meetings to ensure strong community connection. Because Divide Ready by 5 has also worked closely with the school district, we worked with the Hub to build strong ties so the district staff would also refer families to the Hub. District staff know now that they have help through the Hub in supporting families in need. The Hub team comes to the school district Family and Student Services team meeting, allowing coordination between the school district and Hub in terms of services, events, meeting the needs for our community. The Hub team also works with us and the school district as a part of our Kindergarten Round-up; here the Hub 4 team can promote Hub services and reach many new families, as well as discuss literacy, health, child development and parenting issues and having each child screened by the Family Engagement Specialist with the Ages and Stages Social Emotional Questionnaire.

Community Hub 4 is a fundamental part of all the work that Divide Ready by 5 advocates. We strongly support the Community Hub project and hope it will be considered as a must by our county.

Sincerely,

Monica C. Woodall

Monica C. Woodall
Chair, Divide Ready by 5

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

April 7, 2018

Dear Commissioners of the El Dorado County Behavioral Health Commission:

I am writing in support of Community Hubs as part of the Mental Health Services Act Innovations Grant under your consideration. My role as a Board member of Georgetown Divide Ready By 21 has afforded me the chance to see our new Hub 4 in action. Georgetown Divide Ready By 21 acts as the non-profit umbrella organization for many groups, including those that work directly with Community Hubs personnel. Two of those groups are most active in coordinating with Hub 4 – Divide Ready By 5 and Drug Free Divide. We also work closely with our school district - Black Oak Mine Unified--to make sure they have current Hub information regarding services.

Even though the Community Hubs have only been in place for a short time, we have seen concrete work that has greatly improved the lives of some of our most needy families. Divide Ready by 5 connects local families in need of support with services. They have created a network through social media and community events and are known as a community resource for information for families in need. They meet monthly with the Hub 4 team to coordinate events and work together to continue to do outreach with hard to reach families. Divide Ready by 5 has helped Hub 4 create a welcoming space in their home of the Eldorado County Library (Georgetown Branch) and has facilitated connections for the team with our local preschools and the school district in addition to helping the team with all local events. Drug Free Divide includes the Hub team as part of their monthly meetings and helps Hub 4 connect with local junior and senior high school students and their families.

With this help, the Hub 4 team is now known as the premier resource for people who need health, mental health, intervention and parenting support, classes, and information. Divide Ready by 5 and Drug Free Divide have worked with the Hub team to make sure that our school district counselors, administrators, as well as teachers have information regarding Hub services. Divide Ready by 5 and the school district work closely with the Hub team to make sure families in need are connected to and receive services from the Dental Van each fall and spring. The Hub team is also a part of the school district intake process known as Kindergarten Round-up for all new Kindergarten enrollees in the school district. The Hub 4 Family Engagement Specialist meets with each family to take the Ages and Stages Social Emotional Developmental Screen and discuss each assessment with the family. Each family meets with the Hub 4 Community Health Advocate to assess health, dental and mental health needs and get connected to services.

Georgetown Divide Ready by 21 regards Hub 4 now as an integral part of our community services. They support our mission that all youth are "thriving and ready by 21."

Sincerely,

Drew Woodall, Georgetown Divide Ready By 21 Board member

April 22, 2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Dear El Dorado County Behavioral Health Commission,

The El Dorado County Early Care and Education Planning Council strongly supports the continuation and expansion of the Community Hub Project that ensures children and families get connect to services throughout the county. This project is critical to ensure that the children and families of El Dorado County are healthy and thriving.

The El Dorado Early Care and Education Planning Council serves the children, families, and early education programs in the county as well as provides local leadership for the planning and development of quality, accessible, affordable early care and education programs for children and families in El Dorado County. Our fifteen-member council is a public private partnership whose membership is composed of early care providers, parents, business, community agencies and government services.

The family engagement specialists at each of the Hubs successfully connect with families with young children to essential services in the community—mental health, oral health, insurance, literacy specialists, early interventionist, behavioral therapist. By connecting families to services, the Community Hubs strengthen the entire family's health. Additionally, the family engagement specialists lead playgroups for parents to learn about how their child develops and connect to one another. Through intentional curriculum and community, parents and caregivers build resiliency.

Expanding the Community Hub Project will have a lifelong positive impact on the families of El Dorado County. Proactively investing in children and families ensures countywide improvement and strengthening. For these reasons, the El Dorado Local Planning Council respectfully asks for your continued support and expansion of the Hubs.

Sincerely,

Jenna Knight, Council Coordinator

El Dorado Early Care and Education Planning Council

El Dorado County Office of Education
Child Development Programs and Services
6767 Green Valley Road
Placerville, CA 95667

April 16, 2019

Attn: Behavioral Health Commission,

This letter is in support of the El Dorado County Community Hubs and the incredible work that they do for the families in children in our community. As Coordinator of Quality Improvement and Family Support for Together We Grow at the El Dorado County Office of Education, I support with the coordination for the Family Engagement Team and their partnership within the Community Hubs. I speak with the Family Engagement Specialists daily about their efforts and the families they connect with. I am constantly moved by the collaboration at the Community Hubs and their aspirations to provide support for services to all families in need.

When thinking about the individuals we have supported in the Community Hubs, there is one particular story that I feel shows the direct impact of the innovation of our services in connecting families and children to mental health services. This fall, our Family Engagement Specialist, Jesus Cordova, received a call from a child care provider in Hub 3 (Placerville area). The provider expressed concerns about a child's aggressive behavior in the classroom and shared with Jesus that she was considering expelling the child from their center. She reached out to Jesus for ideas of how to support the child, as she had utilized all of her strategies and was unable to provide the child's mother with resources. Jesus met with the child's mother, developed a relationship with the family, learned about several challenges the they were facing, and supported the mother with completing a developmental screening for her child. He then simultaneously referred the family to the Community Hub Public Health partner for case management and New Morning for Parent Child Interaction Therapy (PCIT). The family not only engaged in both services, but the mother and child continued to come to Community Hub programs, such as story times and evening events at the library. All partners in Hub 3 interacted with this family and collaborated in an effort to provide high quality resources. This is one example of many stories we hear from the Community Hubs every day in our county.

As your commission reviews additional letters, please consider additional funds from the Behavioral Health Commission to be allocated towards the El Dorado County Community Hubs. Our teams are passionate about providing innovative services to all individuals in need in El Dorado County.

Sincerely,

Elizabeth Meyer, MS
Coordinator- Quality Improvement and Family Support
El Dorado County Office of Education

El Dorado County Growers Alliance

April 15, 2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Subject: Support For First 5 Community Hubs Through Mental Health Services Act Innovations Grant

To Whom It May Concern:

Community Hubs are more than an innovation. They are a revolution. From our point of view, preventing developmental problems is as great a community revolution as are the changes brought by new communications technology. It is within the community's power to reduce life-time problems such as substance abuse and mental health issues.

Our group seeks to promote the use of hubs as a part of a healthier community. It is essential for the El Dorado County community to support programs that foster healthy development of young people.

Please support the First 5 El Dorado County Community Hubs program with Mental Health Services Act funding.

Thank you for your attention to this matter.

R A Miller

Rod Miller
Legislative Director

530-503-9078
685 Placerville Dr., Suite 1024
Placerville, CA 95667

Infant Parent Center

April 19th, 2019

RE: El Dorado County Behavioral Health Commission

Dear Commission,

The Infant Parent Center is writing a letter in support of the El Dorado Community Hubs. Prevention and early intervention services are vital for our community. The Community Hubs have implemented a culturally diverse staff which allows for greater opportunity for linkage and connection to community providers. Greater cultural diversity in this community allows families to be seen and increases trust. It also encourages families to seek out services within the community. The collaborative approach with Public Health nurses is a wonderful opportunity for expectant families to access health care needs and screenings. Being a parent can be very stressful at times so a place where parents can gather for play groups, create connections, ask developmental questions and normalize parenting experiences is so incredibly helpful.
Any resource that has the potential to remove barriers for families, increase healthy connections, build resilience and decrease any potential toxic stress is a sure path to emotional wellbeing for families and children.

Kind Regards,

Alison Gardey & Jen Kalsbeek
Co-Founders

EL DORADO COUNTY Library

Jeanne Amos
Library Director

On behalf of the El Dorado County Library I would like to extend our support for the Mental Health Services Act Plan. We proudly partner with the Health and Human Services Agency, the El Dorado County Office of Education and First 5 El Dorado in offering services through the Community Hub model as part of the Innovation Project.

Five supervisorial districts are represented by a Community Hub in libraries located in El Dorado Hills, Cameron Park, Placerville, Georgetown, and South Lake Tahoe. Each site has a dedicated space for promoting and delivering Hub services.

We support the Five Protective Factors by:

- Providing a fun safe place where parents can make social connections during programs and in our play areas.
- Being a trusted resource for parents and encouraging active skill-building and building parental resilience.
- Sharing child development tips at every early literacy storytime and having Ages & Stages Questionnaire kits available for check out increases parenting and child development knowledge.
- Promoting Hub services provides a foundation for concrete support in times of need.
- Empowering parents to develop strategies using the social and emotional competence curriculum we have used across programs.

Hub partners regularly attend programs to share their expertise and establish relationships that open up opportunities to intervene early to address concerns or issues that all families may face.

Outside of the sites, Hub services extend beyond our walls. Raising Readers programs are delivered at school sites with a Family Engagement Specialist and an Early Childhood Literacy Specialist who provide child development and early literacy education with resources and incentives.

Our strength is our ability to attract a wide range of families to programming and then to share a wider array of supports. All library staff continue to expand their skills and knowledge. The Library has scheduled a professional development day to help staff become more competent at in serving those with mental health issues and to create an atmosphere of kindness and compassion for all library users.

Thank you for your support of the Community Hub model which provides vital support for our families and our community.

Sincerely,

Jeanne Amos

Jeanne Amos
Director of Library Services

345 Fair Lane
Placerville, CA 95667
Phone (530) 621-5540
FAX: (530) 622-3911
www.eldoradolibrary.org

Hub Story

The creation of Hub 4 at the Georgetown Library has had a significant impact on the Divide community. Hub 4 is able to offer resources formerly unavailable in the area. Library patrons who ask about health services, food programs or other social services are introduced to a Community Health Advocate who can assess their needs and guide them through the process of obtaining services. Communication about the Hubs has spread quickly, often through word of mouth, and community members know they can visit the library for multiple needs. Children have received dental care for the first time because they signed up for the Dental Van at Storytime, families now have access to health insurance and children are able to enter kindergarten on time because Hub 4 guided the family through vaccinations, dental appointments and Kindergarten registration.

A grandfather who has custody of his 4 year old grandson was feeling lost and overwhelmed. He brought him to the library for Storytime. After the program he connected with the Community Health Advocate who helped him through the process of signing his grandson up for health insurance, bringing his vaccinations up to date, and seeing a dentist. Through Storytime at Hub 4, he learned parenting techniques and tips from the Family Engagement Specialist and made social connections with other families. He and his grandson began attending the local co-op preschool. When a new set of grandparents caring for their grandchildren began coming to Storytime, he shared his experience with them and introduced them to the Hub team, The grandfather acknowledges that having a social network, learning about child development and knowing how to seek assistance when needed has given him the confidence and skills to raise his grandson.

345 Fair Lane
Placerville, CA 95667
Phone (530) 621-5540
FAX: (530) 622-3911
www.eldoradolibrary.org

Behavioral Health Network
South Lake Tahoe

4/20/2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Subject: Letter of support for Community Hubs as part of the Mental Health Services Act Innovations Grant considered by the El Dorado County Behavioral Health Commission

Dear Behavioral Health Commission,

The Behavioral Health Network of South Lake Tahoe (BHN) is committed to working with the Community Hubs to directly improve access to timely and responsive services for the most vulnerable members of the community. The BHN is focused on achieving three "pillars" of service which we believe directly align with the purpose and intention of the Community Hub system:

1. Enabling individuals seeking services to easily access them and take ownership of their health.
2. Fostering a community of care and a support system empowering community members to make the most of the services available to them.
3. Providing safe and secure connections between a comprehensive network of service providers on a common technology platform.

We appreciate that the Community Hubs focus on relationships as key at the community level which is specifically aligned with the BHN priority focus on building "connections" based upon relationships with specific under-served community groups. Further we value the Hub attention to fostering resilient families by emphasizing the" five protective forces". This strategy works in close concert with the BHN focus on fostering resilience through mental wellness, amelioration of substance dependencies, and addressing the "whole person" by supporting individuals and families through "wrap around" social services.

The BHN is a community wide "no wrong door" model which includes active partnership with Hub Teams in connecting clients to services, especially those that support prevention, early screening, identification and referral for mental or behavioral health services as identified through consistent screening and referral practices. On behalf of the 20+ organizations, 46 licensees, and 104 BHN network members we offer our unequivocal support for these essential Community Hubs.

Michael Ward

Michael Ward, Network Director
Behavioral Health Network of South Lake Tahoe

South Lake Tahoe
Family Resource Center

April 2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Dear Commission Members,

I am writing this letter in support of the Mental Health Hub in South Lake Tahoe. Our Hub has provided support and information to our Spanish speaking community in their native language. Our Hub has provided culturally appropriate support on a wide variety of issues surrounding our community such as; mental health and services, medical and dental care options, and reading programs.

The HUB 5 has been a success for our Hispanic community. The bilingual staff have done a wonderful job at reaching out into the community ie: meeting at local community offices such as the Family Resource Center, participating and showing up at community events, soccer tournaments, Cinco de Mayo. The staff has also gone out of their way to meet our community after traditional work hours. The Hispanic community appreciates that the staff are long standing members of our community and feel welcomed.

I am pleased to support the El Dorado Community Hubs.

Sincerely,

Bill Martinez
Executive Director

3501 B Spruce Ave. * South Lake Tahoe, CA 96150 * PHONE: (530) 542-0740 * FAX: (530) 542-0397
www.tahoefrc.org
Tax ID #94-2284118

New Morning Youth & Family Services

Changing lives, Restoring hope. A tradition of caring since 1970.

April 17, 2019

El Dorado County Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Dear Commission Members:

On behalf of New Morning Youth & Family Services and the over 1,000 youth and families that we will serve this year I add my request that you continue funding support for the Community Hubs. While I will not repeat adding the number of families that the Hubs have provided services to this past year or the funding that is leveraged to help support those families who are taking advantage of the Hubs to strengthen their families I will offer my own brief perspective on just one instance where we have found the Hubs important to our efforts to bring mental health services to the community:

New Morning has been aware of limited transportation and internet access, to our families living in remote areas of our County, as barriers to accessing mental health services for children and youth in our County. When this was discussed at the Georgetown Divide ACEs meeting, it suggested that the Georgetown Divide Hub could be of assistance for the children on the Divide. What developed was a referral system where referrals for mental health services could be forwarded to the Hub and they could provide outreach to the family, and engage them through the HUB, including having our agency's Intake paperwork sent to the HUB, in which they could help the parent complete. This in just one example where a Hub was solution focused and a superb community partner.

We are all in the same focus area – trying to bring needed services to our community's youth. Please continue your support of the Hubs.

Sincerely,

David Ashby
Executive Director

ASPIRE to Excellence® carf ACCREDITED

Main Office
6765 Green Valley Rd, Placerville, CA 95667
Phone: 530.622.5551 fax: 530.622.5800
www.newmorningyfs.org

Emergency Childrens Shelter
Phone: 530.626.4190
Fax: 530.626.4193

Early Childhood Counseling Center
Phone: 530.622.5551
Fax: 530.622.5800

Pollock Pines-Camino Rotary Club
P.O. Box 88
Pollock Pines, CA 95726
www.pollockpines-caminorotary.org

April 18. 2019

EDC Behavioral Health Commission
c/o First 5 El Dorado Commission
2776 Ray Lawyer Drive
Placerville, CA 95667

Dear Commissioners,

Research tells us the higher number of Adverse Childhood Experiences (ACEs) impacts health outcomes. A 2012 Kidsdata.org report shows children in the county have two or more ACEs. The research also tells us, children living in resilient families are more likely to overcome ACEs. Community Hubs are an innovative approach to building resilient families.

Data from the 2018 Community Hub Profile shows the communities of Pollock Pines and Camion, part of Hub 3, struggle with substance abuse, mental health risks and increased health risks for Latino families. We have 359 grandparents living with their own grandchildren with 35% of those responsible for their care. The average unemployment rate is 14% and 15% of children live in poverty. We need to find new ways to reach and support our families.

Community Hub Teams work in our communities to reach families that are isolated, develop relationships and connect them to critical services.

The Pollock Pines/Camino Rotary supports Community Hubs and believes this strategy works well in rural communities.

Sincerely,

Ginger Swigart, President
Pollock Pines/Camino Rotary
gingerswigart@att.net

Tahoe Valley Elementary

OFFICE
943 Tahoe Island Drive
South Lake Tahoe, CA
96150

PHONE
530-543-2350

FAX
530-543-2362

PRINCIPAL
Christina Grubbs
M.Ed., NBCT

April 4, 2019

To Whom It May Concern,

My name is Fred Buttrick. I am a school nurse at Tahoe Valley Elementary School in South Lake Tahoe. I am writing in support of expanding the services provided by Hub 5 for the South Lake Tahoe community. I have utilized El Dorado County Health Nurses for outreach to my students' families, whether it's facilitating a transition in insurance coverage, obtaining medical or dental services.

I'm learning daily about how the integrated Hub 5 system offers a wraparound approach to helping families in need. The mental health component is especially important to hub services, as families may not be aware that help through counseling and intervention are available. 75% of the families in our student population are below poverty level income. These financial stressors directly affect our student's ability to learn and the parents' ability to help their children learn.

Teaching parents and children cognitive behavioral techniques can be a stepping stone to wellness and better overall health. The Public Health Nurse referrals at Tahoe Valley Elementary help us reach out to our families in the privacy of their own homes. Parents can open up to the nurse and share concerning issues through casual conversation, without feeling self -conscious as in a public setting.

Please consider expanding Hub 5's outreach capabilities and mental health services to better serve my students and their families.

Thank you,

Nurse Fred, RN BSN

SOAR

Where the ARTS come ALIVE!

NEWS RELEASE

Chief Administrative Office
El Dorado County

EL DORADO COUNTY WINS AWARD FOR OUTSTANDING PROGRAM

FOR IMMEDIATE RELEASE
September 9, 2019

CONTACT: Carla Hass
(530) 621-4609

(PLACERVILLE, CA) – El Dorado County's Community Hubs programs received an award from the California State Association of Counties (CSAC) recognizing it as an exemplary and innovative service to the community.

The Community Hub program is located in each of the five supervisorial districts, using the local library as a "hub" to provide prevention and early intervention services to families. The Hubs are comprised of a multidisciplinary team including a public health nurse, a community health advocate, a family engagement specialist and an early childhood literacy specialist. It is a collaborative effort between the Health and Human Services Agency, County Libraries, First Five, and El Dorado County Office of Education.

"The Community Hubs offer families with newborn children to age 18 the opportunity to learn about child development, parenting, the importance of literacy and many other issues facing families today," said Health and Human Services Agency Director, Don Semon.

The Hubs have served more than 6,000 children age zero to five and almost 5,000 parents and caregivers in the last two years. In 2018, Hubs have provided almost 900 literacy activities, nearly 200 family engagements and connected close to 900 families with health providers.

"Libraries are a natural choice to locate the Hubs because families regularly use them and feel safe there," said Library Director, Jeanne Amos. "By offering these services and information here, we connect with families and children who may otherwise not visit a government office."

CSAC's annual statewide program honors innovation and best practices in county government. This year, CSAC received 284 entries – the second largest number in the program's history. An independent panel of judges with expertise in county programs selected the award recipients.

You can learn more about the Community Hubs here:

https://www.counties.org/sites/main/files/file-attachments/eldoradoco_communityhubs93.pdf

For more information about the CSAC Challenge Awards, click here.

###

Providing safe, healthy and vibrant communities; respecting our natural resources and historical heritage.

Heather Longo <heather.longo@edcgov.us>

[MHSA] MHSA Annual Update for BOS meeting 6/25/19 at 11am

1 message

Valerie Akana <vakana@alumni.gsb.stanford.edu> Tue, Jun 18, 2019 at 5:21 PM
To: EDC COB <edc.cob@edcgov.us>, HHSA-MHSA-m <mhsa@edcgov.us>

Hello,

I would like to have this email submitted as a public comment on the MHSA Annual Plan Update which is to be heard by the Board of Supervisors on 6/25/19 at 11am. There is no agenda yet published so I don't know what the agenda item number is...

I fully support the MHSA Plan as proposed by Human Services staff. I especially want to state my support for the Community Hubs project in particular, because there has been much concern expressed by some of the Behavioral Health Commission members as to whether or not this project should be funded by MHSA funds. As I understand it, the Community Hubs project is classified as a MHSA "innovation" project and has already been blessed by the State MHSA team. Getting the State to bless an innovation project is no easy feat and I believe that we should be grateful that this project was approved and thank our staff for their expertise and skill at getting the State to approve it.

Per the State's criteria, an innovation project must advance our learning in some way and I believe the investment in the Hubs has the potential to teach us a lot. In addition, if we do not continue to move this project forward, it is possible that we will lose this funding and it will revert to the State pot. That would be a shame because I believe the Hubs can teach us a lot about how to prevent childhood trauma, and thus one of the environmental factors contributing to mental illnesses. I know that for my family in particular, had there been a Community Hubs program when my youngest siblings were growing up in a severely traumatizing environment, they might have had a better chance of developing resiliency, instead of severe mental illnesses.

My hope for the Community Hubs is that they are so wildly successful, that we eventually eliminate the need for behavioral health services in our County, at least for mental illnesses due in large part to childhood trauma. And, with the Hubs, I hope we could also identify the early signs of organic mental illnesses so that we could try to keep them from becoming severely debilitating for our kids and families. Thank you.

Sincerely,
Val Akana
Placerville

---------- Forwarded message ---------
From: **MHSA El Dorado** <mhsa@edcgov.us>
Date: Mon, Jun 17, 2019 at 1:45 PM
Subject: Re: [MHSA] MHSA update at Board meeting
To: Valerie Akana <vakana@alumni.gsb.stanford.edu>
Cc: HHSA-MHSA-m <mhsa@edcgov.us>

Hello Val,
Thank you for your email. The MHSA Annual Update will be presented to the Board of Supervisors on Tues., June 25 at 11 a.m.

Thank you,
Heather

On Fri, Jun 14, 2019 at 7:53 PM Valerie Akana <vakana@alumni.gsb.stanford.edu> wrote:
Hi All,

> Could you please refresh my memory as to the date/time that the Board of Supervisors will hear the MHSA plan update? I want to submit a letter for this item to the Board Clerk in advance of the meeting.
>
> Thank you! Sincerely, Val Akana

COUNTY OF EL DORADO

BOARD OF SUPERVISORS

330 Fair Lane
Placerville, CA 95667
(530) 621-5652
(530) 622-3645 Fax

JAMES S. MITRISIN
Clerk of the Board

Brian K. Veerkamp
District III

February 11, 2020

Mental Health Services Oversight & Accountability Commission
1325 J St. Suite 1700
Sacramento, CA 95814

It has come to our attention that the Behavioral Health Commission has raised questions as to the appropriateness of using MHSA funds to continue the Community Hubs program.

Our office has supported the program from day one and applaud the efforts of all that have been involved in making it happen. We are proponents of prevention efforts and believe helping our families be as strong and resilient as possible is critical to helping our youth become strong and resilient adults.

We strongly encourage continued support of the Community Hubs program with the MHSA funding.

Sincerely,

Brian K Veerkamp

Letters of Opposition

WELLNESS • RECOVERY • RESILIENCE

NAMI El Dorado County

National Alliance on Mental Illness

12-August-2019

To: MHSOAC Chair and MHSOAC Members

On behalf of our entire Board of Directors we wish to thank you for your leadership and service ensuring careful governance of the MHSA and MHSA funds.

> *"More than 2 million children, adults, and seniors are affected by potentially disabling mental illnesses every year in California. Thirty years ago, the State of California cut back on its services in state hospitals for people with severe mental illnesses, without providing adequate funding for mental health services in the community. Many people became homeless.*
>
> *To address this issue, Proposition 63 was approved by voters in 2004. Proposition 63, also called the Mental Health Services Act, was enacted into law on January 1, 2005. It places a 1% tax on personal income above $1 million; since that time, it has generated approximately $15 billion." MSOAC The Act*

The key words here are *disabling, severe, adequate funding, homeless*. The MHSA was passed by voters in response to the cut backs in state funding for the severe mentally ill without providing adequate funding for community mental health programs.

El Dorado County has received millions of MHSA funds to increase services to this population (~7%). While there have been significant increases in some areas; adult and child Full-Service Partnerships, Intensive Case Management for the most severe, and the Wellness Center program to address the social needs, the total number of individuals served with severe and persistent mental illness remains well below the statistical average of expected cases. For individuals and families attempting to get help, assistance, and treatment for themselves or their loved ones, the road is long and frustrating with too many interactions with law enforcement, the criminal justice system and homelessness. It is especially frustrating that we find that EDC has failed to utilize all of the available MHSA funds and may need to return unspent funds to the state. There are many reasons for this, some of which are due to the very nature of the rigid, fragmented, and restrictive mental health system as it exists everywhere as well as the challenges of a county government bureaucracy that struggles with contracts and wage and hiring practices.

The MHSA was enacted with the best of intentions. However, there are many fault lines that soon developed once counties began developing their programs. These are some of the issues:

1) **Not enough psychiatrists, trained professionals, and line staff to the meet the needs of expanding programs under MHSA statewide, with smaller counties losing out** to the better paying larger wealthier counties. The WET component was inadequate from the start and very difficult for smaller counties to utilize.
2) **Capital and Technology funding depended on county governing bodies** to incorporate zoning, budgets, and existing technology and infrastructure to expand and improve facilities and technologies in use. Small counties have limited options. This has been a long slow and confusing process, especially in utilizing funds for buildings and facilities.

3) **The Innovation Component is impossibly difficult to manage**. So many wasted hours in trying to come up with a plan that, "*never has been tried before*", affects the targeted population positively, and can be sustained.
The "Community HUB" Innovation plan currently in place is an example of innovation that only indirectly affects, if at all, the targeted population of MHSA, and is largely a broad community public health program. Worthwhile, but hardly an innovation that is going to positively improve access to treatment for the severely mentally ill. The "Hubs" were located in our county libraries, which is a logical location given they are frequented by community members needing respite from weather and the vagaries of living with a mental illness. At no time since this program was enacted, has there been provided consistent, reliable, connections to assistance for community members in psychiatric/emotional distress at the HUBS. Concerned library staff are more likely to turn to law enforcement, rather than directing individuals to the Hub station for resources, references, assistance, and empathy.

Kiosks (Mental Health Resources) were offered at no cost to all HUB locations by NAMI El Dorado County, but only two accepted the literature racks which are provided free and stocked monthly by our volunteers with high quality educational brochures and community resources. The reason given was the lack of space for the approximate 24 to 36 inch wide quality literature racks that sit on the floor.

These are the questions posed by the El Dorado County MHSA plan for the Community HUBs project:

- **Does providing services at the library reduce stigma?** *Not if the staff are still relying on law enforcement to "assist" homeless mentally ill in distress. That increases the stigma. PHN's are not provisioned at the library.*
- **Does increasing access to prevention and early intervention reduce long-term mental health costs?** *How do you measure this? SMI is not preventable, but early intervention can reduce the lifelong impact of these conditions. Early intervention should include education of symptoms and signs, crisis care, family support, and housing if needed. Most people do not think of mental illness until it occurs. Early intervention needs to address immediate needs to mitigate the long-term deleterious effects of psychosis, repeated hospitalization, loss of executive function, loss of self-esteem and confidence, and risk of homelessness. There is no indication that the HUB program provides this assistance except peripherally.*
- **Does improving coordination and integration of physical and behavioral health services increase the number of clients accessing mental health services?** *Hard to measure, but it's known that SMI impacts the physical health of individuals. A bias among providers exists that those with SMI will not take care of themselves and so may be reluctant to provide services. With the ACA in effect and the availability of Medi-Cal, getting folks to attend to teeth, eyes, metabolism, etc. should be a regular part of their care. People with serious mental illness may not be aware of their own needs and need assistance in locating providers and setting up appointments. Is this something the HUBS provide?*

- **Does case management by a Public Health Nurse increase client screening and treatment for mental health services?** *Hubs are not set up for this kind of service on a consistent basis. PHN are not necessarily skilled in MH assessments. Rather than a public nurse, a mental health clinician could be on call or rotate between Hubs to provide mental health assessments and would be less expensive and easier to recruit. The PHN's promised as part of the HUB program have not been delivered on. To that end, case management is an essential part of care for SMI, but the case management as provided by these HUBS is not likely to provide the necessary level of care. Assistance for individuals in finding providers and setting up appointments would be helpful. See above question.*
- **Does a trauma-informed approach assist in reaching the hardest to serve mental health clients?** *Having a serious mental health condition is, by its very nature, a trauma. Focusing on the secondary impacts of trauma on a vulnerable individual with a family history of mental illness would be beneficial. However,* ***seeking environmental reasons for a hereditary condition and assuming environmental*** *causes may not be helpful. Please refer to NIMH, BBRFoundation.org and our current NAMI El Dorado County Crucial Conversation brochure (https://namieldoradocounty.org/crucial-conversations-brochure-and-poster/) approved by our local psychiatrists and something we are proactively sharing with teens/tweens in partnership with select local schools.. What governance is being applied to MHSA$ recipients to ensure basic understanding about hereditary condition of serious mental illness?*
- Can Community Hubs be sustained through local planning and leveraging of resources? *As long as resources are not pulled from essential areas.* ***Behavioral Health needs to be included in leveraging community resources, but it should not be losing resources to satisfy a broad-based feel-good program that diverts dollars to areas less in need.***

The county is investing considerable MHSA funds for this program. The benefit for those dollars should be to our county's system of care for the severely mentally ill. **At this time, the HUBS Innovation Plan does not seem to have a clearly defined connection to the MHSA intent and the data gathered in the first 3 years of this program does little to provide evidence to the contrary.** Similarly, some members of our county's Behavioral Health Commission were informed that county clients would suffer if the commission did not support the plan to expand funding for the Community HUBS; this is not in line with reality. The Commission was encouraged to support the HUB funding expansion using MHSA$ as it was encouraged as a perceived better option than returning the money to the State for redistribution to other counties. We support re-distribution to adhere to the purpose set forth by MHSA.

We are asking for your governance help please.

With appreciation,

Jeanne Nelson
President, NAMI El Dorado County

Jan Melnicoe
Past President, NAMI El Dorado County

[redacted]
Namieldoradocounty.org
E2ENAMI@gmail.com
Warmline: 530-306-4101

From: Stephen Clavere <steveclavere@comcast.net>
Sent: Saturday, May 11, 2019 2:03 PM
To: Desormeaux, Wendy@MHSOAC <Wendy.Desormeaux@mhsoac.ca.gov>
Cc: Reedy, Grace@MHSOAC <Grace.Reedy@mhsoac.ca.gov>; Shah, Sharmil@MHSOAC <Sharmil.Shah@mhsoac.ca.gov>
Subject: RE: Community Based Engagement and Support Services project

Thank you for your assistance and prompt reply to my phone call last Thursday. I would like to convey to you and the INN project staff that the El Dorado Behavioral Health Commission has serious concerns regarding the viability and justification of the Behavioral Health contribution to the Community Hubs Project. In fact, we have assigned this extension request to an Ad Hoc Committee to address these very issues, which is scheduled to report their recommendations at our May meeting. I can advise you of the commission's decision shortly thereafter. Please consider our concerns as you deliberate, and let me know if you need any further information.

Steve Clavere, Ph.D.
Chair, El Dorado County
Behavioral Health Commission

From: Jeanne Nelson <f2fnami@gmail.com>
Sent: Monday, July 29, 2019 4:59 PM
To: MHSOAC <MHSOAC@mhsoac.ca.gov>
Cc: Pate, Norma@MHSOAC <Norma.Pate@mhsoac.ca.gov>; Fred Hjerpe <hjerpef@gmail.com>
Subject: Misappropriation of Innovation MHSA$ in El Dorado County; greater governance and measures requested please

Dear MHSOAC Commission Chair,

Will you please direct this to the most appropriate contact within your commission for next steps?
I have also reached out to Gavin Newsom's new Mental Health Czar, Dr. Thomas Insel in parallel.

Funds were provided to El Dorado County for Community HUBS as an Innovation project. Many concerns were raised at multiple BH Commission meetings questioning rationale for using precious MHSA$ on something we view should be funded purely by the county as part of the county's organic business evolution. But since funds were appropriated there must be governance to ensure what was promised is delivered. There is a strong county leniency tone where rules don't apply because this is an Innovation project - where they seem to believe they can learn as they go.
That said, what was promised in order to gain initial MHSA$ has not been delivered AND now additional MHSA$ are being awarded with still no course correction.
This feels very much like a non-malicious bait and switch. Nurses were promised and not delivered. Measures of mental health referrals were assured but not delivered.
Public health nurses at actual physical HUBS were assured. Instead staff workers (not nurses) have been provisioned and HUBS themselves have evolved from their original commitment.

Our affiliate has been in operation for 23 years serving El Dorado County community. This post on our website further details our concerns.

Findings from an El Dorado County grand jury investigation of MHSA$ was made public last month. We feel our county should return MHSA$ for appropriation to other counties that can demonstrate evidence that they are on-track with advertised commitments / measures.

Our little all-volunteer NAMI affiliate receives approximately 700 calls for support every year. Our newsletter has nearly 1000 subscribers and about a 50% readership rate. We are well connected with the local hospital and providers and gaining traction in the schools. Every dollar is precious and we appreciate your role in ensuring oversight and accountability.

Thank you for your consideration in advance.

Cheers,

Jeanne Nelson
President, NAMI El Dorado County
namieldoradocounty.org
FACEBOOK: NAMI El Dorado County "like us" and NAMI El Dorado "friend us"
Warm-line: (530) 306-4101

Cc: Fred Hjerpe, Co-President NAMI El Dorado County

NAMI
National Alliance on Mental Illness
El Dorado County

From: Stephen Clavere <steveclavere@comcast.net>
Sent: Tuesday, August 27, 2019 1:54 PM
To: Reedy, Grace@MHSOAC <Grace.Reedy@mhsoac.ca.gov>
Cc: Shah, Sharmil@MHSOAC <Sharmil.Shah@mhsoac.ca.gov>; Desormeaux, Wendy@MHSOAC <Wendy.Desormeaux@mhsoac.ca.gov>
Subject: RE: Community Based Engagement and Support Services project

Thank you for an opportunity to respond. With regard to your three questions:

- There is no evidence that the comments I provided during the Behavioral Health Commission (BHC) meetings were in any way incorporated into the final plan. In fact during the meetings, Health and Human Services Agency (HHSA) staff replied they were not relevant.
- Yes, I believe the serious concerns regarding the viability and justification of the project remain not only as serious obstacles to the project itself, but also as a hindrance to the reasoned and

empirically valid distribution of MHSA funds to the county as a whole in accordance to the original intent of the Mental Health Services Act (MHSA).

- Yes, the BHC did approve the MHSA update which included the Hub extension request. However, the approval appeared to have not been granted on the merits of the program as described in the attached proposal. Rather, the argument that swayed the majority of commissioners was the HHSA plea that if the project was not approved, the unspent funds would be returned to the Mental Health Services Oversight and Accountability Commission (MHSOAC), and would not be spent improving services to our Seriously Mentally Ill (SMI). So then, why not? What was not stated was the fact that the county should have been more proactive and responsive to the needs of the community, and the funds could have been spent in prior years for INN projects that would have better served the SMI. The minority commissioners, whose view I am representing, believe that in order to maintain the integrity of the MHSA, funding for ill conceived projects should not be allocated simply to avoid returning them to the MHSOAC.

Additional Information:

This project will only fund staff in Public Health Job classifications to perform Public Health duties. In addition, the extension will also fund county Education Department job classifications to perform Education Department duties. Not a single new Mental Health position will be created. For all I know, this may be a common practice throughout the State to divert MHSA funds for the expansion of other county agencies/departments without any significant statistical outcome basis. I hope not.

The extension proposal states on page 14, while acknowledging "anecdotal reports" and "limited data," that, "... the impact to mental health services is not yet fully understood." That assertion is highly inaccurate. In fact, the impact to mental health services is clearly understood. Tracking referrals are used to measure success for half of the project objectives (1,3 & 5), and is particularly focused on mental health services. The data presented on pages 6 and 7 of the proposal show a total of 48 out of 824, or 5.8% of the public health referrals were made for mental health services, with an expenditure of $672,375 ($14,000 per referral). For a county population of approximately 189,000, this represents a trickle, and is well within the statistical margin of error for that population. Therefore, the impact to mental health services is miniscule. A fiscal analysis shows that for the past four years, MHSA funds have been budgeted for 40% of the Community Hubs cost, for a 5.8% share of the referrals. If the extension is approved, this will increase to 54.5% of the cost, a vastly disproportionate return on the expenditure.

To reiterate, I represent the minority position on the commission. However, this position is shared and endorsed by the National Alliance on Mental Illness (NAMI), El Dorado. I will forward their letter in a separate email.

Steve Clavere, Ph.D.
Chair, El Dorado County
Behavioral Health Commission

NAMI El Dorado County

National Alliance on Mental Illness

12-August-2019

To: MHSOAC Chair and MHSOAC Members

On behalf of our entire Board of Directors we wish to thank you for your leadership and service ensuring careful governance of the MHSA and MHSA funds.

> *"More than 2 million children, adults, and seniors are affected by potentially disabling mental illnesses every year in California. Thirty years ago, the State of California cut back on its services in state hospitals for people with severe mental illnesses, without providing adequate funding for mental health services in the community. Many people became homeless.*
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> *To address this issue, Proposition 63 was approved by voters in 2004. Proposition 63, also called the Mental Health Services Act, was enacted into law on January 1, 2005. It places a 1% tax on personal income above $1 million; since that time, it has generated approximately $15 billion." MSOAC The Act*

The key words here are *disabling, severe, adequate funding, homeless*. The MHSA was passed by voters in response to the cut backs in state funding for the severe mentally ill without providing adequate funding for community mental health programs.

El Dorado County has received millions of MHSA funds to increase services to this population (~7%). While there have been significant increases in some areas; adult and child Full-Service Partnerships, Intensive Case Management for the most severe, and the Wellness Center program to address the social needs, the total number of individuals served with severe and persistent mental illness remains well below the statistical average of expected cases. For individuals and families attempting to get help, assistance, and treatment for themselves or their loved ones, the road is long and frustrating with too many interactions with law enforcement, the criminal justice system and homelessness. It is especially frustrating that we find that EDC has failed to utilize all of the available MHSA funds and may need to return unspent funds to the state. There are many reasons for this, some of which are due to the very nature of the rigid, fragmented, and restrictive mental health system as it exists everywhere as well as the challenges of a county government bureaucracy that struggles with contracts and wage and hiring practices.

The MHSA was enacted with the best of intentions. However, there are many fault lines that soon developed once counties began developing their programs. These are some of the issues:

1) **Not enough psychiatrists, trained professionals, and line staff to the meet the needs of expanding programs under MHSA statewide, with smaller counties losing out** to the better paying larger wealthier counties. The WET component was inadequate from the start and very difficult for smaller counties to utilize.
2) **Capital and Technology funding depended on county governing bodies** to incorporate zoning, budgets, and existing technology and infrastructure to expand and improve facilities and technologies in use. Small counties have limited options. This has been a long slow and confusing process, especially in utilizing funds for buildings and facilities.

3) **The Innovation Component is impossibly difficult to manage**. So many wasted hours in trying to come up with a plan that, "*never has been tried before*", affects the targeted population positively, and can be sustained.
The "Community HUB" Innovation plan currently in place is an example of innovation that only indirectly affects, if at all, the targeted population of MHSA, and is largely a broad community public health program. Worthwhile, but hardly an innovation that is going to positively improve access to treatment for the severely mentally ill. The "Hubs" were located in our county libraries, which is a logical location given they are frequented by community members needing respite from weather and the vagaries of living with a mental illness. At no time since this program was enacted, has there been provided consistent, reliable, connections to assistance for community members in psychiatric/emotional distress at the HUBS. Concerned library staff are more likely to turn to law enforcement, rather than directing individuals to the Hub station for resources, references, assistance, and empathy.

Kiosks (Mental Health Resources) were offered at no cost to all HUB locations by NAMI El Dorado County, but only two accepted the literature racks which are provided free and stocked monthly by our volunteers with high quality educational brochures and community resources. The reason given was the lack of space for the approximate 24 to 36 inch wide quality literature racks that sit on the floor.

These are the questions posed by the El Dorado County MHSA plan for the Community HUBs project:

- **Does providing services at the library reduce stigma?** *Not if the staff are still relying on law enforcement to "assist" homeless mentally ill in distress. That increases the stigma. PHN's are not provisioned at the library.*
- **Does increasing access to prevention and early intervention reduce long-term mental health costs?** *How do you measure this? SMI is not preventable, but early intervention can reduce the lifelong impact of these conditions. Early intervention should include education of symptoms and signs, crisis care, family support, and housing if needed. Most people do not think of mental illness until it occurs. Early intervention needs to address immediate needs to mitigate the long-term deleterious effects of psychosis, repeated hospitalization, loss of executive function, loss of self-esteem and confidence, and risk of homelessness. There is no indication that the HUB program provides this assistance except peripherally.*
- **Does improving coordination and integration of physical and behavioral health services increase the number of clients accessing mental health services?** *Hard to measure, but it's known that SMI impacts the physical health of individuals. A bias among providers exists that those with SMI will not take care of themselves and so may be reluctant to provide services. With the ACA in effect and the availability of Medi-Cal, getting folks to attend to teeth, eyes, metabolism, etc. should be a regular part of their care. People with serious mental illness may not be aware of their own needs and need assistance in locating providers and setting up appointments. Is this something the HUBS provide?*

- **Does case management by a Public Health Nurse increase client screening and treatment for mental health services?** *Hubs are not set up for this kind of service on a consistent basis. PHN are not necessarily skilled in MH assessments. Rather than a public nurse, a mental health clinician could be on call or rotate between Hubs to provide mental health assessments and would be less expensive and easier to recruit. The PHN's promised as part of the HUB program have not been delivered on. To that end, case management is an essential part of care for SMI, but the case management as provided by these HUBS is not likely to provide the necessary level of care. Assistance for individuals in finding providers and setting up appointments would be helpful. See above question.*
- **Does a trauma-informed approach assist in reaching the hardest to serve mental health clients?** *Having a serious mental health condition is, by its very nature, a trauma. Focusing on the secondary impacts of trauma on a vulnerable individual with a family history of mental illness would be beneficial. However,* ***seeking environmental reasons for a hereditary condition and assuming environmental*** *causes may not be helpful. Please refer to NIMH, BBRFoundation.org and our current NAMI El Dorado County Crucial Conversation brochure (https://namieldoradocounty.org/crucial-conversations-brochure-and-poster/) approved by our local psychiatrists and something we are proactively sharing with teens/tweens in partnership with select local schools.. What governance is being applied to MHSA$ recipients to ensure basic understanding about hereditary condition of serious mental illness?*
- Can Community Hubs be sustained through local planning and leveraging of resources? *As long as resources are not pulled from essential areas.* ***Behavioral Health needs to be included in leveraging community resources, but it should not be losing resources to satisfy a broad-based feel-good program that diverts dollars to areas less in need.***

The county is investing considerable MHSA funds for this program. The benefit for those dollars should be to our county's system of care for the severely mentally ill. **At this time, the HUBS Innovation Plan does not seem to have a clearly defined connection to the MHSA intent and the data gathered in the first 3 years of this program does little to provide evidence to the contrary.** Similarly, some members of our county's Behavioral Health Commission were informed that county clients would suffer if the commission did not support the plan to expand funding for the Community HUBS; this is not in line with reality. The Commission was encouraged to support the HUB funding expansion using MHSA$ as it was encouraged as a perceived better option than returning the money to the State for redistribution to other counties. We support re-distribution to adhere to the purpose set forth by MHSA.

We are asking for your governance help please.

With appreciation,

Jeanne Nelson
President, NAMI El Dorado County
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Jan Melnicoe
Past President, NAMI El Dorado County

AGENDA ITEM 5

Action

February 27, 2020 Commission Meeting
Identify Legislative Priorities for 2020

Summary: The Commission will consider legislative and budget priorities for the current legislative session, including:

Assembly Bill 2112 (Ramos): Gavin White, Legislative Assistant, Office of Assembly Member James C. Ramos will present AB 2112 which addresses the needs of youth at risk of suicide.

Presenters: Gavin White, Legislative Assistant, Office of Assembly Member James C. Ramos, Norma Pate, Deputy Director, MHSOAC

Enclosures (2):

1. Senate Bill 2112 (Ramos) - Introduced February 6, 2020
2. Fact Sheet - Senate Bill 2112 (Ramos) – Youth Suicide Prevention

Handout: None

ASSEMBLY BILL No. 2112

Introduced by Assembly Member Ramos
(Principal coauthor: Assembly Member Arambula)

February 6, 2020

An act to amend Section 438 of, and to add Section 438.5 to, the Health and Safety Code, relating to youth.

LEGISLATIVE COUNSEL'S DIGEST

AB 2112, as introduced, Ramos. Youth suicide prevention.

Existing law establishes the Office of the Surgeon General within the California Health and Human Services Agency, and provides that the office is responsible for specified activities, including raising public awareness on and coordinating policies governing scientific screening and treatment for toxic stress and adverse childhood events.

This bill would additionally require the office to marshall the insights and energy of specified individuals, including medical professionals and public health experts, to address the needs of youth at risk of suicide, and to establish offices to research and advise the Legislature and the agency on youth suicide and youth behavioral health.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature hereby finds and declares all of the following:

(a) Suicide is a public health crisis that has warranted response from the state.

(b) Suicide risk is especially acute for young people. Suicide is the second leading cause of death for youth ages 10 to 24, inclusive.

(c) Lesbian, gay, bisexual, transgender, or queer youth are especially at risk of suicide. For instance, lesbian, gay, and bisexual youth seriously contemplate suicide at almost three times the rate of heterosexual youth. Lesbian, gay, and bisexual youth are almost five times as likely to have attempted suicide compared to heterosexual youth.

(d) The state has sought to address the causes of youth suicide through bullying and harassment prevention and intervention by parents and teachers, but there is still more work to do to prevent youth suicide.

(e) The state has an obligation to focus resources on combating the crisis of youth suicide.

SEC. 2. Section 438 of the Health and Safety Code is amended to read:

438. The Office of the Surgeon General is hereby established within the California Health and Human Services Agency. The office shall be responsible for all of the following:

(a) Raising public awareness on and coordinating policies governing scientific screening and treatment for toxic stress and adverse childhood events.

(b) Advising the Governor, the Secretary of the California Health and Human Services Agency, and policymakers on a comprehensive approach to address health issues and challenges, including toxic stress and adverse childhood events, as effectively and early as possible.

(c) Marshalling the insights and energy of medical professionals, scientists, and other academic experts, public health experts, public servants, and everyday Californians to ~~solve~~ *do both of the following:*

(1) Solve our most pressing health challenges, including toxic stress and adverse childhood events.

(2) Address the needs of youth at risk of suicide.

SEC. 3. Section 438.5 is added to the Health and Safety Code, immediately following Section 438, to read:

438.5. The Office of the Surgeon General shall establish offices to research and advise the Legislature and the California Health and Human Services Agency on the following issues:

(a) Youth suicide, specifically adolescent and pre-adolescent suicide.

(b) Youth behavioral health, specifically as this issue relates to toxic stress and adverse childhood experiences.

O

Assemblymember James C. Ramos
40th Assembly District

[AB 2112 (RAMOS): OFFICE OF SUICIDE PREVENTION]

SUMMARY

AB 2112 creates a statewide Office of Suicide Prevention within the Office of the Surgeon General to study and address the crisis of suicide, specifically focusing on youth.

BACKGROUND

The State and Legislature have taken a variety of steps to improve access to mental healthcare and improved mental health outcomes. This includes the creation of the Mental Health Services Oversight and Accountability Commission, an independent state agency established in 2004 by voter-approved Proposition 63, the Mental Health Services Act.

In their 2019 report on California's strategic plan for suicide prevention from 2020 to 2025, the Mental Health Services Oversight and Accountability Commission (MHSOAC) made a variety of recommendation to improve policies and outcomes statewide.

In their recommendations, the MHSOAC recommended that the state develop an Office of Suicide Prevention to create visible, state-level leadership on suicide prevention.

PROBLEM

The Legislature has made significant strides in suicide prevention, however, risk of suicide and self-harm remains an issue across our state. Suicide risk is especially acute among adolescents, older adults, veterans, and LGBTQ youth and adults.

Suicide is the second leading cause of death among young people ages 15-24 in the U.S., with a nationwide survey finding in 2015 that 1 in 6 high school students reported seriously considering suicide in the previous year, and more than 1 in 12 reported attempting it.

While resources have been allocated to address this crisis, coordination of state resources has remained a challenge.

SOLUTION

AB 2112 takes a vital step in addressing the crisis of youth suicide by coordinating state resources into a statewide Office of Suicide Prevention. This Office will devote resources to studying this crisis, make recommendations to the legislature, and advise on best practices to ensure that statewide resources are used to properly affect the crisis.

By creating a statewide Office of Suicide Prevention, the legislature can target specific populations and age groups with acute suicide risk to begin to address the root causes of the crisis.

SPONSOR

STAFF CONTACT

Gavin White
Office of Assemblymember James Ramos
Gavin.White@asm.ca.gov
(916).319.2040

AGENDA ITEM 6

Action

February 27, 2020 Commission Meeting

Technology Suite (Help@Hand) Collaborative Update

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will hear a project update from the Technology Suite (now named Help@Hand) Collaborative. The Help@Hand Collaborative is a statewide project leveraging interactive technology-based mental health solutions to help shape the future and improve accessibility and outcomes to connect people with care across the state.

The focus of Help@Hand remains on the following five shared goals:
1. Detect and acknowledge mental health symptoms sooner.
2. Reduce stigma associated with mental illness by promoting mental wellness.
3. Increase access to the appropriate level of support and care.
4. Increase purpose, belonging and social connectedness of individuals served.
5. Analyze and collect data to improve mental health needs assessment and service delivery.

The Help@Hand Collaborative was initiated by Kern and Los Angeles counties and approved by the Commission on October 26, 2017.

The following counties/cities were subsequently approved to join the Collaborative:

- Mono County, approved February 22, 2018;
- Modoc County and Orange County, approved April 26, 2018;
- City of Berkeley, Marin County, Monterey County, Riverside County, San Francisco County, San Mateo County, Santa Barbara County, Tehama County, and Tri-City County, approved September 27, 2018.

In total, the Help@Hand Collaborative is comprised of twelve counties and two cities investing a total of $102 million in Innovation funds.

Presenters for Technology Suite (Help@Hand) Collaborative update:

- Sharon Ishikawa, Ph.D., MHSA Coordinator, Orange County Health Care Agency Behavioral Health Services
- Keris Jän Myrick, MBA, MS Chief of Peer and Allied Health Professions, Los Angeles County Department of Mental Health
- Jeremy Wilson, MPPA, Program Director & PIO California Mental Health Services Authority

Enclosures (2): (1) Biographies for Technology Suite (Help@Hand) Collaborative Presenters; (2) Technology Suite (Help@Hand) Collaborative Project Update.

Handout (1): PowerPoint will be presented at the meeting.

Additional Materials (1): A link to the Technology Suite (Help@Hand) Collaborative Project Update is available on the Commission website at the following URL:

https://www.mhsoac.ca.gov/helpathandprojectupdate02272020

Biographies for the Help@Hand (formerly the Technology Suite Collaborative) Multi-County Collaborative Innovation Project Update

Jeremy Wilson, MPPA Program Director and Public Information Officer (PIO) California Mental Health Services Authority (CalMHSA)

Mr. Wilson began his career in Butte County for the Department of Behavioral Health. Meanwhile, he also consulted for the Center for Applied Research Solutions, a contractor with behavioral health expertise that brought youth together with adult community leaders (appointed and elected) to reduce underage drinking. Early on in his career, Mr. Wilson honed his skill in developing public messaging campaigns for social causes and political candidates. He has worked on public mental/behavioral health programs since 2002.

Mr. Wilson went on to obtain a Master of Public Policy and Administration (MPPA) from Northwestern University. During his tenure with the Butte County Department of Behavioral Health, he served as the Mental Health Services Act (MHSA) Coordinator, Ethnic Services Manager, and Workforce Education and Training (WET) Manager and Public Information Officer (PIO). He has been recognized as a leader at the local and state level for his work in the reducing disparities and inequities. Mr. Wilson has been with CalMHSA since February 2018 and identifies as a cisgender gay man.

Sharon Ishikawa, Ph.D., MHSA Coordinator, Orange County Health Care Agency Behavioral Health Services

Sharon Ishikawa is the MHSA Coordinator for Orange County. She has 25 years of training and experience in clinical research design and data analysis, including as a Research Analyst for Community Services and Supports MHSA programs in Orange County. Sharon obtained her Ph.D. in Clinical Psychology from UCLA, completed research post-doctoral fellowships at the University of Southern California and the University of California Irvine, and served as an Assistant/Associate Project Scientist at the University of California Irvine.

Keris Jän Myrick, MBA, MS Chief of Peer and Allied Health Professions, Los Angeles County Department of Mental Health

Keris Jän Myrick is the Chief, Peer and Allied Health Professions for the Los Angeles County Department of Mental Health. Ms. Myrick was formerly the Director of the Office of Consumer Affairs for the Center for Mental Health Services (CMHS) of the United States Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA). Ms. Myrick was previously President and CEO of Project

Return Peer Support Network, a Los Angeles-based, peer-run nonprofit, the Board President of the National Alliance on Mental Illness (NAMI), and served as a consultant to the American Psychiatric Association (APA) Office of Minority and National Affairs (OMNA) Ms. Myrick is a leading mental health advocate and executive, known for her innovative and inclusive approach to mental health reform and the public disclosure of her personal story. Ms. Myrick has over 15 years of experience in mental health services innovations, transformation, and peer workforce development. An early adopter, self-identified "geek" and interest in leveraging technology to aid in mental health Recovery and wellbeing, Ms. Myrick has recently been selected to serve on the American Psychiatric Association's App Advisor Panel.

Ms. Myrick is featured in the CalMHSA documentary A New State of Mind: Ending the Stigma of Mental Illness and her personal story was featured in the New York Times series: Lives Restored, which told the personal narratives of several professionals living with mental health issues. With her unique combination of executive skills, personal lived experience in the mental health system, Ms. Myrick is an in-demand national trainer and keynote speaker , and authored several peer reviewed journal articles and book chapters. She is known for her collaborative style and innovative "whole person" approach to mental health care.

Ms. Myrick has a Master of Science degree in organizational psychology from the California School of Professional Psychology of Alliant International University. Her Master of Business Administration degree is from Case Western University's Weatherhead School of Management.

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OAC PROJECT UPDATE

December 2019

Determining if and how technology fits within the behavioral health system of care

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I. The Help@Hand Program

BACKGROUND

Help@Hand is a statewide collaborative project comprised of 14 Counties and Cities leveraging interactive technology-based mental health solutions to help shape the future and improve accessibility and outcomes to connect people with care across the state.

The 14 participating cities/counties are at the forefront of innovation to understand how technology is introduced and works, within the public behavioral health system of care. The collaborative offers the benefit of a shared learning experience that increases choices for counties/cities, accelerates learning, and adds in cost sharing.

The focus of Help@Hand remains on the five shared goals shown below. Change at the scale of this project necessitates a robust readiness and change management approach. The project team has focused on building in activities to address these areas for both the project team and the community.

Shared Goals:	1. Detect and acknowledge mental health symptoms sooner.
	2. Reduce stigma associated with mental illness by promoting mental wellness.
	3. Increase access to the appropriate level of support and care.
	4. Increase purpose, belonging and social connectedness of individuals served.
	5. Analyze and collect data to improve mental health needs assessment and service delivery.

Help@Hand intends to provide diverse populations with access to mobile applications designed to educate users on the signs and symptoms of mental illness, improve early

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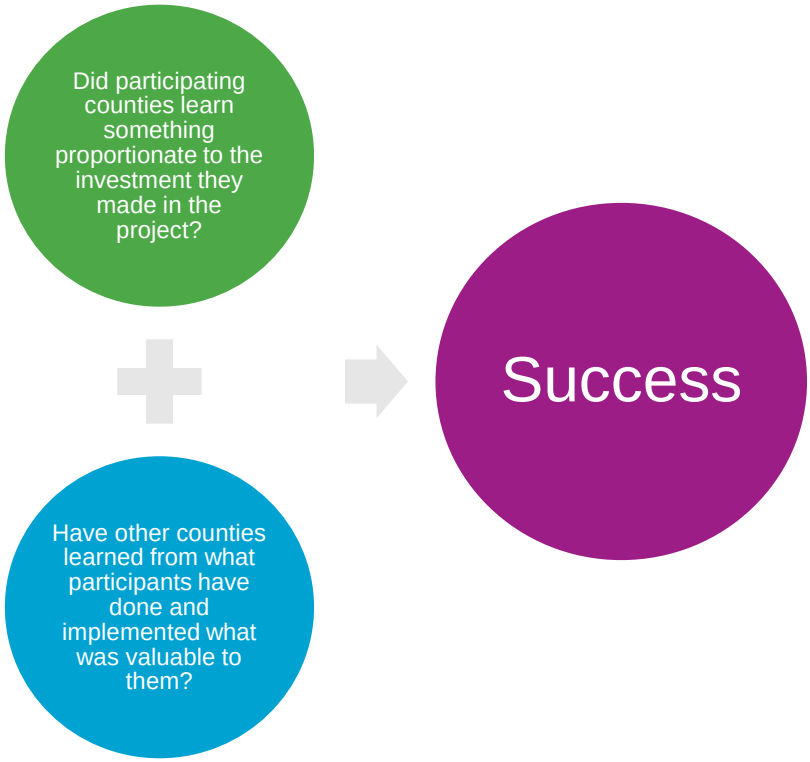
identification of emotional/behavioral destabilization, connect individuals seeking help in real time, and increase user access to mental health services when needed.

The project leads innovation efforts through peer engagement integrating those with lived experience of mental health issues/co-occurring issues throughout the project), safety & security (making sure we prioritize the safety and security of the users and their data), incorporating feedback from a variety of stakeholders (we have a lot of stakeholders with different priorities and so trying to find ways to meet the needs of most, but understanding with conflicting feedback it is not possible to meet the needs of everyone), innovative technology (always exploring if and how tech fits in the behavioral health system of care), applying the learning and incorporating lessons learned as we continue, and demonstrating progress and responsible use of resources.

Typically, we consider projects success based on whether consumer welfare was directly improved because of what a project has done. However, the test of success in an innovation project is more nuanced. Innovation is about transforming the system itself and therefore additional determinations of success include two questions:



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PARTICIPANTS

The Help@Hand Collaborative is comprised of twelve counties and two cities across the state of California. The counties/cities that are currently part of the collaboration include: City of Berkeley, Kern County, Los Angeles County, Marin County, Modoc County, Mono County, Monterey County, Orange County, Riverside County, San Francisco County, San Mateo County, Santa Barbara County, Tehama County, and Tri-City County. Collectively these geographies represent nearly one-half of the population of the state of California. Inyo County is no longer a part of the Help@Hand collaborative.

The counties/cities involved in the collaborative represent the diverse communities that exist within the state. Los Angeles County is one of the largest in the collaborative in terms of size and population while Modoc County is small, and rural with close-knit communities. Los Angeles County offers a significant contribution in terms of testing grounds, and Orange County is similar in its large consumer population. While there are unique markers for each county/city there are similarities in their target populations, and the aggregate data that each county/city can contribute to the project will help make results more robust and will help adapt and customize the interventions for the intended beneficiaries.

TARGET POPULATIONS

One element of innovation is to examine how different aspects of the technology and implementation strategies work when deployed to different settings and target populations. Cities/counties in the innovation project have leveraged the community planning process to understand the needs and desires of their local stakeholders. During this process the collaborative may learn that some of the target populations are better suited for these tech interventions than others.

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Intended Beneficiaries of Help@Hand Products

- Individuals who experience more intense mental health symptoms and struggles
- Family members with either children or adults suffering from mental illness who are seeking support
- Socially isolated individuals, including older adults at risk of depression
- Clients or potential clients in outlying or rural areas who have difficulty accessing care due to transportation limitations
- Individuals at increased risk for or in the early stages of a psychotic disorder
- Existing mental health clients seeking additional support or seeking care/support in a non traditional mental health setting
- Individuals who are struggling with or in duress from their mental health issues
- High utilizers of inpatient psychiatric facilities

Help@Hand cities and counties intend to reach these beneficiaries by accessing Transitional Age Youth (TAY), older adults and isolated seniors, monolingual communities, deaf and hard of hearing consumers, and adults being discharged from inpatient psychiatric facilities.

BUDGET

Help@Hand is a five year project funded by Prop 63 MHSA dollars, with a total budget of approximately $101 million. The budget is aligned to allocate a percentage of the total dollars for collaborative spending on shared resources, and a portion of the budget is aligned to locally directed dollars. As of 10/31/2019, approximately 18% of the total project funding has been utilized, leaving 72% of the project budget available for the

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work ahead.

Different factors contribute to the project budget beyond the technology itself. The collaborative is adapting the original budget model to align the majority of project resources at the local level and giving counties more capacity to implement their project according to their individual needs.

At the collaborative level, funding is appropriated for activities such as project management, procurement, contract management, marketing, implementation readiness, organizational change preparation and testing. These activities are needed at the collaborative level to support the overall administration of 14 separate geographic regions. Each implementation should be considered its own project. Thus, in time, the collaborative will be coordinating multiple implementations of multiple products across the state, possibly with multiple implementations within a single county.

Locally directed funds allow each county to make decisions based on their specific needs. Each county has an opportunity to implement one or more products. Local dollars can be used for activities such as marketing, implementation, technology configuration, licensing, project management, organizational change management and training to support each of the implementations.

ADMINISTRATION

CalMHSA serves as the administrative and fiscal intermediary to facilitate the program management aspect of Help@Hand including contracting with technology vendors, supporting a shared evaluation, and maximize outreach and marketing of the Help@Hand collaborative.

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Principals for collaboration are to:	Create choice and a shared learning structure for participating counties.
	Link the technologies to support a holistic treatment approach.
	Capitalize on shared learning to advance the scope, coverage and effectiveness of the suite.
	Involve end users, peers and stakeholders throughout the development and operationalizing of technologies.
	Utilize data to evaluate impact and inform services/supports for individuals and populations.
	Maintain accountability and transparency with all stakeholders.

Help@Hand also provides administrative support to counties through facilitation of collaborative requests and communication to the Mental Health Services Oversight and Accountability Commission (OAC). Previously, most county projects were designated as 3-year efforts. Through the evolution of the project and ongoing learning, counties determined a longer timeframe was better suited for projects of this scale.

A request was submitted to the OAC for extensions according to the timelines shown below.

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Extension of Project Completion Dates

County	Expense Start Date	Project Length w/extension	Extension End Date
City of Berkeley	7/1/2019	5	6/30/2024
Kern	2/27/2018	5	2/26/2023
Los Angeles	3/1/2018	5	2/28/2023
Marin	1/1/2019	5	12/31/2023
Modoc	4/26/2018	5	4/25/2023
Mono	3/1/2018	previously requested by county	10/18/2021
Monterey	1/1/2019	5	12/31/2023
Orange	4/27/2018	5	4/26/2023
Riverside	2/27/2019	5	2/26/2024
San Francisco	6/1/2019	5	5/31/2024
San Mateo	9/28/2019	3	9/27/2022
Santa Barbara	7/1/2019	5	6/30/2024
Tehama	1/1/2019	5	12/31/2023
Tri-City	1/1/2019	5	12/31/2023

EVALUATION

Experts from the University of California, Irvine (UCI) have been trained by CalMHSA's Peer and Community Engagement Manager in the Mental Health Consumer and Recovery Movement and are leading the evaluation of the state and county-level impacts related to access to care, clinical outcomes, self-reported purpose, belonging, and social connectedness, consumer's ability to identify cognitive, emotional and behavioral changes and act to address them, utilization rates, stigma associated with mental illness, comparative analysis of population level impacts (technology users vs. non-users), penetration or other unmet need metrics.

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To evaluate the outcomes, UCI is examining the following learning objectives:

1. Detect and acknowledge mental health symptoms sooner.
2. Reduce stigma associated with mental illness by promoting mental wellness.
3. Increase access to the appropriate level of support and care.
4. Increase purpose, belonging and social connectedness of individuals served.
5. Analyze and collect data to improve mental health needs assessment and service delivery.

Outcome metrics take time to yield results after deployment and utilization of the technology, therefore the evaluators have elected to also use a formative evaluation process which allows the team from UCI to look beyond outcomes to examine the progress of the project and offer suggestions along the way.

In addition, ongoing learning has occurred as an integrated part of the project. Several key accomplishments support both the progress and the learning for the cities/counties, the collaborative overall and the larger behavioral health community.

UCI has identified control cities/counties for each of the participants to support outcomes evaluation. Market surveillance is conducted on an ongoing basis to understand the technology landscape and products available.

The evaluation team publishes findings on a regular basis to the collaborative and individual counties, and meets quarterly with their Advisory Board. The last advisory board meeting was held December 13, 2019. A Year 1 Evaluation Report will be available in the first quarter of 2020.

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II. Stakeholder Engagement

STAKEHOLDERS

Help@Hand has embraced the participation of stakeholders in the project and has adopted many ways of engaging stakeholders throughout the work. The Peer and Community Engagement manager has attended and presented at multiple venues reaching over 300 stakeholders, including those listed in the table below.

Digital Mental Health Literacy Sessions

June 24, 2019	• MHSA Stakeholder Meeting Orange County
July 17, 2019	• Kern County MHSA Stakeholder Meeting & Peer Meeting
July 24, 2019	• Tehama Recovery Center
July 30, 2019	• San Mateo Older Adults Workgroup
July 31, 2019	• San Mateo Transition Age Youth Workgroup
August 9, 2019	• Marin County Older Adult and Provider Meeting
August 9, 2019	• San Francisco Transwomen Support Group
August 15, 2019	• Tri City Peer Wellness Center

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Digital Mental Health Literacy Sessions, continued

In addition, CalMHSA's Help@Hand team has also supported some of the counties in facilitation and materials for local stakeholder meetings to provide updates on the Help@Hand project. The team attended both Orange and Los Angeles County meetings, and in addition to presenting project background and updates, also engaged stakeholders directly to obtain feedback on project marketing and branding. Additionally, meeting materials and handouts were created for Modoc County stakeholder meetings.

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ENGAGEMENT PLAN

In addition to the local stakeholder meetings, Help@Hand published the first Quarterly Stakeholder Update report September 30, 2019. This is an important step not only to improve visibility into the project and help answer questions for stakeholders, it also creates a channel for stakeholders to receive the latest updates on the project and have a voice into the work by submitting questions to be updated in future reports.

Going forward, Help@Hand will continue to provide stakeholder updates on a quarterly basis. In addition to the written reports, Help@Hand will also offer a regular webinar where stakeholders can hear directly from project participants to understand more of the work that is happening throughout the project. The first webinar is being planned for February 2020.

Links to webinars and other events can be found on the CalMHSA webpage located at https://calmhsa.org/programs/innovation/, and upon launch, on the Help@Hand webpage https://helpathandca.org/.

Help@Hand Stakeholder Report

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PEERS

Peers play an integral role within the project. The vision of the Peer Role in Help@Hand is to incorporate Peer input, expertise, knowledge, and lived experience at all levels of the project, and to support the use of the apps through Peer outreach and training. As this is a multi-county effort, there are several partners to support the project from outreach and engagement, app development and customization, project management, and evaluation.

The Peer component of the project holds significant importance as it:

- Creates transparency around basic cautions, clarity about user choice, and highlighting that technology does not replace in-person mental health services offered
- Provides clarity on the project definition of peers, roles, and serves as an example of a peer staffing ladder
- Supports collaboration of Peer Leads across the state is important to project learning, connection, and problem solving
- Responds to county/city community stakeholder specific needs by developing digital mental health literacy curriculum will support project learning and stakeholder's ability to make informed choices
- Trains the Peer Workforce to facilitate digital mental health literacy sessions will keep the learning at the local level and sustainable
- Trains project partners on Peer culture, experience, and history supports better project integration
- Integrates consumer expertise and voice in evaluation enhances the work
- Incorporates lived experience and perspective on how possible future technology can help the project be responsive to consumer needs

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Help@Hand Peers

In an effort to include voices of those with lived experience of mental health issues/co-occurring issues that will be supporting the work for Help@Hand project, Kelechi Ubozoh developed the Help@Hand Peer Model. This model provides clarity about the definition of a Peer, roles of Peers on the project, and activities and areas where peers should provide direction, input, and insight.

The model was also meant to be responsive to community stakeholders who expressed concern about the role of peers and overall inclusion. Each of the counties and cities are at different places adopting the peer model. However, 12 out of 14 counties have either contracted out to a community based-organization with Peer representatives or directly hired peers at their agencies.

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III. Accomplishments

PROCESS

Preparation and readiness are critical success factors that support product implementation. While these processes may feel cumbersome at times, the project lessons learned and industry best practices speak to the benefit of the foundational work that will drive project success. The following processes are examples of this important foundational work.

Roadmap: Strategic Priorities

A Roadmap Workgroup was formed to identify and make recommendations on the strategic priorities which would best align focus across the collaborative and accelerate progress. The strategic priorities were approved by the Help@Hand leadership in August 2019. From there the collaborative was engaged to identify and prioritize tactics to achieve the priorities. The tactics are in various stages, with most in progress and many near completion. The collaborative will revisit the roadmap during the next workshop planned for February 2020.

Help@Hand Strategic Priorities

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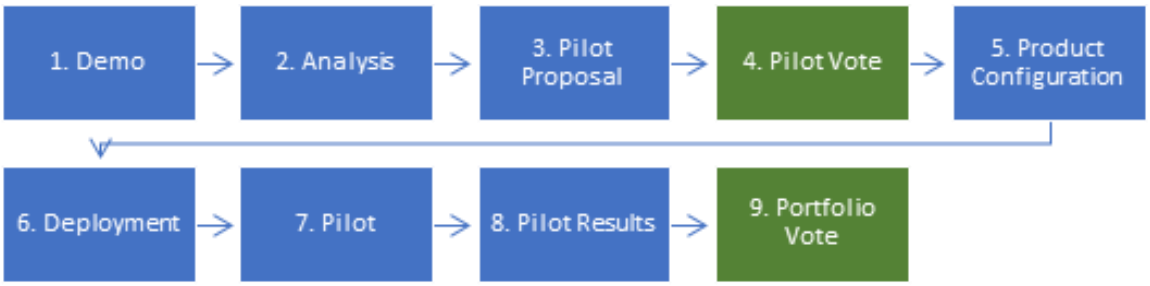
Structure: Pilot > Portfolio

Product alignment and selection is a significant milestone for county implementation. Counties need to comfortably explore products without the constraint of selecting a product before they know it will be a good fit for the unique conditions of the collaborative. To facilitate this, Help@Hand developed a phased process of taking products from a pilot stage to an offering in the Help@Hand portfolio of technology. The figure below outlines the high-level steps including finding the right fit for counties, needs analysis, development of a pilot proposal to define and measure success, configuration of the product to meet county needs, pilot launch and execution, pilot results report, and a collaborative vote as to whether a product is added to the Help@Hand portfolio of technology. This process creates alignment in understanding and selection of products as well as clarity for the product vendors and helps give stakeholders an understanding of how products are selected.

Help@Hand Pilot to Portfolio Process



Readiness

Implementation success is the result of many different factors, one of which is readiness. Several processes and decisions contribute to a successful readiness approach, including product selection, organizational change management (OCM), and risk and liability analysis. Help@Hand created templates and facilitated training sessions to introduce and support cities/counties in completing these inputs for their implementation. While each has been simplified as much as possible, thorough completion of the templates requires a commitment and level of effort from the cities/counties as well as subject matter expertise from Help@Hand and others within their local infrastructure.

The Fit-Gap Analysis assists counties in determining their needs and selecting the product that best aligns to the needs. The OCM plan addresses the human aspects of

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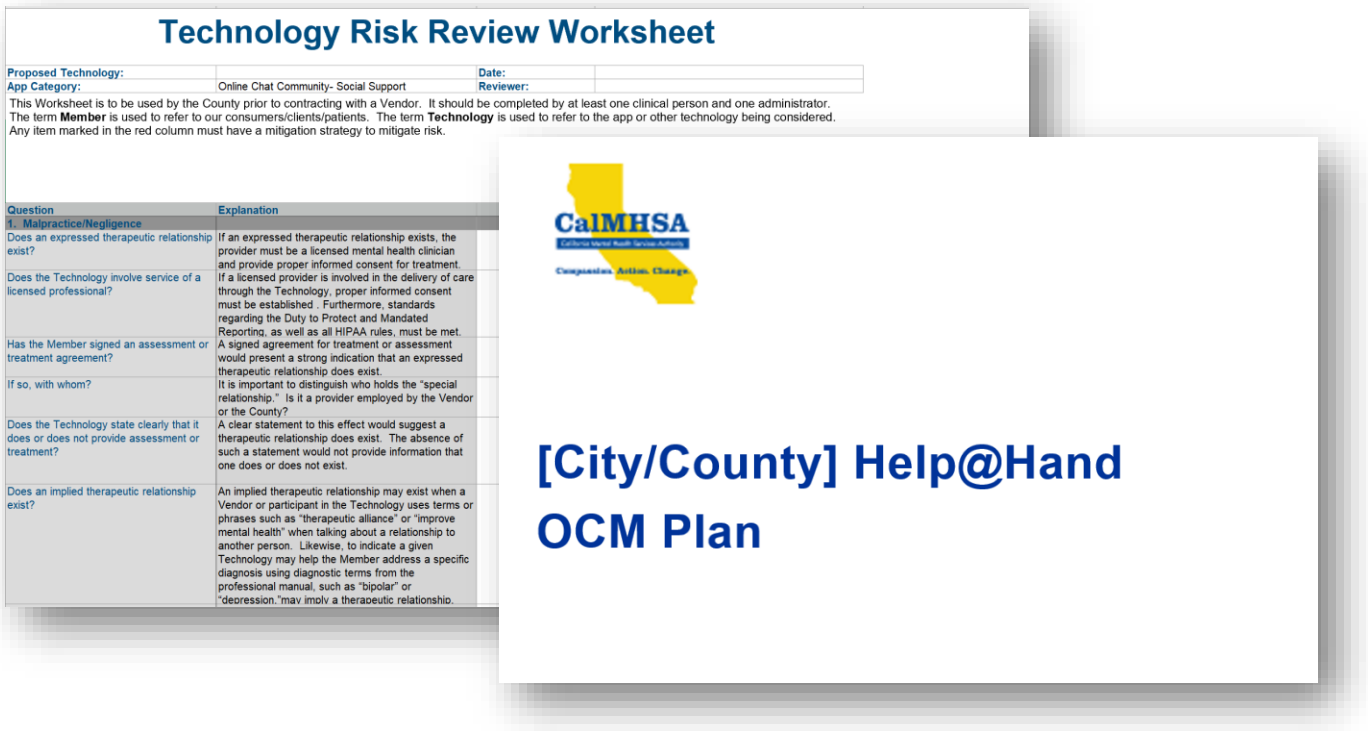
implementation, including leadership, communication, training, and process changes within the city/county. Risk and liability analysis supports the identification and mitigation of the inherent risk associated with technology and innovation.

Examples of Help@Hand Readiness Templates



RFSQ

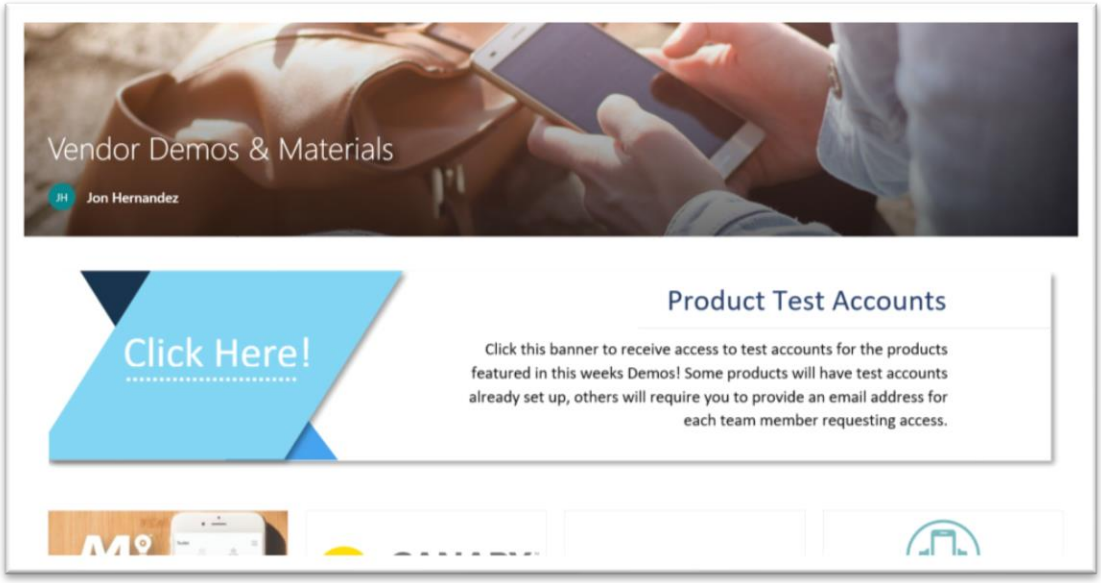
In September, Help@Hand launched an RFSQ (Request for Statement of Qualifications) allowing additional technology vendors to apply to be part of the Help@Hand project. The procurement was open through October 7, 2019. During the 30-day window, 112 applicants submitted responses through the procurement.

The applicants were reviewed by a panel of judges with a variety of backgrounds including experts in technology, digital health solutions, mental health, and Peers. The judging process took place between October 14th and 31st. Each application was reviewed by at least three judges with different expertise and scored against categories such as strength of match, current market validation, product fit in public health system, product capability to address behavioral health, technical and professional standards, scalability, product presentation and content are recovery oriented.

As a result of the scoring 93 vendors were qualified for pilot consideration. Product demonstrations for the top 16 products have been hosted for the entire collaborative.

Collaborative members have access to a portal where county teams obtain materials provided by the vendors to assist their product selection.

Help@Hand RFSQ Portal on SharePoint



MARKETING AND BRANDING

Marketing and outreach are essential elements of the Help@Hand effort as they support the overall awareness, adoption and sustainability of the project and products. As there are multiple activities and timelines to support this work, the Help@Hand marketing plan provides a strategic roadmap for marketing activities for the overall statewide brand, as well as for pilot and portfolio implementations. Help@Hand engaged expert guidance to develop a thoughtful and focused brand concept which includes a logo, graphic illustrations and color scheme.

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Help@Hand Branding Guidelines

Brand development was informed by many activities including the following:

- Conducted market analysis and research of current mental wellbeing apps
- Held two message mapping sessions: one with Cohort 1 counties and one with Cohort 2 counties
- Held focus groups with target populations on conceptual strategies
- Key informant interviews with Help@Hand project members
- Exploration of naming options
- Presentation of preliminary brand names to project leadership
- Integration of feedback from stakeholders on preliminary brand names
- Review of newly created vision statement and other project materials
- Development of new potential brand names and concepts based on the above-mentioned steps
- Selection and approval by Help@Hand leadership

The Help@Hand brand concept is intended to appeal to the wide-ranging audiences the counties hope to engage. All components are friendly, approachable, and designed to reinforce the positive message behind reaching out for support.

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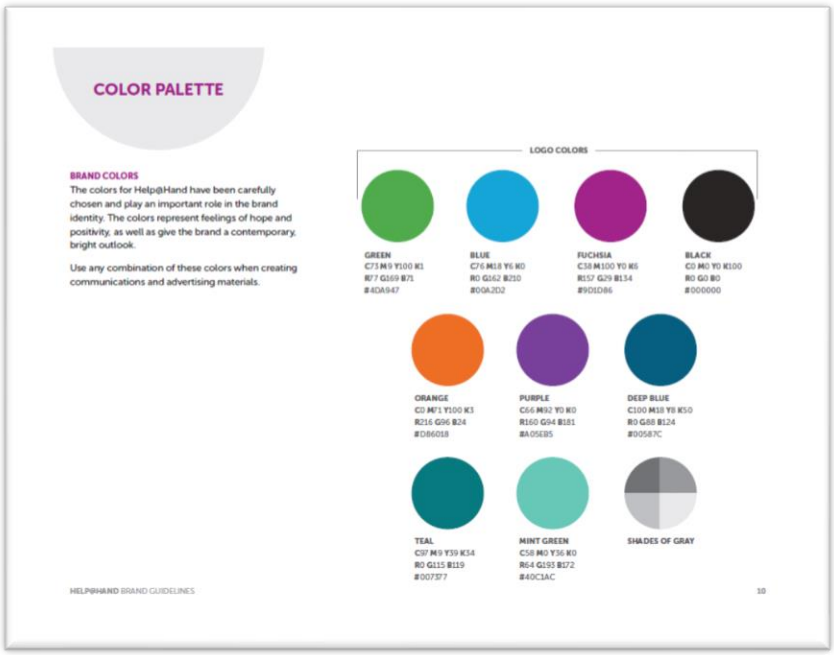
The colors for the Help@Hand brand have been carefully chosen and play an important role in the brand identity. The colors represent feelings of hope and positivity, as well as give the brand a contemporary, bright outlook.

Excerpt from Help@Hand Brand Guidelines



The theme within the marketing plan includes a wide variety of hands and arms shown reaching for support as shown in the image of the Help@Hand webpage as shown below.

An overall marketing strategy and draft plan was developed to outline recommended and optional activities to support the outreach and engagement. Cities/counties will select marketing and engagement activities from the available options as part of implementation planning.

Another key component of marketing and outreach is a website which allows stakeholders to access information about the Help@Hand project. With input and support from project Peers, stakeholders and the collaborative, a landing page has been developed to give Help@Hand a web presence. Cities/counties have the opportunity to create sub-pages with content unique to their implementations using local dollars. The webpage will be live by 1/31/2020 and can be accessed at https://helpathandca.org/.

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Help@Hand Webpage

PEERS

- Support UCI, the Project Evaluator, to facilitate a Peer Panel at their Stigma Conference to include consumer expertise in their approach to measuring stigma
- Ensure Peer Judges review all of the New Technology applications

Peer Summit workshops were held in Northern and Southern California. Peers and mental health advocates highlighted the need for education on digital mental health literacy for mental health consumers and community stakeholders to better understand the unique needs of each community and further engage them in the project. Help@Hand partnered with counties to engage their community members to share their concerns and needs around technology to support the development of Digital Mental Health Literacy Curriculum.

Digital mental health literacy education will help support decision making about technology usage, provide insight on security and privacy, and a better understanding of how to engage in the digital world.

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From June to August 2019, Help@Hand facilitated community stakeholder sessions in 11 of the 14 participating counties/cities reaching over 300 community stakeholders.

Findings and outcomes from these meetings will be used to inform the Digital Mental Health Literacy curriculum. This important curriculum will be provided not only to the Help@Hand counties, but will be made available to the public at large.

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IV. Learning

Protocols and practices that we are learning from this project will help future technology implementations within this project and beyond.

ALIGNMENT

Although counties desire to engage collaboratively, the diverse needs of their infrastructure and populations they serve demand much of their decision-making be driven locally, rather than jointly with other members of the collaborative. Therefore, the project sought guidance from a financial strategist to develop a budget model that has a greater emphasis on local decision-making as described earlier in the financial section. The model was finalized in December 2019.

CONTRACT LANGUAGE AND TEMPLATES

To help address the digital landscape, Help@Hand engaged digital legal expertise to assist in developing contracts and supporting documents that reflect the current digital environment, including aspects such as pricing, product development, ownership, data, security, and other factors.

TECHNOLOGY

Help@Hand has learned more than two technology options are needed to meet city/county needs. Mindstrong was previously piloted in Kern County, and is currently being piloted in a limited way in Los Angeles and Modoc counties. A different variation of the product is expected to be deployed in Orange County starting in January 2020. 7 Cups no longer has a contract with the project.

Diverse needs and target populations require a broad range of options to explore before implementing a specific product. Counties have widely varying levels of technical staff and consumers. Counties are helping each other learn the important factors of technology, but the technology vendors need to be educated on the city/county perspective and the consumer movement.

Translating tech language to non-tech language is challenging but vital. Describing legal and technology language at a 6th grade reading level poses a challenge. Help@Hand

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has developed documents that provide initial disclosures and basic cautions for users of technologies written at a 6th grade reading level and will be shared with all users prior to engaging with any of our technology offerings.

Social media - Technology changes quickly and public perception of technology is very heavily influenced by media. Additionally, counties use of social media varies significantly (from none to extensive) and not all have the infrastructure to maintain responsiveness and manage crisis that may be directed to social media channels.

Help@Hand has developed a crisis response protocol that provides a step by step process for handing off a potential crisis to the county where it will then be addressed by the county's existing crisis response system. This protocol requires the vendors to develop a method for identifying a potential crisis and initiating a paper trail which will be closed by a designee within the county.

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V. Looking Forward

PILOTS

Counties are eager to begin piloting the newly vetted technology however not every available technology will work for each of the counties. Determining the right fit for each county is a significant learning from Cohort One and the project has taken great care in establishing a right-fit process to help counties navigate the options. As counties are evaluating their options and determining fit, preliminary data indicates as many as five counties will be engaged in pilots in the first quarter.

DIGITAL MENTAL HEALTH LITERACY CURRICULUM

Technology is not a part of many consumers' daily lives thus creating a gap in understanding the technology and how it applies to their lives. To remedy this challenge, Help@Hand is working with subject matter experts to develop digital mental health literacy curriculum to expand knowledge in this area and provide a service to the state overall.

Curriculum is being developed based on the learnings from digital mental health literacy workshops and industry and academic best practices. Material is expected to be available soon. Help@Hand Peers will assist in delivering this training throughout the project, and content will also be accessible to the general public.

STAKEHOLDER ENGAGEMENT

The voice of stakeholders throughout the project has been and will continue to be a critical component. Help@Hand will continue to produce quarterly stakeholder updates. In addition, the project is eager to offer its first webinar update which will be hosted in February 2020.

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AGENDA ITEM 7

Action

February 27, 2020 Commission Meeting
Innovation Incubator Update

Summary: The Chief of Innovation Incubation will provide an update to the Commission on the incubator's projects and the process underway to identify additional projects.

Background: In 2018 the Legislature authorized the Commission to establish an innovation incubator and allocated $5 million in one-time funds to work with counties to reduce the potential for criminal justice involvement among people with mental health needs.

The Commission has allocated about half of those funds to support three multi-county collaboratives. The Commission has been assessing opportunities for additional collaboratives.

The presentation will describe how this project contributes to the Commission's goal of transforming the mental health system, provide an update on the current projects and the opportunities for additional projects to support system-level improvements.

The Commission at its April meeting will review and potentially approve the outlines for the additional projects.

Presenters: Jim Mayer, Chief of Innovation Incubation.

Enclosure: (1) Memo to county behavioral health directors and MHSA coordinators regarding additional incubator projects (Dated January 30,2020.

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

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

LYNNE ASHBECK
Chair
MARA MADRIGAL-WEISS
Vice Chair
TOBY EWING
Executive Director

January 31, 2020

To: County Behavioral Health Directors & MHSA Coordinators

From: Toby Ewing, Executive Director

Subject: Initiating additional multi-county collaboratives

Summary

The Mental Health Services Oversight and Accountability Commission is seeking to initiate additional multi-county collaboratives with the potential to reduce criminal justice involvement among people with behavioral health needs. The Commission initiated three collaboratives in 2019 and has identified additional ways to help counties improve their performance and develop the capacity for system learning and innovation. The Commission is seeking feedback on these additional opportunities and is prepared to work with county behavioral health officials who would like to tailor a new collaborative to address their priorities.

The MHSOAC Innovation Incubator

The Mental Health Services Act was designed to drive the transformational change required to significantly reduce the costly, disabling and heartbreaking consequences of unmet mental health needs. The innovation component of the act enables transformation by requiring counties to dedicate 5 percent of MHSA funds to testing new approaches that increase access to services, improve the quality of services and outcomes, and promote interagency collaboration.

To catalyze and support innovation, the Commission, in partnership with several counties, has initiated multi-county collaboratives designed to improve existing practices and develop new approaches with the potential to improve outcomes statewide. The collaboratives are supported by planning grants from the Commission that in most cases are linked with county investment of MHSA innovation funds.

The incubator is an innovation by itself. In 2018, the Legislature authorized the Commission's Innovation Incubator and directed it to initially focus on supporting collaboratives with the potential to reduce criminal justice involvement among those with mental health needs. State policymakers are increasingly concerned about the expensive downstream impacts – including a swollen caseload of defendants who have been declared incompetent to stand trial, and disproportionately high incarceration rates for people with unmet mental health needs.

The Commission was allocated $5 million to work with counties to prevent people with mental health needs from becoming involved in the criminal justice system. At the same time, the Department of State Hospitals was allocated $100 million to distribute to counties to increase community-based services as a way to curb growing caseloads of defendants found incompetent to stand trial. As described below, this is just one of many opportunities to align activities to achieve sustainable improvements.

In 2018, the Commission conducted a series of public engagement and project design sessions to improve the agency's overall role in helping county behavioral health departments and their community partners design, execute and evaluate innovation projects. Those sessions also informed a strategy for piloting the Innovation Incubator as a statewide support mechanism.

The Commission and several partnering counties launched three incubator projects in 2019. All three involve multiple counties participating in learning collaboratives with expert technical assistance and staff support:

- **The Data Driven Recovery Project**. Five counties are working together to link criminal justice and behavioral health data to better understand the pathways and needs of individuals with mental health needs in the criminal justice system. The counties are building capacity to deploy data-informed practices, as well as to pilot new strategies to improve outcomes developed from Sequential Intercept Models. The counties formed a community of practice to share ideas and implementation issues, as well as solve technical problems and program code.
- **Full-Service Partnerships**. Six counties are evaluating their Full-Service Partnerships to assess how well the "whatever it takes" approach is serving clients and how they can improve services and coordination among agencies to improve outcomes, especially criminal justice involvement and homelessness. Another 20 counties are participating in a "learning community" on FSP best practices.
- **Psychiatric Advanced Directives.** Three counties are working to deploy advanced directives as a way to improve the response to individuals who are in crisis from law enforcement, as well as physical and behavioral health workers.

Opportunities for Additional Innovation

The Commission is exploring additional multi-county collaboratives to be launched in early 2020. The Commission is interested in projects that have the characteristics of transformational change, including: **1) integration** of funding, data and services; **2) capacity** for continuous improvement in productivity and outcomes; and, **3) sustainability** of leadership, management and funding. Some examples:

1. Projects that can reduce incarceration, as well as one or more of MHSA's other "negative outcomes" (i.e. suicide, unemployment, prolonged suffering, homelessness).
2. Projects intended to reduce the length of incarceration and future criminal involvement, and have a mechanism for calculating quantitative and qualitative costs and benefits.
3. Projects that integrate technologies, best practices and process improvements to produce more efficient delivery systems so savings can be reallocated to sustain services with available resources.
4. Projects that link and leverage one-time funding with ongoing funding, and evaluate and refine services to achieve a financially sustainable model by demonstrating cost avoidance, reallocating available budget dollars, shifting costs to federal entitlement programs, or other strategies.
5. Projects that develop formal cross-sector partnerships to capture system-scale savings or benefits and produce budget analytics and a funding model for financial sustainability.

The Commission sees a particular opportunity to develop learning collaboratives among counties with significant one-time funds to address homelessness and/or criminal justice involvement among people with mental health needs. While these funds were directed to reduce a surging homeless population

and the number of people who are incarcerated without having been convicted of a crime, the unmet needs are not new and will not be met when the one-time funds are expended. One-time funds include:

- Pretrial Pilot Program grants from the Judicial Council
- Funding from the Department of State Hospitals to divert those found incompetent to stand trial or likely to be found incompetent on felony charges into community-based services
- No Place Like Home grants from the Department of Housing and Community Development
- Justice Assistance Grants from the Board of State and Community Corrections
- Homeless service grants from the Department of Health Care Services and the Homeless Coordinating and Financing Council

Possible Additional Incubator Projects

Based on conversation with state and local officials, policy analysts and technical experts, the Commission has identified the following specific opportunities as a starting point for interested counties to engage and develop projects they would like to pursue.

1. **Mental health screenings and referral to services.** The Judicial Council of California awarded $75 million to 16 court programs for projects that incorporate the use of pretrial risk assessments to inform judges' pretrial release decisions. Some 60 percent of jail inmates have not been sentenced to a crime and may be incarcerated due to their inability to afford bail. This pilot encourages release decisions to be based on the defendant's risk to commit new crimes or fail to appear in court; behavioral health needs are not typically assessed with the pretrial tools. Early jail-based screening and service referrals for behavioral health issues may result in increased compliance with pretrial release conditions and decrease the amount of time individuals with behavioral health needs are incarcerated. Some of the participating counties also are receiving funding from the Department of State Hospitals for mental health diversion programs, creating the opportunity for a cohort of counties that, in addition to the risk-related screenings, could provide behavioral health / mental health screenings, link to services and appropriately prioritize diverted individuals. Universal screening and assessment are recommended for counties participating in the Stepping Up initiative,[1] and Calaveras and San Luis Obispo counties have already been recognized for their work on this.[2]

2. **Long-term and sustainable funding models.** Many public agencies struggle to move funding from low-performing strategies to high-performing strategies and from expensive "downstream" responses to cost-effective "upstream" interventions. Counties also struggle to meet MHSA expectations that effective innovation-funded programs will be sustained with other ongoing funds. And more broadly, local governments struggle to sustain programs funded by limited-term grants. With significant one-time money available now, counties could be developing ways to assess what is providing the greatest value and sustain those programs. Among the options:

    a. **Planning tools.** Develop a complete understanding of the fiscal implications of caseloads, program effectiveness and financial liabilities to encourage long-term and system-scale investments in new capacities and better services. The California Association of County Executives and Stepping Up California developed a brief on this opportunity and planning

[1] https://stepuptogether.org/wp-content/uploads/Next-Phase-Two-Pager_FINAL.pdf
[2] https://stepuptogether.org/innovator-counties

tools are available from CSG's Justice Center.[3] Words to Deeds also has explored and encouraged such efforts.

b. **Budgeting tools**. Develop the good "fiscal hygiene" to track costs, cost avoidance, and other benefits, making it possible to link performance and evaluation information with budgeting decisions. The civic sector organization Social Finance has worked with governments to develop these practices.

c. **Fiscal tools.** Develop financing and service models to shift costs to federal entitlement programs, leverage flexible funds like MHSA, and use discretionary funds among inter-agency partners to shift spending from low value to high value.

3. **Supportive housing / service improvement and financial sustainability plans.** No Place Like Home funds, along with other funding to address the homelessness crisis, are providing new opportunities to address the critical issues related to housing and support services. However, the funds are not adequate to meet the entire need and are of limited term. Counties could explore how to use one-time funding for system improvements with the greatest benefits that can be sustained over time with available ongoing funds.

4. **Data Integration.** A number of larger counties are using Whole Person Care funds to develop integrated data systems for case management, program management and evaluation, as well as policy development and budgeting. A number of counties have expressed an interested in making sure their data systems enable them to identify and better manage the needs of those with mental health needs who are involved, or at risk of being involved in, the criminal justice systems.

5. **Continuum of Interventions.** The authority of AB 1810/SB 215 to divert individuals with mental health needs, along with the various funding streams addressing diversion and homeless-related issues, provides an opportunity for counties to develop more integrated service systems based on the Sequential Intercept Model – from crisis intervention teams to collaborative courts to services during re-entry. Counties – working through a collaborative and supported by expert technical assistance – could integrate and augment programs into a coordinated strategy that could be sustained beyond one-time funds.

Proposed Timeline

The Commission staff will engage with county behavioral health and other potential partners in February to gather feedback on these and other options and to identify potential county partners interested in helping to design and lead a multi-county collaborative.

In March and April, the Commission seeks to develop grant agreements and associated contracts for projects that would run through June 2021.

All counties are eligible to participate in a multi-county collaborative. If you have questions or are interested in participating in a project, please contact Sharmil Shah at Sharmil.Shah@mhsoac.ca.gov.

[3] Available online at: https://csgjusticecenter.org/mental-health/publications/integrated-funding-to-reduce-the-number-of-people-with-mental-illnesses-in-jails-key-considerations-for-california-county-executives/