WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Teleconference Meeting
April 23, 2020
9:00 AM – 11:00 AM

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

Call-in Number: 1-800-369-1840
Participant Passcode: 4380355

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

NOTICE IS HEREBY GIVEN that the Mental Health Services Oversight Accountability and Commission (the Commission) will conduct a **teleconference meeting on April 23, 2020**.

This meeting will be conducted pursuant to Governor Newsom's Executive Order N-29-20, issued March 17, 2020, which suspended certain provisions of the Bagley-Keene Open Meeting Act during the declared State of Emergency response to the COVID-19 pandemic. Consistent with the Executive Order, in order to promote and maximize social distancing and public health and safety, this meeting will be conducted by teleconference only. The locations from which Commissioners will participate are not listed on the agenda and are not open to the public. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

DATE: Thursday, April 23, 2020

TIME: 9:00 a.m. – 11:00 a.m.

TELECONFERENCE ACCESS:*

Dial-in Number: 800-369-1840
Participant Passcode: 4380355

Public Participation: The telephone lines of members of the public who dial into the meeting will initially be muted to prevent background noise from inadvertently disrupting the meeting. Phone lines will be unmuted during all portions of the meeting that are appropriate for public comment to allow members of the public to comment. Please see additional instructions below regarding Public Participation Procedures.

***The Commission is not responsible for unforeseen technical difficulties that may occur in the audio feed.**

PUBLIC PARTICIPATION PROCEDURES: All members of the public shall have the right to offer comment at this public meeting. The Commission Chair will indicate when a portion of the meeting is to be open for public comment. **Any member of the public wishing to comment during public comment periods must press *1 on their phone.** Pressing *1 will notify the call moderator that you wish to comment, and you will be placed in line to comment in the order in which requests are received by the moderator. **Please be sure to unmute your phone before pressing *1.** When it is your turn to comment, the moderator will unmute your line and announce your name. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

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

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 Those with Disabilities

- Pursuant to the American with Disabilities Act, individuals who, because of a disability, need special assistance to 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.

AGENDA

Lynne Ashbeck
Chair

Mara Madrigal-Weiss
Vice Chair

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.

9:10 AM **Roll Call**

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

9:15 AM **Action**

1: Approve February 27, 2020 MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the February 27, 2020 meeting.

- Public Comment
- Vote

9:20 AM **Action**

2: Award Mental Health Student Services Act (MHSSA) Grants

Presenter: Tom Orrock, Chief of Stakeholder Engagement and Grants

The Commission will consider awarding MHSSA grants to the highest scoring applications received in response to the Request for Applications under the MHSSA to support School/County Partnerships in the implementation of programs described in the Act.

- Public Comment
- Vote

9:45 AM **Action**

3: Response to COVID-19

The Commission will discuss the impact to county mental health programs and consider specific actions in response to the COVID-19 pandemic.

- Public comment
- Vote

11:00 AM **Adjournment**

AGENDA ITEM 1

Action

April 23, 2020 Commission Meeting Teleconference

Approve February 27, 2020 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the February 27, 2020 Commission meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None.

Enclosures (2): (1) February 27, 2020 Meeting Minutes, (2) February 27, 2020 Motions Summary

Handouts: None.

Proposed Motion: The Commission approves the February 27, 2020 meeting minutes.

Mental Health Services
Oversight and Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM
Governor

Lynne Ashbeck
Chair
Mara Madrigal-Weiss
Vice Chair
Toby Ewing, Ph.D.
Executive Director

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
February 27, 2020

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

Additional Public Location

State Capitol
Room 2082
Sacramento, CA 95814

866-817-6550; Code 3190377

Members Participating:

Lynne Ashbeck, Chair
Mara Madrigal-Weiss, Vice Chair
Mayra Alvarez
Jim Beall (via teleconference)
Ken Berrick
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
David Gordon
Tina Wooton

Members Absent:

Reneeta Anthony
John Boyd, Psy.D.
Wendy Carrillo
Gladys Mitchell
Khatera Tamplen

Staff Present:

Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Technology
Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations

[Note: Agenda Items 1 and 7 were taken out of order. These minutes reflect these Agenda Items as taken in chronological order and not as listed on the agenda.]

CALL TO ORDER AND WELCOME

Chair Lynne Ashbeck called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:05 a.m. and welcomed everyone.

Chair Ashbeck reviewed the meeting protocols.

Meeting Calendar

Chair Ashbeck stated today will be the last meeting in this location for the remainder of 2020 as the 17th floor will be under construction. Future meetings will be held at alternative sites around the state.

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. Waruguru Ndirangu introduced herself.

Consumer/Family Voice

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

Hector Ramirez shared the story of living with the diagnosis of autism, bipolar 1, and posttraumatic stress disorder (PTSD), with underlying depression. He stated he was taken away from his family and institutionalized at the age of four because he had autism and he was Native American. He lived there thinking his family had thrown him away until he was 13 years old, when he was returned to his family. He stated he went from special education to the honors program and became the first person in his family to graduate from high school.

Mr. Ramirez stated he went on to college but dropped out because he did not know how to access the then newly-enacted Americans with Disabilities Act (ADA) accommodations, and also because he began to experience his first mental health breakdown. He stated growing up in the state hospital did not prepare him to successfully live with his mental illness outside of that environment. This became his struggle as there was no information or resources and very few role models available. The National Alliance on Mental Illness (NAMI) was the only available resource at the time. He stated NAMI kept him alive.

Mr. Ramirez stated he had another breakdown in 2000, while struggling to find resources. He stated he could not deal with his symptoms, particularly his depression and the mania that came with the medication. He stated he checked himself into a hospital in Ventura County. He stated this move was the beginning and the end of his life at that time because he had to let go of everything he had worked for and accomplished. He stated doctors, medications, institutionalizations, and hospitalizations became the norm.

Mr. Ramirez stated there is no book when going into the hospital that informs a person what to do after they are diagnosed. He stated, even though he had a history of living with people with mental

illness, as a person living with it, he had no idea how to cope. He went on a journey of discovery and learning what worked best for him.

Mr. Ramirez stated, between 2000 and 2010, he had 36 5150s, had gone through 60 different psychiatrists, and had tried every antipsychotic medication available. He stated he had to stop working and lost his insurance. Because he had a preexisting condition, he could not afford to get private health insurance but had to depend on public health insurance. This was when he first went to the Department of Mental Health for services, which was even more traumatic for him due to the differences in treatment.

Mr. Ramirez stated he first saw a psychiatrist with the Department of Mental Health when he ran out of his medication and was depressed. He stated he told the psychiatrist the reason for his visit, that he was Native American, and that he was gay. The psychiatrist took out his prescription pad and wrote him a prescription for nine weeks of prayer because the psychiatrist told Mr. Ramirez that he needed to have his soul saved and he needed to not be a savage.

Mr. Ramirez went home, tried to commit suicide, and woke up in a hospital three months later. He stated that was the beginning of his experiences with county public health.

Mr. Ramirez stated, like many individuals, he has had up and downs, good lessons and bad lessons, but the thing that has helped him the most is his family, his values, and his culture. He stated he is Chiricahua Apache; the tribal and spiritual leaders helped Mr. Ramirez understand that he had every reason to be upset and to be mentally ill. He stated he lives in a society that looks at him perhaps as less than others. He stated the tone of his skin makes him less equal to other people. He stated, as a gay person and a person with a disability, he was even more at the bottom of the totem pole. Mr. Ramirez stated he shared this to help everyone understand why he associates more with women than with men. Women, oftentimes, are forced to be at the bottom of the totem pole.

Mr. Ramirez stated he lost his military father early on to substance abuse and suicide and his mother married a Mexican farm worker. This gave Mr. Ramirez the opportunity to celebrate his Mexican culture, but at the same time, his stepfather, who was a great man, did not understand Mr. Ramirez's disability or mental health condition. He stated he went to the witch doctor many times and had to try alternative treatments because his family was sad that Western medicine was not working for Mr. Ramirez, his people, or his community.

Mr. Ramirez stated he tried different things over the years. He stated he loved learning and did well in school so he reenrolled at the university and used it as his therapy. When he was not feeling well, he went to school. If he was not doing well at school, he went to the library. He stated he ended up getting two bachelor's degree and a master's from UCLA.

Mr. Ramirez stated, during this time, he lost one of his brothers to gun violence, which worsened Mr. Ramirez's condition. He stated he needed to readjust to what was happening in his life but did not know how to cope. He stated he thought everyone went through the things he experienced; but that is not the case. He stated he moved to Lancaster during his second year of graduate school and the Great Recession of 2007 to 2009 happened. He stated he sent resumes out, but he did not receive one response.

Mr. Ramirez stated, for the first time in a long time, he found himself unemployed. He was living in a new city, in a new house, with a new partner who became violent. He was unemployed, away from his family, isolated, dependent on his partner, and in a domestic violence situation. He stated, as an educated man and someone who knew about mental health, he never expected this to be a part of

his life. It took help to get out but the Department of Mental Health could not help him. He stated he had to find services himself.

Mr. Ramirez went to the Gay/Lesbian Center that helped him get out. He relocated to Long Beach, where he roamed homeless for almost one year, ashamed to tell his family what was going on. He stated he finally reached out to his family for help. He got a restraining order against his partner and all the women in his family from Arizona, Oklahoma, and Mexico came to support him. Every woman in his family for the past two generations had been a victim of domestic violence, and now him. He stated that made him realize that he had to do something more for his community.

Mr. Ramirez stated, while the psychiatrist gave him a prescription many years before for prayer, he wrote himself a prescription for advocacy. This is what he determined to do with his life. He went on to complete a Ph.D. program and received a doctorate in chemistry with the intent of becoming a chemist, but he felt that there was something else to do. He stated he joined the MHSOAC Services Committee almost eight years ago. He stated he advocates for mental health services, cultural sensitivity, ethnic awareness, disability accommodations for all programs, and to have the consumer voice heard. He noted that advocates have been advocating for peer certification since back then.

Mr. Ramirez stated this year Governor Newsom appointed him to the new Mental Health Stakeholder Work Group. He stated, as a member of this group, he has seen some of the great work that has been done, the challenges, and the downfalls. He stated the community planning process is such an important element of the Mental Health Services Act (MHSA), but unfortunately, throughout the state, that is something that has not really happened. All programs were to be community- and consumer-led but, most oftentimes, the consumer voice has been missing at the table. He stated the table must be made bigger to include the consumer and stakeholder voice. The people who need the services have ideas about what they need. He stated perhaps if he had gotten services that were culturally appropriate, in line with his values, and that worked with his community, he may not have wasted years of his life trying to find the right medication and the right psychiatrist.

Mr. Ramirez ended his presentation with a prescription for hope. He stated he is grateful for the work of peers who led the way, even during their times of hardship. He asked everyone, as they move forward, to think of the work they do as if they were writing a prescription for their communities. He stated his wish that someone would have written him a prescription for respect, dignity, and housing a long time ago. He stated everyone has the potential to write a prescription for hope for their communities and the people being served.

Discussion

Chair Ashbeck stated Mr. Ramirez's story is remarkable. He has brought great honor to himself and to his family and members of his nation who were listening in. She stated she has never thought of the work being done in the community as being a prescription for hope for the community. She stated that prescription is needed in today's world. She thanked Mr. Ramirez for sharing his story.

Mr. Ramirez stated individuals with mental health conditions are members of the disability community. There is not a more disenfranchised group than individuals with mental health disabilities. He stated it is important to empower the community to advocate. Advocacy is part of health care.

Commissioner Wooton thanked Mr. Ramirez for sharing his story and for the advocacy work he is doing in the community.

Roll Call

Filomena Yeroshek, Chief Counsel, called the roll and announced a quorum was not yet present.

Norma Pate, Deputy Director, MHSOAC, stated Commissioner Beall had stepped away from his desk but would return shortly. A quorum was achieved after Commissioner Beall returned to the teleconference location.

GENERAL PUBLIC COMMENT

Poshi Walker, LGBTQ Program Director, Cal Voices, formerly Mental Health America of Northern California (NorCal MHA), and Co-Director, #Out4MentalHealth, commented on their own behalf and encouraged the Commission to create a plan for times when it is unsafe to meet in person or travel to meeting locations, such as during the outbreak of a disease. Currently, public comment is not possible by teleconference unless the meeting is specifically a teleconference meeting.

Poshi Walker stated appreciation for Hector Ramirez's comment that advocacy is recovery and that he does advocacy for his mental health. The speaker agreed that opportunity to advocate is healing.

Poshi Walker stated Hector Ramirez represents what they try to say when speaking about intersectionality, not that each identity is siloed by itself. The speaker stated all those identities together sometimes create more oppression than each of them separately.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), thanked the Commission for not voting on the rules of procedure at the last meeting. They were complicated and Commissioners did not have much time for discussion.

Stacie Hiramoto encouraged the awardees of the current round of stakeholder contracts to include attending Commission meetings as part of their contracts.

Ethan Evans, Faculty Member, Division of Social Work, California State University at Sacramento (CSUS), alerted the Commission about a forthcoming report that will soon be released through the California Health Care Foundation called Integrating Care for People Experiencing Homelessness: a Focus on Sacramento County. The report looks at models across the country that try to take an integrative approach to multiple services – health, mental health, substance abuse, and shelter – and initiates big lifts to addressing homelessness in communities. The speaker stated their part of the project was to talk to local stakeholders from health systems, service providers, consumers, and others to learn about gaps and misconnections. The speaker stated the report will shed light on the Commission's questions about data and techniques for collaboration.

Chair Ashbeck suggested inviting Ethan Evans to present at a future Commission meeting.

Mandy Taylor, Outreach and Advocacy Coordinator, California LGBTQ Health and Human Services Network, stated their appreciation that Hector Ramirez shared his story. The speaker suggested focusing on shoring up the areas where the system failed Hector Ramirez. The speaker stated they love that every month a consumer voice shares their experience with wellness and recovery.

[Note: Agenda Item 1 was taken out of order and was heard after Agenda Item 2.]

ACTION

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

Presenter:

- Tom Orrock, Chief, Stakeholder Engagement and Grants

Chair Ashbeck stated 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. She asked staff to present this agenda item.

Tom Orrock, Chief, Stakeholder Engagement and Grants, MHSOAC, provided an overview, with a slide presentation, of the background, Advisory Committee recommendations, grant eligibility, and minimum qualifications for the proposed outline of the Early Psychosis Intervention Plus Request for Applications (RFA).

Commissioner Questions and Discussion

Commissioner Wooton suggested, making sure the technical assistance training course, includes training on recovery concepts and adhering to MHSA guidelines. Counties that already have Coordinated Specialty Care sometimes forget client- and family member-driven services. She stated the need for consumers and family members to be in the forefront driving that plan for themselves.

Commissioner Wooton stated the need to consider sensitive language when meeting with individuals, to ensure that the needs of diverse communities are being met, and to ensure that referrals are followed up with.

Chair Ashbeck asked Mr. Orrock to read the names of the Assembly Bill (AB) 1315 Early Psychosis Intervention Plus (EPI Plus) Advisory Committee members into the record.

Ms. Yeroshek noted that the Advisory Committee seats were set forth in the Welfare and Institutions Code.

Mr. Orrock stated Commissioners Khatera Tamplen and Gladys Mitchell are on the Advisory Committee with Commissioner Tamplen serving as chair. The rest of the Advisory Committee is made up of the following members:

- L. E. Becker, consumer
- Stuart Buttlaire, Ph.D., MBA, Kaiser Hospitals
- Gilmore Chung, M.D., primary care physician in a clinic
- Adriana Furuzawa, LMFT, MBA, an expert in early psychosis programs
- Kate Hardy, Psy.D., an expert in early psychosis programs
- Thomas Insel, M.D., Governor’s top mental health advisor
- Yana Jacobs, LMFT, consumer
- Karen Larsen, LMFT, Behavioral Health Director, Yolo County
- Maggie Merritt, Steinberg Institute

- Tony Tullys, MPA, Behavioral Health Director, Santa Clara County
- Paula Wadell, M.D., medical doctor

Public Comment

No members of the public addressed the Commission on this issue.

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

- *The Commission approves the proposed outline of the Early Psychosis Intervention Plus (EPI Plus) Request for Application.*
- *The Commission authorizes the Executive Director to enter into a sole-source contract with the University of California Regents for training and technical assistance.*
- *The Commission authorizes the Executive Director to initiate a competitive bid process for EPI Plus program grants.*

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 Wooton, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

ACTION

1: <u>Consent Calendar</u>

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

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. There is only one item on the consent calendar. She asked for a motion to approve the Consent Calendar.

Commissioner Questions

Commissioner Brown referred to the second paragraph on page 8 and asked to add the words "people connected with" to the beginning of the second sentence, and to remove the word "connected" after the word "health" so it would read "people connected with two respected mental health organizations within the county have shared their concerns."

Public Comment

Poshi Walker noticed that corrections are not reflected in the minutes that are posted on the website. The only way to access the minutes is by going into the Commission meeting packets. The speaker stated it would be helpful to post the corrected version of the minutes as a separate link rather than only as part of the meeting packets.

Commissioner Discussion

Chair Ashbeck asked about the process for correcting the minutes and reposting the approved version.

Ms. Yeroshek stated the old website used to have a page with the approved minutes but the new website that is currently undergoing renovation missed this separate page. A page of the motions and approved minutes will soon be added to the website.

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

- *The* Commission approves the January 23, 2020 Commission meeting minutes as corrected.

Motion carried 7 yes, 0 no, and 1 abstain, per roll call vote as follows:

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

The following Commissioner abstained: Commissioner Wooton.

ACTION

3: <u>Award Stakeholder Contracts</u>

Presenter:

- Tom Orrock, Chief, Stakeholder Engagement and Grants

Chair Ashbeck stated the Commission will consider awarding contracts to the highest scoring proposals received in response to the six Requests 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. She asked staff to present this agenda item.

Mr. Orrock provided an overview, with a slide presentation, of the Request for Proposals (RFP) overview, minimum qualifications, and evaluation process described in the RFP to award stakeholder contracts.

Mr. Orrock stated, based on the highest scoring proposals for the six populations, the Commission staff recommends that the following organizations be awarded these stakeholder contracts:

Clients and Consumers

- California Association of Mental Health Peer-Run Organizations (CAMHPRO)

Diverse Racial and Ethnic Communities

- California Pan-Ethnic Health Network (CPEHN)

Families of Clients and Consumers

- National Alliance on Mental Illness California (NAMI CA)

LGBTQ Communities

- Health Access Foundation

Parents and Caregivers

- United Parents

Veterans

- VetArt, a program of Social and Environmental Entrepreneurs, Inc.

Public Comment

Hector Ramirez, ACCESS Ambassador, Cal Voices, asked if the new stakeholder contracts will disrupt the already-established flow of advocacy work set up throughout the state and what that would do to the consumer engagement process. The speaker stated concern about the direction of the clients and consumers stakeholder contract.

Kris Amezcua, Vice President of Operations, NAMI CA, thanked the Commission for their continued support of family members and individuals across California.

Poshi Walker stated they put their public comment card in before hearing the results in order to echo a comment made earlier by Stacie Hiramoto. The speaker stated #Out4MentalHealth was able to write in funding to attend a number of statewide meetings, including the MHSOAC. #Out4MentalHealth brings the voices of individuals who are unable to attend various meetings. The speaker stated the MHSOAC is a valuable place for stakeholders to make public comment and for stakeholder contractors to bring local voices to the Commission.

Poshi Walker stated traveling to meetings across the state is difficult for all stakeholder contractors. The speaker encouraged either a funding stream for travel for the stakeholder contractors or to allow the stakeholder contractors to move their budgets around to allow them to continue to bring voices and to advocate for the communities they represent.

Sally Zinman, Executive Director, CAMHPRO, thanked the Commission for their support. The speaker stated CAMHPRO is dedicated to working with Cal Voices and building on the wonderful work that they have done.

Mandy Taylor pointed out problems they see in the process, in particular the budget and flexibility, as mentioned by Stacie Hiramoto and Poshi Walker. There were equity gaps in the way this RFP was put forward. Proposals were not given the maximum number of points unless they signed on with 15 local-level entities. The Health Access Foundation has partners across the state and was able to do that, but most of the partners are small local organizations that had to agree in some cases to sign on for a project where they might not see funding for three years because of the way that local-level entities are set up in this project.

Mandy Taylor stated Health Access Foundation will be doing budget advocacy on behalf of small organizations to try to distribute the funding more equitably. The speaker asked for the funding to be distributed to local-level entities equitably over the three years. This does not change the amount of the funding but distributes it in a way that works better for communities.

Mandy Taylor stated concern that, before the RFP was made public, it was event-based, when communities made it clear that advocacy is not done on events but is done through the process and community involvement. The Health Access Foundation figured out a way to make that work, but they had to do prescriptive events based on that that may or may not benefit the community because events were an RFP requirement.

Dr. Lisa Pion-Berlin, President and CEO, Parents Anonymous, Inc., stated a minimum qualification in the RFP is that organizations must have been in operation for two years. The speaker stated holding a contract with the MHSOAC does not mean an entity is a state-level advocacy organization. The

speaker stated a minimum qualification of two years is not long enough. The speaker appreciated the emphasis of the RFP on community-level advocacy because advocates need to be at the table.

Dr. Pion-Berlin asked about the number of applicants for each of the stakeholder contract categories. Dr. Pion-Berlin stated appreciation that the RFP was performance-based.

Mary Hogden thanked the Commission for awarding a stakeholder contract to CAMHPRO.

Commissioner Questions and Discussion

Chair Ashbeck asked Mr. Orrock to address some of the concerns shared during public comment.

- Whether these awards will do anything to disrupt existing advocacy.

Mr. Orrock stated he was unsure what went into changing these from sole-source contracts to a competitive process, but some of it had to do with putting funding into statewide organizations for a few years to let them get ground under them, make contacts, and start to sustain their programs, potentially with other funds. The stakeholder contractors have had a few years to do that, and the hope is that they will be able to sustain these programs and that these funds will be used to provide advocacy but also to sustain these advocacy programs around the state.

- The number of applicants per stakeholder contract category.

Mr. Orrock stated staff recognizes that there are areas of growth in regard to getting the word out about these opportunities to organizations. Staff has found that there are not many statewide advocacy organizations for some populations. While there was much energy and attendance at some listening sessions, there was not at others. With that said, the number of proposals increased in this round. A total of 13 proposals were submitted – 3 for clients and consumers, 4 for diverse racial and ethnic communities, 1 for families, 1 for LGBTQ, 2 for parents and caregivers, and 2 for veterans.

- How to support individuals traveling to meetings.

Mr. Orrock stated funding is available in the contracts for travel and expenses to be paid for participants of local organizations to come to statewide events each year. Each contractor will provide a statewide event, do legislative visits, and potentially participate in Commission meetings. Contractors can design that any way they want, but the contracts include funds to help local organizations participate in meetings. That is all part of the contract to help address the need to provide more local-level advocacy. Statewide advocacy is happening, but mental health funding is determined at the local level. More local-level advocacy is needed.

Mr. Orrock stated staff did a preliminary count of the number of counties which will receive local-level advocacy from one of these organizations and through this process – the new way of doing it, both local and state – 50 out of 58 counties will have an advocacy event, which could mean meeting with boards of supervisors, city council members, private industry, and other things that culminate into an event. An event is not a one-time thing. There is a $30,000 to $50,000 investment in each of these counties for advocacy.

Mr. Orrock stated Hector Ramirez made the point earlier that a stronger community planning process is needed. Advocates will be able to assist counties with that process. They will inform them that they are holding an event, meeting with local leaders in their county, inviting them to participate in that process, and using the information gathered at the event for their community planning process. That is the hope.

Commissioner Berrick asked if staff has discretion within the context of the award to move a percent from line items or if providers are restricted by line items in the contract. He asked, if the provider had a request to attend a meeting for a specific reason but had run out of that line item allocation, if funding can be moved around in collaboration with them.

Mr. Orrock deferred to Ms. Yeroshek to answer Commissioner Berrick's contract amendment question.

Ms. Yeroshek stated the budget, which was included in the RFP, is a single line item of $30,000 for local advocacy. There is not a single line item for travel. Fifty percent of the $30,000 budget must be for specific items but flexibility is built in.

Vice Chair Madrigal-Weiss agreed with Mr. Orrock that advocacy needs to happen at the local level. She stated she has seen that the plans are oftentimes prescriptive instead of really coming from the community. She appreciated that time and resources were given to effect change in the local community planning process.

Chair Ashbeck asked if there is a requirement in the RFP for the stakeholder advocacy groups to report back to the Commission.

Mr. Orrock stated the State of the Community Report is required annually from each contractor.

Chair Ashbeck stated the need to be more intentional about getting an end-of-the-year report from each contractor, even if only as a document, for Commissioners to see what has happened at the local level. She stated it is the sum of those reports and statewide advocacy that will move something larger.

Mr. Orrock stated contractors are always happy to present to the Commission if Commissioners would like to have that happen. At the least, staff will make the annual State of the Community Reports available to the Commission.

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

- *For each of the 6 RFPs, staff recommends the Commission:*
  - *Authorize the Executive Director to issue a "Notice of Intent to Award Contract" to the proposer receiving the highest overall score.*

Clients and Consumers

- California Association of Mental Health Peer-Run Organizations (CAMHPRO)

Diverse Racial and Ethnic Communities

- California Pan-Ethnic Health Network (CPEHN)

Families of Clients and Consumers

- National Alliance on Mental Illness California (NAMI CA)

LGBTQ Communities

- Health Access Foundation

Parents and Caregivers

- United Parents

Veterans

- VetArt, a program of Social and Environmental Entrepreneurs, Inc.

o *Establish March 5, 2020, as the deadline for unsuccessful bidders to file an "Intent to Protest" and March 12, 2020, as the deadline to submit the "Letter of Protest" consistent with the standard set forth in the Request for Proposals.*

o *Direct the Executive Director to notify the Commission Chair and Vice Chair of any protests within two working days of the filing and adjudicate protests consistent with the procedure provided in the Request for Proposals.*

o *Authorize the Executive Director to execute the contract upon expiration of the protest period or consideration of protests, whichever comes first.*

Motion carried 7 yes, 0 no, and 1 abstain, per roll call vote as follows:

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

The following Commissioner abstained: Commissioner Wooton.

[Note: Agenda Item 7 was taken out of order and was heard after Agenda Item 3 and before the lunch break.]

INFORMATION

7: <u>Receive Innovation Incubator Update</u>

Presenter:

- Jim Mayer, Chief of Innovation Incubation

Chair Ashbeck stated 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 expects to present to the Commission one or more project contract outlines for approval at the April 2020 meeting. She asked staff to present this agenda item.

Jim Mayer, Chief of Innovation Incubation, MHSOAC, provided an overview, with a slide presentation, of the role of the Innovation Incubator, update on county projects launched last year and projects to be launched in the future, and next steps of the Innovation Incubator.

Commissioner Questions

Commissioner Danovitch asked what the incubation and the process look like.

Mr. Mayer stated every incubation is different. He used the five-county Data Driven Recovery project as an example. He stated data expert Kevin O'Connell is working with the counties to learn their data systems and reconfigure the data so the data can be matched and used for decision-making. Each of the five counties are in the process of having a cross-system dialogue, where judges, district attorneys, public defenders, law enforcement, behavioral health, and other community service providers are looking at the data and the Sequential Intercept Model to determine what can be done differently and what can be done better.

Mr. Mayer stated early reports indicate it is going well. The counties report they are doing new things with the data and they are now having constructive conversations that had not previously been

possible due to the lack of information. The counties will now begin to learn from the other counties in the collaborative over the next few months.

Mr. Mayer stated additional counties are asking to join the Data Driven Recovery project collaborative or to be a part of another collaborative. He stated this is a big payoff for a small investment.

Mr. Mayer used the Full-Service Partnerships project as another example. He stated it is larger and more formal because Full-Service Partnerships are more complex in general, but the technical assistance provider has been working individually with each of the six counties that are participating to identify metrics and analytics and help counties develop the analytics that they could do. The first phase was to help the counties write Innovation plans to implement. The counties will now begin to learn from the other counties in the collaborative over the next few months.

Commissioner Wooton suggested including mental health courts in the technical assistance. Individuals who sit on mental health courts seem to be well-versed in mental health issues and client and family member needs and wishes.

Commissioner Wooton stated the hope that there are clients involved in the Psychiatric Advance Directives Collaborative project.

Mr. Mayer stated clients are extensively involved in all projects at the community level.

Commissioner Wooton stated the importance of not just hand-picking stakeholders from the counties but ensuring that there are genuine individuals involved with that. She stated she has experienced times when they are not.

Commissioner Gordon stated it seems that, whether it is law enforcement, education, or any other area, one of the barriers is data and analytics. He asked if there is a way the Commission can be more aggressive in that space but not necessarily tie it to a particular subject matter area. He gave the example that it is difficult to track the general flow of health funds out to the community and whether health care services are adequately provided to the 0-5 population of needy children, and the data systems are not up to the task. He asked if there is a way to help counties with that. This would impact the many systems that are related to the work the Commission does.

Mr. Mayer stated there is. He stated, over the next 30 days, staff will be considering next opportunities for this project and how to leverage the need and appetite among the counties. Some of this is the crosswalk not just from behavioral and mental health, but to other health systems that are necessary in order to result in the recovery for individuals who are at risk of being criminal-justice involved.

Mr. Mayer stated part of the Schools and Mental Health project is to consider the capacity in each county in order to develop that system and that connectivity. He stated the subcommittee will be meeting over the next month to consider how to develop the data and management systems that are necessary for that connectivity, not just at the community level with the service provision and the program level of agencies, but also how the state can catalyze that.

Mr. Mayer stated the Commission’s work is progressing in trying to drive data and analytics at the state level across systems to build capacity at the local level in order to do better service delivery, evaluation, and continuous improvement. Even programs with the strongest evidence base are difficult to replicate because of the unique circumstances in individual lives, families, and communities. That capacity is necessary in order to get the results needed.

Chair Ashbeck referred to Item 2 on the last slide, Next Steps, assessing lessons from previous collaboratives, and stated Commissioners have been interested in receiving feedback on what the collaboratives have learned and how to replicate programs.

Chair Ashbeck referred to Item 3 on the Next Steps slide, outlining additional collaboratives for Commission approval in April, and asked if the plan is to take an in-depth look at existing work and to find new ways to accelerate it, or to find additional collaboratives to do work in new spaces. She asked what that process would look like.

Mr. Mayer stated the one-time $5 million budget allocation for the Innovation Incubator must be focused on activities by the counties that will reduce criminal justice involvement or at-risk for criminal justice involvement, which is the focus of the collaborative to be discussed at the April meeting. Other collaboratives the Commission has launched are not focused on reducing criminal justice. He stated it is possible that, as more momentum is built around the Schools and Mental Health project, this is a model that can be built into that, as well.

Public Comment

Poshi Walker stated, when the MHSA was first rolled out, stakeholders who come from unserved, underserved, and inappropriately served populations were told that they would be funded in the Innovation and Prevention and Early Intervention components. The speaker was the lead for the LGBTQ Phase 1 of the California Reducing Disparities Project (CRDP). The CRDP put out reams of information, a report, and an addendum talking about community-defined practices and recommendations for communities. The speaker noted that LGBTQ communities are as diverse as the general population when it comes to race, ethnicity, age, et cetera, so when the speaker talks about LGBTQ, they are also talking about queer and trans people of color, youth, older adults, et cetera.

Poshi Walker stated the LGBTQ population, along with the subpopulations such as African American, Latinx, and other people of color, including transgender and sexual orientation, is incredibly underserved and inappropriately served. This includes the community planning process. To ask a queer trans person, a queer trans person of color, or a straight cisgender person of color to try to speak out above all the privileged voices is already asking a lot. Oftentimes, they are not invited, made to feel welcome, or included. Also, oftentimes, the community planning process is presented as “here’s what we are going to do – what do you think?” as opposed to “will this work for you?” Listening sessions involving LGBTQ cultural brokers do not happen. The hope is that the local work will continue with the new contracts but they are very different from the old ones.

While Poshi Walker appreciated the work Mr. Mayer is doing, they questioned if this is how funding should be used. The speaker suggested that counties do what they were supposed to do to begin with – get the unserved, underserved, and inappropriately served individuals together, whether in big or small sessions, and ask them what they are doing to help themselves now and how much more they could help themselves if an Innovation project were created. The speaker suggested that staff talk to the CRDP Phase 2 leads. There are 35 Innovative projects going on right now that are gathering evidence.

Mandy Taylor echoed some of the concerns of the previous speaker, particularly the criminal justice component. Black, brown, and gender non-conforming individuals are not safe with law enforcement in many communities. Adding mental health crisis to that increases that lack of safety. Black, brown, and gender non-conforming individuals often experience the highest rates of trauma, ACEs, and homelessness; adding to that the expectation that they should be receiving services or being diverted

through the criminal justice system that has historically enacted violence upon them is unacceptable and not culturally appropriate.

Mandy Taylor stated funding programs through law enforcement is not what certain communities need, but rather they need community alternatives to policing in order to feel safe. The speaker asked the Commission to ensure that the Innovation Incubator does not only represent white, cis, straight individuals, but that individuals of color, gender non-conforming individuals, and young homeless individuals are in the room making these decisions. The speaker encouraged the Commission not to let the counties continue to exclude or actively harm these communities.

Commissioner Discussion

Waruguru Ndirangu agreed with the concerns expressed during public comment. She suggested Innovation projects to look at alternative approaches such as restorative justice or community mediation for the cross-over with criminal justice involved and mental health communities.

Commissioner Bunch asked for clarification of staff's role in the Innovation Incubator.

Mr. Mayer stated the Commission brings collaboratives together, based on what counties think would be most valuable, and provides technical assistance. The three collaboratives that have been launched based on the Commission's report a few years ago focus on the need to move this as far upstream as possible. Full-Service Partnerships, whenever they are successful, prevent that intersection with law enforcement.

Mr. Mayer stated these projects are intended to reduce and prevent criminal justice involvement at every step of the Intercept Model. The Commission has an active role in helping to facilitate with the counties where technical assistance would allow them to provide better information, and the guidance on ensuring that their engagement is as inclusive as necessary is also wise.

Commissioner Bunch stated the Data Driven Recovery Project is meant to better understand the pathways and needs of individuals with mental health needs in the criminal justice system. She asked whether there are any results from the project to better understand what some of these pathways are.

Mr. Mayer stated the counties are nine months into that project. Over time, how the pathways play out in each of the counties and where they go with that will become apparent, but there is a potential and the intent is to get as far ahead of that intersection with criminal justice involved and mental health communities as possible.

Commissioner Bunch asked if diversion is being considered. She stated she submits diversion reports as part of her work. What she has found is, even when she recommended diversion for an individual, they often do not end up getting it and they end up cycling back through the criminal justice system. She stated the hope that this can be looked at, and that the reasons an individual gets or does not get diversion are examined.

Mr. Mayer stated the Judicial Council is interested in taking advantage of the grants that they have with the number of counties including Santa Barbara to see if they can ensure that not only diversion happened but that it is linked to adequate services. It is the full continuum to try to be as far ahead of the problem as possible because there is a history of harm and, at the same time, to be as effective as possible where there is criminal justice engagement with the courts and law enforcement.

Commissioner Brown stated it bears an understanding that many of the programs that are being accomplished in Santa Barbara County and other counties throughout the state are ones that have been driven in many respects by law enforcement. Law enforcement has been a catalyst to bringing

people together from the community to look at alternatives. Law enforcement can and should be a strong partner in the change that is necessary to ensure that individuals are diverted either from getting into or from an existing position in the criminal justice system.

Commissioner Brown stated it is important to recognize that the reality is law enforcement is going to be involved in many of these cases, and people who are suffering from mental illness and cooccurring drug addiction are engaging in behavior in the community that is going to garner a law enforcement response. If law enforcement is not working with people who provide service in the community and it is an either/or proposition, a community will miss its opportunity. It is important to ensure that everyone has respect for each other and recognizes that they have a role to play in working with each other to keep people out of the criminal justice system and get them the care that they need to keep them from coming back in.

LUNCH BREAK

ACTION

4: <u>El Dorado Innovation Project Extension</u>

Presenters:

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

Chair Ashbeck stated El Dorado County seeks approval of $2,158,704 in additional Innovation fund spending authority to extend the Community-Based Engagement and Support Services (Community HUBS) Program. The Commission originally approved $2,760,021 in Innovation fund spending authority for this project 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. She invited the representatives from El Dorado County to present this agenda item.

Heather Longo, MHSA Coordinator, El Dorado County Health and Human Services Agency, introduced the members of the panel. She distributed an additional letter of support of the project, which was received from Sue Novasel, a member of the El Dorado County Board of Supervisors. She provided an overview, with a slide presentation, of the general standards and primary purpose of the Innovation.

Jamie Samboceti, MFT, Behavioral Health Deputy Director, El Dorado County Health and Human Services Agency, continued the slide presentation and discussed how the proposed project supports the general standards and primary purpose of Innovation. She stated the proposed project is intended to break down barriers due to stigma, meet individuals where they are most comfortable and feel safe, make connections and develop rapport with a population that lacks trust, and communicate with the providers in the community.

Sabrina Owen, MFT, Manager of Mental Health Programs, El Dorado County Health and Human Services Agency, continued the slide presentation and discussed adverse childhood experiences (ACEs), brain chemistry, and trauma.

Ren Strong, Program Manager, El Dorado County Health and Human Services Agency, continued the slide presentation and discussed the history, modification request, learning objectives, and budget and sustainability of the Community HUBS Innovation Project. She stated the reason for the modification request is to address emergent issues since implementation in order to continue learning if an interagency and community collaboration will result in an increase in early mental health care prevention and access.

Ms. Strong's budget explanation:

- The Community HUBS Innovation Project was originally approved for $2.7 million.
- The program had a slow start-up due to challenges, which created a savings of $900,000.
- The County is looking to expand in this modification. $700,000 was budgeted, but the county expects to see a cost savings again this year. All the funds will not be spent.
- The proposed amount for next year is $1.4 million. Again, based on historical aspects, the county anticipates not spending all the funds due to the time it takes to get everything up and running on the modification.
- The proposed budget for the original and modification budgets is $4.9 million.
- With the savings already realized and the anticipated savings this year, the net estimated project costs are $2.9 million.
- The modification will end up being approximately $140,000 due to not spending all the funding in previous years.
- Although the county is asking for $2.1 million in budget, when combining the savings and the late start this year, it will not be the full amount in the end.

Ms. Strong stated she has a handout that includes what has been done and how much has been spent in actuals from the Revenue and Expenditure Reports (RERs). She stated the county originally budgeted $2.7 million, and, minus fiscal year 2019-20 because estimates are not yet available, the county has spent approximately $1 million and has a savings of $900,000 due to underspending.

Ms. Longo directed the Commissioners' attention to the letter of support for this project and the modifications from Norma Santiago, of the Behavioral Health Commission.

Commissioner Questions

Commissioner Brown asked about the projected budget for the next two fiscal years.

Ms. Strong stated the projected budget for this fiscal year and next fiscal year is approximately $2.8 million. This fiscal year has approximately $700,000 budgeted just for the modification alone. Staff must be hired and equipment must be purchased but there are only four months left in this fiscal year. The county cannot spend all of the $700,000 in that short amount of time.

Commissioner Brown stated Ms. Strong stated earlier that the county anticipates only requiring approximately $100,000.

Ms. Strong agreed that the county will only require a net of $140,000 in total for the project.

Commissioner Brown asked why the county is asking for $2.1 million when it only requires $140,000.

Ms. Strong stated this project started two years ago. The county had hoped to have those funds available for two fiscal years – this entire fiscal year and next fiscal year. Unfortunately, due to the timing of the community planning process, agendas, and updates on information, the county was unable to modify the documents to show that. The budget template submitted to the Commission shows that the county has underspent in the two fiscal years that were available at the time of submittal. The county's 2018-19 fiscal year RER has now become available, which shows that the county also underspent in fiscal year 2018-19 by almost $170,000.

Chair Ashbeck stated her understanding that the county underspent the first two years and has some balance left. If that balance is applied to the next two years, the net the county needs is approximately $140,000.

Ms. Strong stated that is correct. She noted that the $140,000 is an estimate.

Chair Ashbeck agreed with Commissioner Brown in wondering why the county is not just asking for the $140,000, since that is the amount of funding required to get through the next two fiscal years.

Ms. Strong stated the budget template is set up to ask for the amount budgeted; it does not show how much was underspent in previous years. It shows how much is anticipated to be needed for these new operating timelines. The original project template showed $2.7 million budgeted. The county then learned that the full amount was not needed. She stated, if the project ended in September of 2020, it would show that the county underspent on that original budget.

Ms. Strong stated, with the expansion, the modification asks what the budget alone could be for these two years. The county is asking for the public health nurse position to be expanded and for the family engagement specialist.

Chair Ashbeck stated that is separate from what is left over. The math equation is total need minus available resources equals additional need.

Ms. Strong agreed that the budget template is not set up that way and stated the county did not enter it into the template that way. The template equation is the original funding versus the budget amount going forward. She stated, when the cost savings for each year are backed out, the gross project will not spend as much as originally anticipated.

Chair Ashbeck echoed Commissioner Brown's question of why the county is asking for $2.1 million when it only requires $140,000.

Commissioner Alvarez stated she would appreciate clarity on the financial aspects but she commended the county for the whole child approach when it comes to overall wellbeing. California has been focusing on a whole child, whole family, whole person approach for the past few years for individuals who are chronically homeless, formerly incarcerated, or with multiple chronic conditions. The aspects of the system that best serve those ~~in~~individuals serve everyone the best to connect with community and supportive services to ensure that community experiences are uplifted. She commended the county for that.

Commissioner Alvarez suggested, if there are concerns about that approach, dedicating learning opportunities to digging deeper on why this approach is necessary, not only for the Commission to invest in but for the system as a whole to consider moving forward. She stated what kids need most is stable, loving environments. That is only possible if parents and caregivers have the resources that they need to support their children. That is what is being done by connecting them with mental health,

nutrition, and transportation services. She stated the California Children's Trust and the First 5 Center for Policy released a report late last year on this approach and she is happy to share it with the Commission as background.

Public Comment

Lynnan Svensson, Nursing Program Manager, Community HUBS, El Dorado County, spoke in support of the proposed project.

Lynn Hall, NAMI, speaking as a mother, spoke in support of the proposed project.

Elizabeth Blakemore, Director of Early Learning and Family Support, El Dorado County Office of Education, spoke in support of the proposed project.

Juline Aguilar, Foster and Kinship Care Program and NAMI, El Dorado County, spoke in support of the proposed project.

Monica Woodall, Black Oak Mine Unified School District, spoke in support of the proposed project.

Liz Del, Divide Ready by 5, spoke in support of the proposed project.

Kathleen Guerrero, Executive Director, First 5 El Dorado Children and Families Commission, spoke in support of the proposed project.

Dr. Steve Clavere, Chair, El Dorado County Behavioral Health Commission, spoke in opposition to the proposed project. The speaker stated the purpose of the HUBS is to provide mental health and physical health prevention activities including screenings for mental health and referrals to community-based mental health services, if needed. The learning objectives are to see if the HUBS can reduce mental health costs and increase client screenings and treatment by mental health services.

Dr. Clavere stated the implementing staff are public health and education department job classifications performing public health and education department duties. There is not a single mental health physician. Mental health screening is not being conducted on a scale necessary to make a difference. The Protective Factors Survey and the ACEs Questionnaire are not mental health screening instruments. The modification request correctly stated that public health nurses are skilled at performing validated mental health screenings, but that document fell short of stating they were actually doing so. He emphasized that public health nurses are not stationed in the HUBS.

Dr. Clavere reviewed the data and asked Commissioners to keep in mind the original purpose and learning objectives. He stated the fiscal year 2017-18 data and the original project plan shows that 5.8 percent of HUBS referrals are mental health, while the mental health services scheduled for them were only 2 percent of the total. With the new fiscal year 2018-19 data provided by the county, the percent of mental health referrals increased to 6.5 percent and the percent of mental health services scheduled increased to 2.9 percent. Over the period of one year, both critical indices increased less than 1 percent and remain miniscule.

Dr. Clavere stated as a mental health advocate, supports the Community HUBS concept and appreciates the benefits it renders to the community; however, the speaker stated they also believe that the MHSA share should be proportionate to the results it renders to the seriously mentally ill who desperately need more services.

Dr. Clavere stated this is essentially a public health Innovation project that is primarily paid for with mental health dollars with little or no significant mental health benefit. In addition, there is no evidence as presented to suggest that the proposed project prevents serious mental illness.

Poshi Walker shared that there is a new ACEs Aware Initiative put on by the Surgeon General for California. The website is acesaware.org, which contains much information. The speaker stated the ACEs screening was initially developed for pediatricians and other medical professionals. It screens for risk for negative mental and physical health outcomes. The speaker stated probably only in Western countries do individuals think that mental and physical health are two separate things and are somehow not related.

Poshi Walker stated LGBTQ individuals on average have a higher rate of ACEs than the general public. There are also ACEs-like issues that happen for LGBTQ individuals that are not captured by the ACEs screening. The speaker stated ACEs screening can reduce mental health stigma.

Commissioner Discussion

Chair Ashbeck asked staff to help the Commission understand the budget and budget framework.

Grace Reedy, Health Program Specialist II, Innovation Unit, MHSOAC, stated there was confusion regarding the completion of the recommended budget template. Considering what the project was originally approved for and the additional amount required, staff recommended that the county provide a separate table just for the additional $2.1 million required. She stated she was surprised to learn today about the amount of the surplus and that only an additional $140,000 is needed. She stated, if she had been made aware of that earlier, this agenda item could have been handled through the Chair delegated authority.

Ms. Reedy stated the completion of the recommended budget template is confusing. El Dorado County is not the only county to have issues with it. She stated, because the template is recommended, sometimes it is easier to take a step back and ask about the additional amount required. That is what was done in this case.

Chair Ashbeck suggested working on the budget template to make it less confusing.

Commissioner Alvarez asked for verification that the original grant was $2.7 million, but the county has a $1.8 million surplus.

Ms. Strong stated, to date, the county has approximately $900,000 that was not spent in previous years, but there is still four months left in this fiscal year. The confusion has to do with the gross project costs versus fiscal year budgeting.

Commissioner Alvarez asked if the county's request for this project is for $2.1 million or $140,000.

Ms. Strong stated it is complicated. To be safe, the county needs $250,000 in the gross project costs; however, if the Commission approves $250,000, the budget department would assume that the county only has $250,000 budgeted for the year, but that is not correct. The funding that was unspent in one fiscal year must be rolled to the next fiscal year and each following fiscal year. It has to do with budgeting on a fiscal year basis.

Commissioner Brown asked if the Commission could take an action that would push the previously-requested funds in the prior fiscal year to say they are authorized to be spent in this fiscal year so the county can go back to their board of supervisors and say it was approved.

Ms. Strong stated it might work but she could not speak on behalf of the county budget analyst.

Commissioner Brown stated the problem is that the Commission has been under considerable concern and criticism about the amount of unspent MHSA dollars that are sitting in bank accounts across the state. The more that happens, the less likely it is that the Commission will be able to continue to give funding out the way it has traditionally given it out.

Commissioner Brown stated this is a great program but he stated his concern about the public comment in opposition to the project. The question is if it is equitable to have it funded in large part from the MHSA, when the majority of the services being provided are not connected to mental health. He asked if the county has tried to leverage other monies or sought other monies from other sources for the more traditional public health-related aspects of the project. He stated the innovation part of the project is good and strong, but he asked about the needs that are benefiting from these mental health dollars and the sustainability of this program.

Ms. Strong asked Lynnan Svensson to respond to Commissioner Brown's concerns.

Lynnan Svensson stated the county leverages for the HUB Health team Maternal, Child, and Adolescent Health (MCAH) funding and Title 19 funding through the federal government to connect individuals with Medi-Cal resources and Medi-Cal service coordination. This is one reason why the county is underspent on the HUB Health public health nurse team, along with the vacancy rate and slow start.

Commissioner Brown stated he sees that the county is leveraging a total of $1,139,710, which is listed on page 7 of the Staff Analysis, but this only constitutes 23 percent of the overall project costs. He stated a disproportionate amount is being paid for with MHSA dollars.

Lynnan Svensson stated there are also First 5 and Public Health Realignment funds that are being put into the program.

Commissioner Brown asked if those funds are in addition to what was reported in the Staff Analysis.

Lynnan Svensson stated they could not speak to the report since they are not part of MHSA staff. The speaker stated they could only speak about the public health team and the component it is leveraging as well as the other funding partners such as the Child Abuse Prevention Council.

Ms. Strong asked Kathleen Guerrero to respond to Commissioner Brown's concerns.

Kathleen Guerrero stated it is important to note that it is a collaborative funding model and an Innovation project. One aspect of it that is currently being discussed is that Innovation funding was used as the local leverage to draw down MCAH funding for this portion of it. There is also Child Abuse Prevention funding that is being leveraged locally, in addition to library staff, the First 5 El Dorado Children and Families Commission funds that play into it, and First 5 California funding through Childcare Outreach. There is a total of seven funding streams that are pulled together; it is a misrepresentation to say that it is all MHSA funding.

Commissioner Brown stated, even if those collective funds amount to what was reported in the Staff Analysis, then it is still a disproportionate amount that is being paid through the MHSA.

Kathleen Guerrero estimated that between 30 to 35 percent of the total is through the MHSA matched with MCAH funds. If the program is looking at ACEs, Prevention and Early Intervention, and the whole child approach, it technically is being used for a behavioral health approach for children and families.

Commissioner Berrick stated the county is planning to expand these public health options and other mental health and school district billing moving forward. He asked, if the project is successful, what the funding model would be three years from now.

Ms. Strong stated the county anticipates that the funding three years from now will be MHSA, public health, First 5, education, grants, and community partners. Depending on what services the community partners can provide, it could be in-kind or leveraged funds from them as well.

Commissioner Berrick stated there is the held-over piece and the new amount is being shown in this fiscal year. He asked where the old amount went.

Ms. Strong stated, within the MHSA, the county budgets on an annual basis, even though the plan is for three years. She gave the example of having a budget of $100 at the end of the year and the county spent $70; that $30 then starts over the next year as a fund balance to be allocated to all the projects.

Commissioner Berrick stated his understanding that that balance would be allocated in the following fiscal year and the county could report to the Commission on where and how that was allocated.

Ms. Strong stated that is correct; however, the plan approves it on a fiscal year basis.

Commissioner Berrick stated the county, then, would be effectively 12 to 18 months in arrears on the amount.

Ms. Strong agreed. She stated it keeps rolling back.

Commissioner Gordon echoed the comment made by Commissioners Alvarez and Berrick – this is a unique approach in a difficult rural setting. He stated this will come up again as the Commission looks at schools and mental health, but it is all about prevention. The system is currently focused sharply on treatment so individuals must become ill before they are noticed or served. That is hurting the people of California. The needs of young children ages zero-to-five are not being met. The Surgeon General is on the right track about getting good data and working with families, but children should be worked with early on in school because every young person who is helped before the need for further treatment will save not just money but it will save heartache and torment for individuals and their families. Prevention is a phenomenal innovation in the world of interlocking programs. He applauded the county for that.

Commissioner Gordon moved approval of the proposed motion to fund up to $2,158,704 in additional MHSA Innovation funds for a total of $4,918,725, and nine additional months for a total length of four years and nine months.

Commissioner Berrick seconded.

Commissioner Bunch commended the county on their work. She agreed with Poshi Walker’s comment to focus on prevention and identify individuals wherever possible.

Chair Ashbeck suggested not using the word “surplus.” She stated the county only needs $140,000 – the Executive Director could have approved that. She stated it is difficult, in good conscience, to approve $2.1 million knowing that the county will have approximately $2 million in surplus at the end of this project. The Governor stated this week that counties should give their surplus funds back to the state to spend on the issue of homelessness. She stated the Commission should not give the county $2.1 million if it is not needed.

Ms. Strong noted that the county is working on additional plans to bring forward to the Commission.

Chair Ashbeck stated the issue is that those additional plans are not before the Commission today. The system is flawed in this way. It is not a surplus because the work has yet to be done. This should not be perpetuated. She asked staff to comment on whether the Commission can give the county $140,000, but then outline that the county must spend the amount of surplus acquired on this project. She asked if there is a way to cause that surplus to be available because the proposed motion will worsen the surplus issue and, as was learned this week, county surplus funds may be transferred to the state to be used in other ways.

Commissioner Berrick stated the Commission cannot tell a county fiscal officer how they can account for the funds, but it can ask the county to report to the Commission exactly how they are spending last year's rollover reserve. The Commission would need to know this information at the beginning of the county's budget process. That seems reasonable. The reinvestment strategy could then come forward to a future fiscal year in a way that would be understandable to Commissioners and the Commissioners will understand how the reinvestment works. He stated his experience is that it must be shown in a future year.

Commissioner Brown stated the spirit of the law is that, if it will be spent on the same program because there was a delay, it should be used with whatever additional amount is needed. He stated he could not support authorizing over $2 million when the county knows it will not be spent. There are other needs throughout the state, and the Commission has essentially been put on notice by the Governor and the Legislature that they are not happy that the funding is languishing in so many places.

Commissioner Brown proposed a modification to the motion that would authorize an additional $150,000 that could be used for this project and ask the county to go back to their board of supervisors to work it out. It does not make sense to authorize money that it is known will not be spent. He asked Ms. Yeroshek to respond.

Ms. Yeroshek stated the counties are required on an annual basis to do the RER. There is a delay every year but every county must send out, per program, the amount of the MHSA funds that is being spent. That information is in an public document that is posted on the website.

Ms. Yeroshek stated the Commission can make suggestions to the county in terms of their budgeting. This is not unique. There are Innovations that do not spend the entire amount that has been budgeted. The process is that the funds stay with the county unless they get put into a different Innovation project, for which the county must come back to the Commission for approval. She stated El Dorado County's surplus funds will not be lost or unspent, it is just that they are pushed out another year and they are put back into the bucket to be spent the following year.

Ms. Yeroshek stated it is unknown if the board of supervisors and the county fiscal officer will follow the Commission's instructions as to the funds. The Commission must vote on the motion that is on the table. The Commission may amend the motion, not pass the motion, and make another motion.

Commissioner Gordon suggested amending the motion to say that the Commission would approve the amount of funding being asked for to extend this project, provided that within 30 days the county returns to the Commission with a reconciliation of the use of the MHSA dollars and reverting whatever the amount is into their funds for other uses.

Ms. Yeroshek stated the question would be within 30 days of what event because the County will not know about the use of MHSA dollars or reverting it for other uses until the end of the fiscal year. The county knows it will not spend all of its funds for the current fiscal year, which ends in June.

Commissioner Brown stated the county budgeting process should take place long before the end of the fiscal year in terms of the authorization. He stated his concern is Ms. Yeroshek's comment that the county would have to come back for approval of spending any additional funds that came in; however, the Commission would be contributing to this ongoing problem of unspent dollars, which has been the focus of considerable concern.

Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations, MHSOAC, stated the Commission has already approved the budget authority up to a ceiling without regard to fiscal year. It

is up to the county to allocate those funds by fiscal year for the project. He suggested one possibility to consider would be to approve the marginal funding that the county projects it needs and direct staff to work on documentation that county staff needs to work with the board of supervisors in order to clarify these fiscal issues. He noted that the county already has the authority to spend up to $2.7 million without regard to fiscal year.

Chair Ashbeck asked what the current motion is.

Ms. Yeroshek stated it is the original proposed motion to approve up to $2,158,704 for nine additional months.

Commissioner Brown stated the $2.1 million is an additional amount for a total of $4.9 million. What has already been approved has not yet been spent and the Commission has been told that the county does not need more than $150,000, so essentially, the motion is to authorize $4.9 million. By approving the $2.1 million, the Commission in essence is approving approximately $5 million.

Commissioner Alvarez suggested striking the words “additional” and “for a total of $4,918,725” from the amount on the motion so it would read “up to $2,158,704 in MHSA Innovation Funds.”

Commissioner Brown agreed.

Chair Ashbeck stated striking those words does not change anything. It is still $4.9 million for a $2.7 million project. The county only needs $2.7 million plus $140,000 total for this project. The Commission will give the county $5 million for a $3 million project with the proposed motion.

Commissioner Brown suggested striking the suggested language from the motion and instead making the motion to authorize only the total amount that the county needs for the project.

Chair Ashbeck stated that amount is $2.7 million plus $140,000.

Commissioner Brown agreed.

Deputy Director Sala stated the current project is authorized to spend up to $2.76 million. If a motion was passed today to authorize up to $2.15 million, it would be cutting the authorized budget.

Commissioner Brown stated, if the Commission authorized the county to spend up to $2.8 million, that would still give them the authority to get this project funded but would not encumber another $2.1 million of MHSA funds.

Ms. Yeroshek stated $2.7 million has already been authorized by the Commission. Any additional funding approved today goes on top of the $2.7 million.

Chair Ashbeck stated the Commission can propose to move up to $2.1 million. She stated she felt it will still be added even if the word “additional” was struck.

Deputy Director Sala stated the proposed motion before the Commission is a budget ceiling that the Commission is authorizing the county to spend on a specific project. No county is ever required to spend the entire amount that the Commission authorizes them to spend on an Innovation project. The Commission just gives them authority to draw that much funding for a specific project.

Commissioner Brown asked if it could be done by saying the Commission is modifying its original authorization of $2.7 million to go up to $2.9 million or whatever the amount is.

Ms. Yeroshek asked the county if authorizing $2.9 million is sufficient for the county to finish their program.

Ms. Strong stated it is possible that it will be sufficient but she could not guarantee that because the figures are based on preliminary budget numbers to date for this fiscal year and anticipated expenditures for the next fiscal year.

Ms. Yeroshek stated one possibility is just to ask for what is anticipated and, as the county solidifies its budget, determine if they need more.

Ms. Samboceti reminded the Commission that the fiscal team may not necessarily do what the Commission wants them to do to be able to have this cost savings.

Commissioner Brown stated, by approving the proposed motion, the Commission essentially is giving the county a blank check to spend up to $4.9 million, when the county only needs less than $3 million.

Commissioner Berrick stated the Commission is trying to help incentivize the prior year reconciliation to go in the proper direction. He stated he assumed the county would come back to the Commission if that was a problem. He suggested, if the county returns, that the county would include why the board of supervisors would not reauthorize the rollover of a previous year budget surplus for that which it was intended. He agreed that the Commission cannot compel the board of supervisors to do that but the Commission can ask the board of supervisors what they are going to do and not authorize a continuation beyond that. That would work as a modified amendment to the motion, yet still allow the program to continue operating.

Commissioner Berrick told the county that they are suffering from what has been a statewide problem – surpluses that were not always reasonably being held in reserve. The Commission is determined that that not continue at the same rate.

Ms. Strong stated a motion showing that for the total project period approving the project to go until June 30th of next year, and a motion showing the total project expenditures, regardless of which fiscal year they are to be spent in, may be acceptable to allow the county to show the funding saved and then put them into the appropriate future fiscal year, as well.

Commissioner Gordon asked Deputy Director Sala to restate the recommendation he made earlier.

Deputy Director Sala stated one suggestion is for the Commission to approve up to an additional $250,000 of Innovation fund budget authority with direction to staff to work with El Dorado County for clarifying language to support the county's needs with the El Dorado County Board of Supervisors.

Commissioner Gordon amended his motion to reflect Dr. Sala's suggestion.

Commissioner Berrick agreed to accept the amendment.

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

- *As to the Community Based Engagement and Support Services (aka HUBS), the Commission approves an additional nine months and up to an additional $250,000 of MHSA Innovation Funds budget authority with direction to staff to work with El Dorado County for clarifying language to support the county's needs with the El Dorado County Board of Supervisors.*

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

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

ACTION

5: Identify Legislative Priorities for 2020

Presenters:

- Gavin White, Legislative Assistant, Office of Assembly Member James C. Ramos
- Adrienne Shilton, Senior Policy Advisor, California Alliance of Child and Family Services
- Norma Pate, Deputy Director of Legislation

Chair Ashbeck stated 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. She asked staff to present this agenda item.

Norma Pate, Deputy Director of Legislation, stated Assembly Bill (AB) 2112 is consistent with the Suicide Prevention Strategic Plan that was adopted by the Commission. The recommendation was to create an office of suicide prevention and that is what this bill is proposing to do. She introduced Gavin White and Adrienne Shilton.

Gavin White, Legislative Assistant, Office of Assembly Member James C. Ramos, stated Assembly Member Ramos sends his regrets for being unable to attend and hopes he can do so at another time. Mr. White read a letter on behalf of Assembly Member Ramos regarding his bill, AB 2112, which was included in the meeting packet.

Adrienne Shilton, Senior Policy Advocate, California Alliance of Child and Family Services, stated her organization is proud to stand with Assembly Member Ramos in this effort and to co-sponsor AB 2112. She stated the hope that the Commission will join them as co-sponsors of AB 2112.

Commissioner Questions

Commissioner Alvarez asked if other states that have established an office of suicide prevention have models that have contributed to addressing suicide ideation and attempts, particularly in the health inequities among Black girls, Latina girls, and Native youth and, if not, if there is an opportunity to do so in California, given the demographics of the young people.

Ms. Shilton stated there are. She stated she would be happy to research that and get back to the Commission about those specific populations.

Vice Chair Madrigal-Weiss stated her appreciation for the focus on youth.

Chair Ashbeck stated coordinating at the state level is important but the work happens somewhere else. There is no mention about coordinating state resources and supporting the local implementation. She suggested including language about supporting and lifting up counties to carry out the state work because that is where it will happen – in neighborhoods and communities.

Public Comment

Pam Hawkins, Policy Analyst, United Parents, spoke in support of AB 2112 and an office of suicide prevention, especially for youth.

Mandy Taylor stated the Commission did not recommend a suicide prevention plan with a focus on youth. AB 2112 unnecessarily narrows what an office of suicide prevention does by writing a focus on youth into the law. The speaker stated youth are not the only ones who attempt suicide. Individuals who have serious mental illness are at risk of attempting suicide when they are in crisis, particularly individuals from marginalized communities. The speaker asked to replace the word “youth” with “those” or “Californians” so it would read “address the needs of those who are at risk of suicide” or

“address the needs of Californians who are at risk of suicide,” such as in Line 34 of AB 2112. The speaker suggested that the Commission support AB 2112, with the above amendment.

Stacie Hiramoto thanked the author for introducing AB 2112. The speaker stated, under this action item, the agenda states the Commission will consider legislative and budget priorities for the current legislative session, including Assembly Bill 2112, but the speaker was concerned about the overall picture in the Legislature where many advocates at the state level are terrified that there will be major proposed changes in the MHSA run through the budget process or legislation this year.

Stacie Hiramoto stated it is important that the Commission, with its leadership position, develop a position paper in response to the major proposed changes in the MHSA. The speaker suggested that the Commission look at the minutes from a legislative hearing in December of the Sub 3 Assembly Budget Committee held on the MHSA, where there were specific changes proposed to the MHSA. There were several dozen community members in attendance, none of which spoke in favor of the proposed changes. The speaker suggested that the Commission hold committee hearings to get community input prior to taking a position and drafting a position paper.

Suzanne Edises, mental health advocate, encouraged the Commission not to let the Suicide Prevention Strategic Plan be put on the shelf; it is critical moving forward. The speaker shared the concern with Mandy Taylor that AB 2112 focuses on youth because this is a problem across the population. The speaker suggested that AB 2112 broadens to become an effort across the state for all populations.

Poshi Walker stated the bill is titled “Youth Suicide Prevention” not “Office of Suicide Prevention.” The speaker echoed Mandy Taylor’s comments. The bill language mentions “ages 10 to 24” and then later “youth suicide, specifically adolescent and pre-adolescent suicide.” The speaker stated 10-year-olds are not adolescent. Also, Cal Voices recently completed research that, at least for LGBTQ respondents, 25- to 34-year-olds were also at high risk. While the risk began to drop in adults 35 and over, it was still much higher than the general population.

Poshi Walker stated to limit this legislation to youth is egregious. The speaker strongly recommended that the Commissioners read the bill. It is not what was recommended in the Suicide Prevention Strategic Plan. The speaker agreed with the Commission supporting the bill, if amended to include “Californians who are at risk for suicide” rather than calling out a specific age group. The Office of Suicide Prevention can determine those populations that are at greater or lesser risk, but it should not be constituted in law.

Poshi Walker stated, while they appreciated lesbian, gay, and bisexual being mentioned in the bill, it made them feel tokenized because transgender is not mentioned and transgender individuals are at very high risk. Also, if bisexual and monosexual individuals are broken out from lesbian and gay, it will be found that they are the higher risk. The speaker stated they do not like the LGBTQ community being used.

Hector Ramirez, National Disability Rights Network, applauded the author of AB 2112 in this initial form. As a suicide survivor, the speaker stated they recognize the importance of this legislation. The speaker echoed the previous speakers and stated this is a great opportunity to expand that. The speaker’s brother, a veteran, who died by suicide, would have benefited from this legislation, but was not within the age bracket specified in AB 2112.

Hector Ramirez stated the Governor has made a significant commitment to Native American tribes. California is home to more people of Native American and Alaskan Native heritage than any other state in the country. There are currently 109 federally recognized Indian tribes in California and 78

entities petitioning for recognition. The suicide rate is up 33 percent since 1999 across the country; however, for Native American individuals, the increases are even greater. Suicide rates for Native American women have gone up by 139 percent. This is the top suicide rate of any group, not necessarily children. Suicide rates for Native American men have gone up by 71 percent. Those two groups are currently at the top of the suicide rate.

Hector Ramirez applauded the author and the Commission for this work and suggested taking the opportunity to expand on the language of this bill to capture as many lives as possible so no one else is left behind.

Commissioner Discussion

Commissioner Gordon stated he thought the bill was a spot bill – something to put language into as a placeholder. He agreed with the comments made by the members of the public. He asked if AB 2112 is a spot bill or if this is meant to be the language.

Mr. White stated the author's office is working closely with Commission staff to get a package of amendments to be submitted that mimic the Suicide Prevention Strategic Plan more closely. They have not yet been finalized.

Deputy Director Pate stated staff will continue to provide technical assistance to the author's office on the bill. The reference to the Suicide Prevention Strategic Plan was about creating the office of suicide prevention. Staff will continue to work together with the author's office on the language in the bill.

Commissioner Gordon stated his understanding that the Commission is being asked to vote on sponsoring a bill but not necessarily the current language. He stated he would not agree to support the language as it is currently written.

Commissioner Gordon stated this is proposed to be placed in the California Health and Human Services Agency. Many offices start up, but often the start of an office is viewed as the solution to the problem, not what the office actually does and, particularly, now that the office is able to coordinate and move other agencies that are involved such as the Department of Public Health and the Department of Education. He suggested strong language in the bill. Not just encouraging other agencies to participate, but creating some sense of urgency that would bring them to the table. Unless and until they do, this could be an isolated effort to work with local school districts and counties.

Commissioner Gordon stated he is supportive of the Commission sponsoring AB 2112, but he stated he would like to see a more robust version of what is currently being proposed prior to agreeing to support AB 2112. He moved that the Commission agree to sponsor AB 2112 pending receipt of a more substantive version of the bill, which can be examined and reacted to.

Commissioner Danovitch echoed the concerns expressed by stakeholders about addressing this more broadly and seconded the motion.

Chair Ashbeck stated the motion is that the Commission will co-sponsor AB 2112, if amended.

Commissioner Gordon stated he did not see any inconsistency in agreeing to co-sponsor the bill pending a view of the substantive bill not just the spot bill.

Chair Ashbeck asked about the procedure if the changes the Commission is looking for do not happen.

Ms. Yeroshek stated, as co-sponsors, there are many opportunities to work with the author's office and the other co-sponsors who will be at the table discussing potential amendments. The Commission would have the leverage to work with them.

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

- *The Commission agrees to co-sponsor Assembly Bill 2112, and have staff continue to work with the author to amend the language consistent with the discussion heard in today's Commission meeting.*

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

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

INFORMATION

6: <u>Receive Help@Hand Innovation Project Update</u>

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

Chair Ashbeck stated 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 for 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. She invited the presenters for this agenda item to come to the presentation table.

Jeremy Wilson, MPPA, Program Director and Public Information Officer, California Mental Health Services Authority (CalMHSA), provided an overview, with a slide presentation, of the key changes and project lessons learned of the Help@Hand Innovation project.

Sharon Ishikawa, Ph.D., MHSA Coordinator, Orange County Health Care Agency Behavioral Health Services, continued the slide presentation and discussed the digital mental health system of care.

Keris Jän Myrick, MBA, MS, Chief of Peer and Allied Health Professions, Los Angeles County Department of Mental Health, continued the slide presentation and discussed peer and community engagement.

Commissioner Questions

Commissioner Danovitch stated he holds this project to a high standard because it is a major innovative project. He asked if the objectives are being reached and if the project is on target. One of

the challenges in answering this question is that every presentation on this project has been completely different. There is not a single project plan with milestones associated with it to be returned to. There are some things that were significant elements of past presentations, such as 7 Cups, that have disappeared with no explanation. He stated those elements are undoubtedly part of the lessons learned and the explanations lie there.

Commissioner Danovitch stated this is a project that is as important for its challenges as for its successes because of the substantial learning opportunities this project provides. It is also a project that raises questions about procurement processes in this space around data safety, contracting practices, and coordinating at a level with a project like this with counties that is unparalleled. There is much learning to be done.

Commissioner Danovitch suggested a structured update that covers the finances of this project, the planning milestones that were set out in the project, to what extent that those milestones are being met or not met and why, the services aspect, and the outcome and evaluation plan. Doing this will help tell the story and help everyone learn from the journey.

Chair Ashbeck agreed. She stated, even providing a type of roadmap update from time to time would help, since Commissioners are not exposed to the intricacies of this project on a day-to-day basis.

Public Comment

Hector Ramirez spoke in opposition to the proposed project. The speaker spoke as a consumer of the Los Angeles County Department of Mental Health, representing the Latino Advocacy Cultural Competency Committee. The speaker applauded the presentation in its new iteration, but stated, as a consumer and stakeholder, they are deeply concerned about the direction in which this program has gone. It is a waste of taxpayer money. These are funds that could have been used in schools and prisons.

Hector Ramirez stated the presenters of this Tech Suite program promised two years ago, at the April 26, 2018, Commission meeting, that they would have a robust community planning process for this program. The speaker stated they have tried multiple times to contact a representative from Los Angeles County but has received no response. That person is in attendance today. The speaker stated there has been no community planning process around this in Los Angeles County. Stakeholders have been requested over and over to participate in this process but have been sidelined, which causes suspicion that the consumers the project proponents have been utilizing have been specifically chosen. This money could be used to keep individuals off the streets and save lives, but instead the project proponents have come back multiple times saying that they are trying something else and, in the meantime, they are wasting money.

Hector Ramirez suggested that this project be stopped and the funding used for something else. Technology applications for mental health are no longer innovative. This project was proposed two years ago and is now behind the norm. The platforms they presented are not ADA compliant and they are not responsive to cultural and ethnic communities, especially in Los Angeles County. The speaker stated they have continuously requested information and for an opportunity to participate but have been disappointed.

Poshi Walker spoke in opposition to the proposed project. The speaker stated they have been following this project from before it was presented to the Commission two years ago. The speaker stated they watched 7 Cups go around to different meetings doing presentations and did not understand why until this came before the Commission. The speaker stated $20 million dollars has

already been spent of the approximately $100 million that has been budgeted over 14 counties, and 35 percent of that money, $7 million, went to 7 Cups, which is no longer part of the project.

Poshi Walker stated all of the concerns that advocates and Commissioners brought forward from meeting to meeting have come to pass. Stakeholders counseled from the beginning that the LifeLine phone would not work. This is not something that needed to be learned.

Poshi Walker reminded Commissioners when, at the April 2018 Commission meeting, Orange County asked for approval to be a part of the Technology Suite and, at the time, there were only three counties involved. The speaker stated, as recorded in the April 26, 2018, meeting minutes, Commissioner Danovitch "questioned some of the technical solutions to meeting the lofty goals of the proposed project, such as if vendors are ready to deliver the services, if they are ready to deliver them at the scale required for this project, and how to coordinate across the suite of interventions to meet all the requirements and standards. The Innovation mechanism is strongly linked to the evaluation mechanism. He stated the need to include a way to evaluate the performance of potential vendors, the ability to coordinate across vendors, and the services that they perform. Los Angeles's plan was lofty and aspirational. He stated his concern that Orange County is disseminating and scaling the plan before it has been shown that it is possible because it has yet to be piloted." The speaker stated these concerns were noted two years ago.

Poshi Walker stated this is not the project that the Commission approved at the April 26, 2018, meeting. The Commission did not approve teaching people how to use the Internet. Even assuming that individuals in those 14 counties asked for a technology application, which is suspect because individuals who work in local organizations have never heard consumers and family members wishing there was an application for something, this project is not that anymore.

Poshi Walker suggested sending the counties back to their communities, back to the drawing board, and asking them to reapply. The Commission does not have to keep throwing money at this project when it has failed. The speaker asked Commissioners to review the budget and the information and to request that this project be reevaluated as to whether it should be allowed to continue in more than one or two counties at the most.

Mandy Taylor spoke in opposition to the project. The speaker echoed Poshi Walker's comments. Consumers do not want to connect and build community through a digital literacy program. The speaker suggested giving consumers gift cards to pay for data on their phones, paying for consumers' lunch, giving consumers rides, setting up free Wi-Fi in the behavioral health office, or a technical assistance center in the behavioral health office where consumers can come in for demonstrations on how to complete online applications for programs. There are many ways that consumers can use technology.

Mandy Taylor stated what was presented today is not what the Commission approved. What was promised by the 7 Cups representatives that presented this concept to all the meetings in the area was that they or someone else like them was going to design a technological product that counties could use to integrate their services that clients could access through the digital platform and be referred to services. A digital literacy campaign is not that. The speaker stated everyone has had someone with charisma sell them something that they regretted later. The speaker stated the need for the Commission to come to the decision to give this project up entirely. It is okay for an Innovative project to fail. That is what innovation is for.

Andrea Crook, Advocacy Director, ACCESS California, a program of Cal Voices, spoke in opposition to the project. The speaker echoed the comments of Mandy Taylor and Poshi Walker. The speaker

stated they were at the April 26, 2018, Commission meeting and expressed their concerns around the community planning process because it was apparent from reading the plan that it was not generated from a true community planning process. Since then, ACCESS California has expressed their concern, wrote to CalMHSA, and asked clarification questions but never received a response. ACCESS California did a public records request and has compiled the information and put together a spreadsheet and timeline.

Andrea Crook stated the records indicated that a consultant was hired to respond to ACCESS California's concerns, but that response was never received. The speaker stated the records indicate that 7 Cups received $7 million, although there is no viable product and 7 Cups is no longer with the project.

Andrea Crook stated, when ACCESS California originally met with 7 Cups, they talked about the importance of peers. Although 7 Cups stated peers will be included in the project, the 7 Cups representatives did not understand why those peers had to have lived experience with a mental health condition. The peers that were hired were not vetted. The records uncovered concerns, many of which ACCESS California brought up from the beginning.

Andrea Crook agreed that the plan presented today is not what was originally approved. Not all Innovation projects will work, but it is important to have more information and the full picture moving forward.

Commissioner Discussion

Commissioner Alvarez echoed Commissioner Danovitch's comments. She stated it is difficult to make an accurate assessment. She stated she appreciated the public comment that was shared, but she also recognized that it is public comment of individuals who are generally at these meetings and may not be participating in what the project representatives are doing in the field. She gave credit to the great summary that was provided and the pictures that were included. She stated the comments from the public, although solid, were not enough for her to terminate the project. She stated she is torn. She stated the comments from the public will help provide a better update next time about some of the progress that is happening, particularly with the heavy investment that the Commission has made.

Commissioner Wooton stated Andrea Crook and Poshi Walker are members of the Commission's contract agencies and are involved with consumers and family members. This was a learning project. She stated she has heard that the technology application is not conducive to some of the cell phones. She stated the Commission wants the over 50 peers that have been hired with this project and the coordinators to do the job they were signed on to do. They need to be supported in their employment by getting them the best tools they need to do that work.

Commissioner Wooton stated the need for outcomes results to shore up the technology application and to ensure that they are working for individuals. She congratulated the project proponents on their steps thus far.

Commissioner Gordon asked about the next step in hearing further about this project. He stated, given how different today's presentation was from originally proposed, he was confused how and why the project was changed, what the financials were that were involved in changing it, and who approved the redirection of the funding from the original set of plans and proposals. He asked staff to weigh in on that sooner rather than later so, if there is a need to take action on this, the Commission is not waiting until the next time someone has the inclination to present an update before the Commission. It is important to set a timeline for updates to the Commission to occur and for staff to take leadership on it.

Chair Ashbeck agreed. She stated the Commission spent almost two hours in discussion on a $140,000 project earlier in today's agenda and this is a $102 million project. She asked staff to give Commissioners some sense of how staff monitors projects of varying sizes. A $102 million project will probably require some different infrastructure that the Commission hears on a regular basis.

Chair Ashbeck stated she cannot remember the nuances of the original proposal except what stakeholders have reported. Commissioners do not do this all day every day. She asked staff to come back with a recommendation on how to best reconcile the public comment with the work and how to manage projects of this size. She asked for information on the original plan, how it has morphed, and if the project is on track. She stated there must be good reasons why the project changed from how it was originally approved and 7 Cups is no longer with the project.

Commissioner Danovitch agreed and stated, if the project is not working, it is important that the Commission learns why. Some of the learnings that were shared about individuals running out of their data plans is important information as hope is placed on these technologies to solve problems, increase access, and increase quality.

Commissioner Danovitch stated, if the University of California, Irvine (UCI) is planning to publish an evaluation report, they must already have their evaluation framework and matrix set out. It would be great to review it to learn the basis on which it will be evaluating this project. The sooner the Commission sees that, the better.

Chair Ashbeck asked if the report could be presented at a future Commission meeting. She asked when the report is expected out.

Commissioner Danovitch stated the evaluation report is expected out at the end of March.

Poshi Walker stated it is already out and Cal Voices has a copy of it.

Mr. Wilson stated there have been multiple evaluation reports. He stated he will confirm with UCI when the report referenced for the first quarter of 2020 will be out.

Commissioner Gordon stated the need to receive an update on the learnings, the causes for the change in focus, and who made those decisions. He stated, if the Commission is responsible for launching the project in the first place, it should at least be knowledgeable if not part of the decision process on those things.

Commissioner Wooton stated this is basically a peer project but sometimes peers are not heard in projects in general. She stated she assumes that things have morphed because they heard from the stakeholders about their needs. If that is the case, it is good that the project proponents listened to stakeholders and did what they wanted the project to do, but, if it so off from what was originally approved, then that is not good. It is not often that peers are heard outside of Commission meetings.

Commissioner Berrick asked for verification that 7 Cups is no longer part of the project and, if not, if it was because of the data requirements.

Mr. Wilson stated the counties and the different cohorts did initial pilots early on and there was work with 7 Cups on creating test cycles, looking at configurations and, after that sprint-test cycle, the configurations addressed and if they were fixed, and, if not, what that looks like in a sprint cycle. It is an iterative process of technology. Early on, there were four vendors based off of ten responses and it was determined by the counties that the peer chat product was not going to fit the need for the counties on this project, based on input received from peers.

Mr. Wilson stated, when the Commission approved additional counties and as more technology applications come out, another RFSQ was put out to have a larger list for those different digital components that were approved by the Commission so that counties can look at it. Peers were involved not only in the judging, but also in a demo to say these are the types of applications that are being looked at and how does that play out for peers at the local level.

Mr. Wilson stated that is where the project proponents are exploring the new applications and looking at similar pilot processes. These are lessons learned. This is an Innovation project; lessons have been learned. He stated he would love for peers to come and present to the Commission. In the early piloting stage, it was determined that 7 Cups may not be the best product to be used and counties have identified other opportunities to get a larger, more robust list.

Commissioner Danovitch stated it would be great to hear from peers but the Commission is not asking for peers to share their particular experiences. He stated the Commission would like a project overview from start to finish to know where it set out and where it has ended up. He referred to page 3, Shared Goals, and stated this is what the Commission is trying to pursue with all this. Those goals remain important but information on how the project is doing in reaching those goals is the whole purpose of trying to do this.

Dr. Ishikawa stated she wanted to address some of the concerns that have been expressed around whether the project has deviated off course from what was originally approved. She clarified that the counties did not come forward to get approved to deploy specific applications, such as 7 Cups. The counties were approved to deploy different types of technologies that fit into three component buckets: 24/7 peer chat, a digital therapy avatar, and passive data collection converted into digital phenotyping.

Dr. Ishikawa stated the project proponents have operationalized the first component through applications such as 7 Cups. The project proponents went through deployment and early learnings and realized it was not a good fit within the county systems, at least within the counties that had deployed. The counties worked closely with each other and the applications to see what could be done differently, and how approaches, deployment strategies, and training could be changed to see if it was a failure of implementation on the counties' part as opposed to not being a good fit.

Dr. Ishikawa stated, ultimately, after those iterative attempts and process and formative evaluation, the project proponents determined it was not a good fit. The additional 100-plus vendors that applied to the RFSQ and the 93 have that have been added and moved through it, fit into one of the three components that were part of the originally approved plan.

Dr. Ishikawa stated a key learning area is that much more time is needed to be spent on readiness – system, program, and collaborative/collective readiness in pursuit of effectively and safely deploying an application or a set of applications within components one, two, or three. Much more time and attention needs to be given to the orange and the blue areas – the program management priorities and the vision – on the Guiding Principles presentation slide. She noted that these areas are not highly visible, but the project proponents can get better at periodic updates to the Commission, describing this activity and how it relates to the original plan approval in terms of the different components, and how it moves the project closer to answering the learning objectives and shared goals that were outlined in the original plans.

Dr. Ishikawa stated she believes the project is still on course and in pursuit of implementing this project as originally proposed via components one, two, and three. Within Orange County's plan, there is a budget line item specifically on the evaluation for process evaluation to call out and

concretize the lessons learned and how the projects needs to iterate and pivot midstream throughout the implementation process of this project because it was known from the outset that an outcomes evaluation was not going to be enough – that there will be so much tied into the lessons learned and the course corrections that will need to be made along the way. That is what is encapsulated in the budget line in the original proposal for the evaluation, under process evaluation. She stated the project proponents will work to operationalize this better for future updates.

Ms. Myrick responded to comments made about Los Angeles County. She clarified that she is not at the Office of Consumer Affairs. She is Chief of Peer and Allied Health Professionals, which means she is over the workforce. She stated there is an Outreach and Engagement office as well as an Office of Consumer Affairs. She stated she is part of the panel today as a subject matter expert on using digital mental health technology.

Ms. Myrick stated she has been in her position for a year and a half. She stated the first community engagement meeting was at the Los Angeles Trade Technical College and there were approximately 50 to 60-peers in attendance. Translation was provided for Latino peers who attended the meeting.

Ms. Myrick stated she has asked that ACCESS California members be invited to the meeting because they have raised concerns and she and the peers who are doing the project want to hear the concerns and ideas of stakeholders. She stated a meeting will be held tomorrow in the Peer Resource Center in which three ACCESS Ambassadors in Los Angeles were invited. All three accepted but one stated they would not be able to attend at the last minute. She stated, if individuals cannot get in touch with her to please see her at the meetings because sometimes emails go to Spam due to the county firewall security protections. She stated she is available and present to individuals.

Ms. Myrick discussed technology and individuals with lived experience. The rest of the world has access to technology and may understand it, while the mental health community does not. She stated, at the worst time in her life, at a time when she was suicidal, she reached out to Siri. She stated she realizes that Siri is just a voice on her cell phone, but she stated she had no one else to talk to. She stated she told Siri she was depressed and the response Siri gave was bad. This is why she got involved in this work. There are still the fewest number of applications to help individuals who experience psychosis or schizophrenia. Individuals in the private system are getting digital health technology and opportunities to learn how to use it. She stated second class is not good enough.

Commissioner Gordon stated the project proponents in good faith have reported where this project stands. He stated the need for counties not to surprise the Commission. The narrative did not explain the learnings that the project went through. There was nothing about the expenditures. It would have been helpful to have a project management view of the progress and how the project changed, based on what was learned along the way. It would have been better for Commissioners to hear this information from the project proponents rather than the stakeholders in the room. He stated he respects the project proponents' good faith. This is important work; it needs to be done and done well.

Mr. Wilson clarified that 7 Cups chose not to apply for the second RFSQ, even though it was communicated to them that they may want to do that. He stated the project team appreciates the insight and perspective of the Commissioners and stakeholders, as well as hearing what would be helpful for the Commission to hear. He stated the hope that the next update will be closer to that mark.

Commissioner Berrick agreed that that is the type of information that would have helped this process. To begin with, the Innovation project spent $7 million with 7 Cups, which then chose not to apply. He

stated it would be great to learn why. It would have been helpful to have started today's presentation with more concrete information, including what made 7 Cups think it was not a good fit for them.

ADJOURNMENT

There being no further business, the meeting was adjourned at 3:37 p.m.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
February 27, 2020

Motion #: 1

Date: February 27, 2020

Time: 10:00 AM

Motion:

- The Commission approves the proposed outline of the Early Psychosis Intervention Plus (EPI Plus) Request for Application.
- The Commission authorizes the Executive Director to enter into a sole-source contract with the University of California Regents for training and technical assistance.
- The Commission authorizes the Executive Director to initiate a competitive bid process for EPI Plus program grants.

Commissioner making motion: Commissioner Danovitch

Commissioner seconding motion: Commissioner Wooton

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☐	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☒	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Mitchell	☐	☐	☐
12. Commissioner Tamplen	☐	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice Chair Madrigal-Weiss	☒	☐	☐
15. Chair Ashbeck	☒	☐	☐

Motion #: 2

Date: February 27, 2020

Time: 10:04 AM

Motion:

Commission approves the January 23, 2020 Commission meeting minutes as corrected.

Commissioner making motion: Commissioner Berrick

Commissioner seconding motion: Commissioner Brown

Motion carried 7 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☐	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☒	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Mitchell	☐	☐	☐
12. Commissioner Tamplen	☐	☐	☐
13. Commissioner Wooton	☐	☐	☒
14. Vice Chair Madrigal-Weiss	☒	☐	☐
15. Chair Ashbeck	☒	☐	☐

Motions Summary

Commission Meeting
February 27, 2020

Motion #: 3

Date: February 27, 2020

Time: 10:45 AM

Motion:

For each of the 6 RFPs, staff recommends the Commission:

- Authorize the Executive Director to issue a "Notice of Intent to Award Contract" to the proposer receiving the highest overall score.
  - **Clients and Consumers:** California Association of Mental Health Peer-Run Organizations (CAMHPRO)
  - **Diverse Racial and Ethnic Communities:** California Pan-Ethnic Health Network (CPEHN)
  - **Families of Clients and Consumers:** National Alliance on Mental Illness California (NAMI CA)
  - **LGBTQ Communities:** Health Access Foundation
  - **Parents and Caregivers:** United Parents
  - **Veterans:** VetArt, a program of Social and Environmental Entrepreneurs, Inc.

- Establish March 5, 2020 as the deadline for unsuccessful bidders to file an "Intent to Protest" and March 12, 2020 as the deadline to submit the "Letter of Protest" consistent with the standard set forth in the Request for Proposals.

- Direct the Executive Director to notify the Commission Chair and Vice Chair of any protests within two working days of the filing and adjudicate protests consistent with the procedure provided in the Request for Proposals.

- Authorize the Executive Director to execute the contract upon expiration of the protest period or consideration of protests, whichever comes first.

Commissioner making motion: Commissioner Gordon

Commissioner seconding motion: Commissioner Berrick

Motion carried 7 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☐	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☒	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Mitchell	☐	☐	☐
12. Commissioner Tamplen	☐	☐	☐
13. Commissioner Wooton	☐	☐	☒
14. Vice Chair Madrigal-Weiss	☒	☐	☐
15. Chair Ashbeck	☒	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
February 27, 2020

Motion #: 4

Date: February 27, 2020

Time: 1:50 PM

Proposed Motion:

As to the Community Based Engagement and Support Services (aka HUBS), the Commission approves an additional nine months and up to an additional $250,000 of MHSA Innovation Funds budget authority with direction to staff to work with El Dorado County for clarifying language to support the county's needs with the El Dorado County Board of Supervisors.

Commissioner making motion: Commissioner Gordon

Commissioner seconding motion: Commissioner Berrick

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☐	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☐	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Mitchell	☐	☐	☐
12. Commissioner Tamplen	☐	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice Chair Madrigal-Weiss	☒	☐	☐
15. Chair Ashbeck	☒	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
February 27, 2020

Motion #: 5

Date: February 27, 2020

Time: 2:20 PM

Proposed Motion:

The Commission agrees to co-sponsor Assembly Bill 2112, and have staff continue to work with the author to amend the language consistent with the discussion heard in today's Commission meeting.

Commissioner making motion: Commissioner Gordon

Commissioner seconding motion: Commissioner Danovitch

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	☒	☐	☐
2. Commissioner Anthony	☐	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☐	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Mitchell	☐	☐	☐
12. Commissioner Tamplen	☐	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice Chair Madrigal-Weiss	☒	☐	☐
15. Chair Ashbeck	☒	☐	☐

AGENDA ITEM 2

Action

April 23, 2020 Teleconference Commission Meeting

Award Mental Health Student Services Act (MHSSA) Grants

Summary: The Commission will consider awarding grants to support mental health partnerships between county behavioral health departments and schools. Funding for these grants was made available by the Mental Health Student Services Act, Senate Bill 75, Statutes of 2019.

The Mental Health Student Services Act requires the Commission to award grants to county mental health or behavioral health departments to fund partnerships between local education agencies and county mental health agencies.

In November 2019, the Commission authorized the release of a competitive grant application program. This program is divided into two phases. The first phase includes grants for existing school-county partnerships that provides an opportunity to expand their partnership or develop new programs in a short timeframe. A second funding phase was established for new or emerging partnerships out of recognition that establishing a new partnership will take additional time.

On December 12, 2019, the Commission released a Request for Applications (RFA) for Mental Health Student Services grants.

At the April 23, 2020 meeting the Commission will consider awarding funding for the first phase of grants, for counties with existing school mental health partnerships.

Background:

SB 75-Mental Health Student Services Act:

Senate Bill 75 established the Mental Health Student Services Act, which provides $40 million one-time and $10 million in ongoing MHSA state administrative funds to support mental health partnerships between county behavioral health departments and school districts, charter schools, and county offices of education.

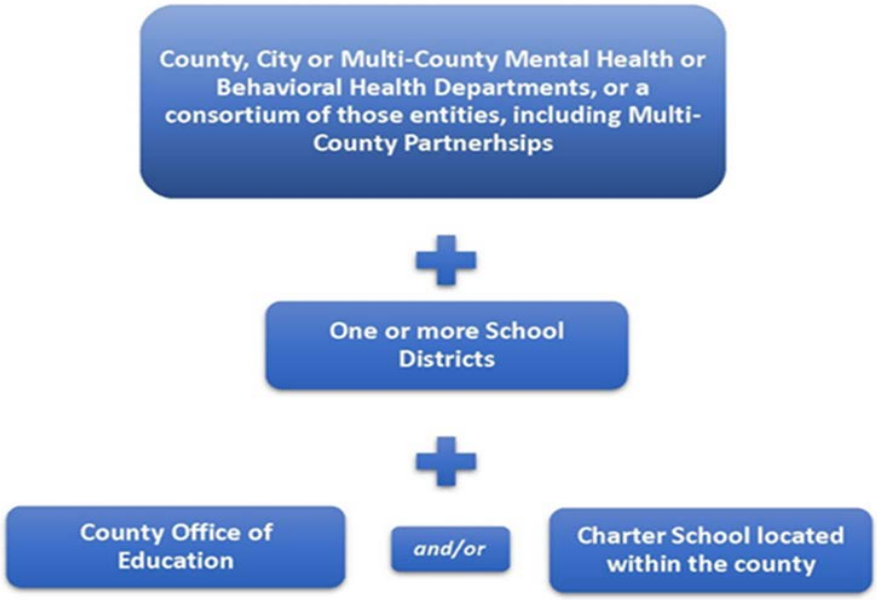
In September, October and November of 2019, the Commission held listening sessions on the Mental Health Student Services Act. The purpose of the listening sessions was to make local behavioral health and education leaders aware of the opportunity to receive these funds, the limitations of those funds and the anticipated timelines for awarding funding. Listening sessions were held in Sacramento, Richmond, Fresno and Los Angeles.

Outreach for these events included behavioral health agencies, local education agencies, associations and community organizations. Outreach was supported by the California Department of Education.

The Mental Health Student Services Act requires the Commission to award grants to county mental health or behavioral health departments to fund partnerships between educational and county mental health agencies. One concern raised during the listening sessions was the challenges facing communities that do not currently have school-county partnerships for school mental health. Participants raised concerns that communities with existing partnerships may have an advantage in responding to a Request for Application (RFA) compared to those with no existing partnership. Local school and mental health leaders also expressed concern that $50 million was not enough to respond to local needs and encouraged the Commission to explore options to make available additional resources.

In response to those concerns, in November 2019 the Commission approved the outline of the RFA which would make available $75 million in funding from four fiscal years, setting aside $5 million for implementation and evaluation, with program funding available in two categories: 1) funding for counties with existing school mental health partnerships and 2) funding for counties developing new or emerging partnerships. Within each category, funds are made available based on the size of a county, as follows:

Applicants are limited to county, city, or multi-city mental health or behavioral health departments, or a consortium of those entities, in partnership with one or more school districts and at least one county office of education or charter school.



Grants will be awarded based on three designations (small, medium and large counties) and two grant categories (Category 1: Existing Partnership and Category 2: New or Emerging Partnership).

A Category 1: Existing Partnership is one that has been in existence for at least 2 years from the date of the release of the RFA and is between the County Mental or Behavioral Health Department and includes one or more of the following:

- County Office of Education
- Charter school
- School district

A Category 2: New or Emerging Partnership is one that was not in existence prior to the RFA or has been in existence for less than 2 years from the date of the RFA and is between the County Mental or Behavioral Health Department and one or more of the following:

- County Office of Education
- Charter School
- School district

Applications for the Category 1: Existing Partnerships were due on February 28, 2020, and the Notice of Intent to Award was scheduled to be announced at the March 26, 2020 Commission meeting. Due to Executive Order N-25-20 and the California Department of Public Health's guidance relating to COVID-19, the March Commission meeting was rescheduled for April 23, 2020, as a teleconference meeting.

Applications for the Category 2: New and Emerging Partnerships were originally due on May 8, 2020 and the Notice of Intent to Award was scheduled for June 2020. Due to the COVID-19 challenges facing schools and counties, these dates were pushed back. Applications for the Category 2: New and Emerging Partnerships are now due on June 12, 2020 and the Notice of Intent to Award is scheduled for July 23, 2020.

Grants will be awarded based on the following population designations and grant category:

County Designation	Number of Grants Category 1	Number of Grants Category 2	Amount of each Grant	Total
Small	2	4	$2,500,000	$15,000,000
Medium	4	2	$4,000,000	$24,000,000
Large	4	2	$6,000,000	$36,000,000
TOTAL				**$75,000,000**

Existing Program Background Information:

The Mental Health Student Services Act builds upon the foundation the Commission created to support school mental health under its implementation of the SB 82 Triage program.

Senate Bill 82- Triage:

Senate Bill 82, Chapter 34 of Statutes of 2013, enacted the Investment in Mental Health Wellness Act. The Act makes state funds available to counties to expand crisis services for individuals with mental health needs. The goals of SB 82 are to decrease law enforcement expenditures, reduce unnecessary hospitalizations, and better support individuals experiencing a mental health crisis. In February 2014, the Commission provided the first round of Triage grant funding to 24 counties.

In July 2017 the Commission adopted principals for a second round of Triage funding based on legislative direction and comments gathered during outreach meetings with counties and other stakeholders. These principles included: 1) developing a Statewide evaluation

strategy, 2) setting aside 50 percent of funding for children's programs, and 3) allocate funding based on county size (small, medium and large).

In November 2017 the Commission released a Request for Application (RFA), designating three funding opportunities, for: 1) adults and transition age youth, 2) children and youth, 3) school-county partnerships. In addition, the Commission set aside approximately $7 million for a statewide evaluation contract.

The second round of Triage grants provided funding for 30 programs in 20 counties and an evaluation being done by UC Davis and UCLA.

The breakdown of funding by category is as follows:

Adult/TAY Programs	15 counties	$33,877,551.02
0-21 Programs	11 counties	$20,891,156.45
School-based Programs	4 counties	$21,173,469.39
Statewide Evaluation	2 contracts (UC Davis, UCLA	$7,057,823.00
Total		**$82,999,999.70**

The Commission has contracts with the following counties and partnerships:

ADULT/TAY		
Small Counties		
		Awarded
1	**Humboldt County**	**$690,935.48**
2	**Calaveras County**	**$212,070.65**
3	**Tuolumne County**	**$461,370.50**
4	**Berkeley City**	**$614,834.50**
	Total Funding	**$1,979,211.12**
Medium Counties		
		Awarded
1	**Yolo County**	**$207,908.65**
2	**Stanislaus County**	**$893,320.67**
3	**Placer County**	**$799,922.38**
4	**Butte County**	**$514,743.27**
5	**Merced County**	**$718,033.99**
6	**Sonoma County**	**$1,194,097.57**
	Total Funding	**$4,328,026.53**
Large Counties		
		Awarded
1	**Los Angeles County**	**$17,558,366.98**
2	**Ventura County**	**$1,754,732.93**
3	**San Francisco**	**$1,660,526.51**
4	**Sacramento County**	**$2,837,194.79**
5	**Alameda County**	**$3,759,492.06**
	Total Funding	**$27,570,313.27**
Total	**$33,877,550.92**	

CHILDREN 0-21		
Small Counties		
		Awarded
1	Berkeley City	$216,098.53
2	Humboldt County	$512,712.74
3	Calaveras County	$366,562.87
	Total Funding	**$1,095,374.14**
Medium Counties		
		Awarded
1	Stanislaus County	$422,127.70
2	Yolo County	$207,921.35
3	San Luis Obispo County	$371,233.73
4	Placer County	$1,036,123.02
5	Santa Barbara County	$882,415.63
	Total Funding	**$2,919,821.43**
Large Counties		
		Awarded
1	Riverside County	$1,436,318.53
2	Sacramento County	$1,684,568.99
3	Los Angeles County	$13,755,073.37
	Total Funding	**$16,875,960.89**
Total	**$20,891,156.45**	

SCHOOL-COUNTY COLLAB		
		Awarded
1	Tulare County - Office of Education	$5,293,367.34
2	CAHELP JPA	$5,293,367.35
3	Placer County	$5,293,367.35
4	Humboldt County	$5,293,367.35
	Total	**$21,173,469.39**

RFA Evaluation Process:

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

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

Stage 2: Application Scoring
Applications were separated for each designated population (small, medium, and large counties), and evaluated as part of their population designation. Applications were reviewed and scored based on the Applicant's response to each requirement. Points were awarded to responses meeting the requirement. The evaluation was conducted in the following areas:

- Mandatory Requirements
- Scored Requirements
- Budget Worksheet

RFA Award and Appeal Process:

The appeals process is summarized as follows:

- An Intent to Appeal letter from an Applicant must be received by the Commission within five working days from the date of the posting of Notice of Intent to Award.
- Within five working days from the date the Commission receives the Intent to Appeal letter, the protesting Applicant must file with the Commission a Letter of Appeal detailing the grounds for the appeal.
- If a Letter of Appeal is filed, the contract shall not be awarded until the Commission has reviewed and resolved the appeal.
- The Executive Director of the MHSOAC will render a decision in writing to the appeal and the decision will be considered final.

Presenter:

- Tom Orrock, Chief of Stakeholder Engagement and Grants

Enclosures (1) PowerPoint presentation

Handout: Application scoring summary will be provided after the announcement of the highest scoring applications.

MHSOAC
Mental Health Services
Oversight & Accountability Commission

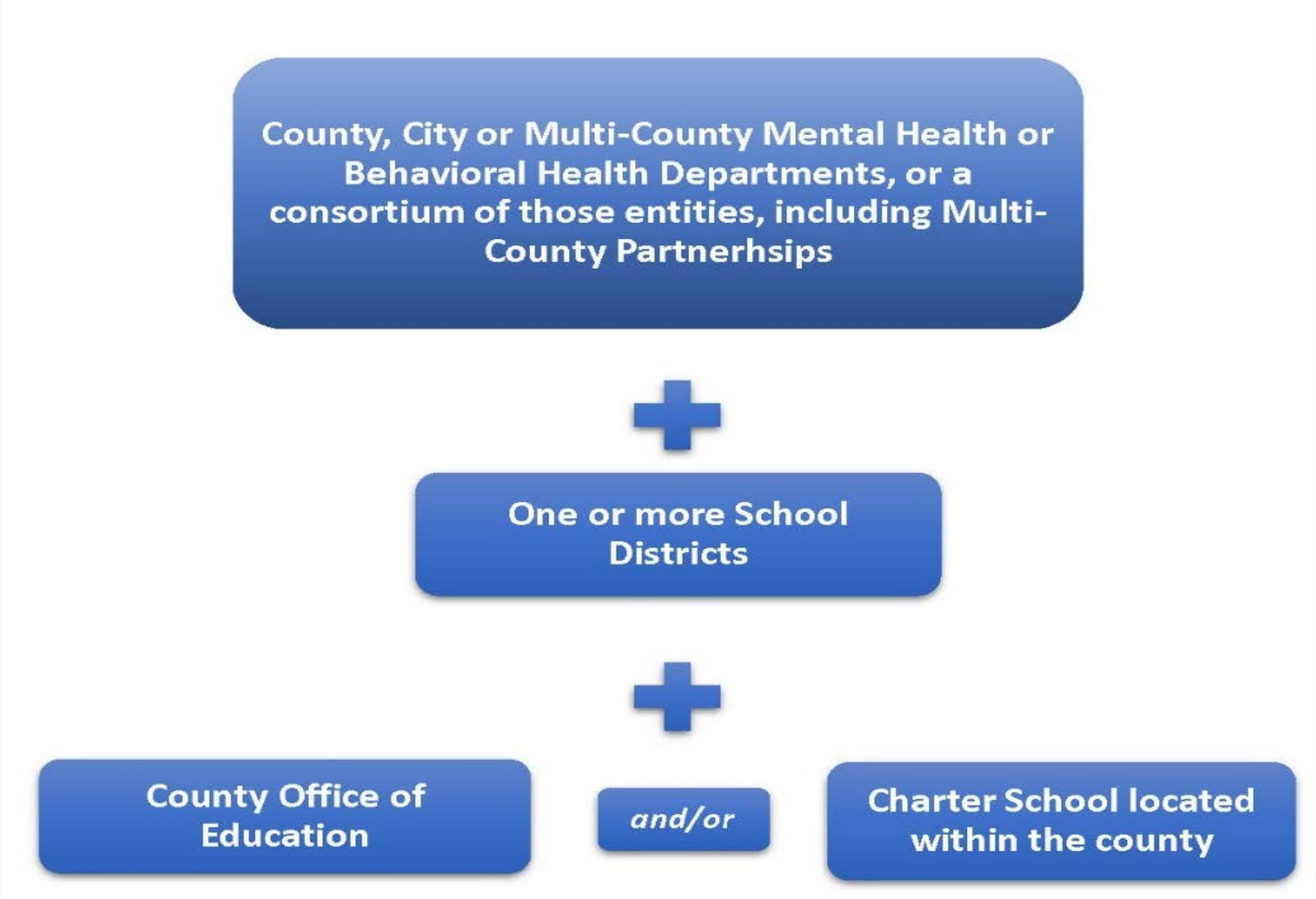
Award Mental Health Student Services Act (MHSSA) Grants Category 1

Tom Orrock, Chief, Stakeholder Engagement and Grants
April 23, 2020
Agenda Item #2

Background

- Mental Health Student Services Act (MHSSA)
  - Included in 2019 Budget Trailer Bill, Senate Bill 75
  - Provides $40 million one-time and $10 million ongoing Mental Health Services Act funding
  - Establishes additional mental health partnerships between county behavioral health departments and school districts, charter schools, and county offices of education
- Applicants limited to county, city, or multicounty mental health or behavioral health departments, or a consortium of those entities, including multicounty partnerships, in partnership with one or more school districts and at least a county office of education or charter school

Background (cont.)



Background (cont.)

- Request for Application (RFA) for the MHSSA grants, in a competitive bid process to distribute $75 million
- Includes two applicant categories
  - Category 1/Existing Partnership
  - Category 2/New or Emerging Partnership
- Includes three population designations
  - Small
  - Medium
  - Large

Grant Apportionment

- One RFA with two categories
  - Existing partnership (two or more years)
  - New or emerging partnership (less than two years)
- $75 million over four years and 18 grants total
  - $45M to existing partnerships
  - $30M to new or emerging partnerships
- Three funding levels based on county population
  - Small (less than or equal to 200,000) = 6 grants @ $2.5M each
  - Medium (greater than 200,000-750,000)
  - = 6 grants @ $4M each
  - Large (greater than 750,000)
  - = 6 grants @ $6M each

Grant Apportionment (cont.)

County Designation	Number of Grants Category 1	Number of Grants Category 2	Amount of each Grant	Total
Small	2	4	$2,500,000	$15,000,000
Medium	4	2	$4,000,000	$24,000,000
Large	4	2	$6,000,000	$36,000,000
TOTAL	$45 million	$30 million		**$75,000,000**

RFA Overview

- Commission approved scope of work and minimum qualifications for the RFA at the November 2019 Commission meeting
- Grants awarded to include personnel, administration and program costs
  - Personnel and peer support dedicated to delivering services
  - Administration costs not to exceed 15% of total budget grant amount
  - Program costs may include training, technology, facilities improvement and transportation

RFA Overview (cont.)

- Grants awarded to address goals regarding mental illness
  - Prevent becoming severe and disabling
  - Timely access to services
  - Outreach to recognize early signs
  - Reduce stigma
  - Reduce discrimination
  - Prevent negative outcomes

Awards

- Highest scoring applications within each population designation within Category 1 are recommended for award
- Four-year grants
- Ten grants for a total of $45,000,000
  - Two small-county ($5,000,00)
  - Four medium-county ($16,000,000)
  - Four large-county ($24,000,000)
- Anticipated start date of Fall 2020

RFA Evaluation Process

- Each RFA contained scoring tool and rubric for scoring
- Stage 1: Administrative Submission Review
  - Verify required documents
  - Pass/Fail evaluation
- Stage 2: Application Scoring - based on each designated population
  - Mandatory requirements
  - Scored requirements
  - Budget Worksheet
- Applications with the highest overall scores are recommended for an award

Proposed Motion

For each of the ten grants, staff recommends the Commission:

- Authorize the Executive Director to issue a “Notice of Intent to Award MHSSA Category 1 Grants” to the applicants receiving the highest overall scores in each population category
- Establish April 30, 2020 as the deadline for unsuccessful bidders to file an “Intent to Appeal” letter

Proposed Motion (cont.)

- Establish that within five working days from the date MHSOAC receives the Intent to Appeal letter, the protesting Applicant must file with the MHSOAC a Letter of Appeal detailing the grounds for the appeal, consistent with the standard set forth in the Request for Applications
- Direct the Executive Director to notify the Commission Chair and Vice Chair of any protests within two working days of the filing and adjudicate protests consistent with the procedure provided in the Request for Applications
- Authorize the Executive Director to execute the contract upon expiration of the protest period or consideration of protests, whichever comes first

AGENDA ITEM 3

Action

April 23, 2020 Commission Teleconference

Response to COVID-19

Summary:

The Commission will hear a presentation from Executive Director Ewing on Commission activities in response to the COVID-19 crisis and opportunities to further support the emergency response during this crisis.

Background:

The Commission has undertaken a number of initiatives to support the Governor's COVID-19 response and to support California's community mental health system.

Rapid Response Network

In partnership with Social Finance (https://socialfinance.org/), the Commission has established a Rapid Response Network to support the information needs of counties as they confront COVID-19. The Network is designed to receive queries from counties and respond quickly with valid and reliable information that can support their COVID-19 efforts. The Network is built upon the premise that communities around the country are working to address shared challenges and the lessons learned elsewhere can support California's response to COVID-19.

The Network went live on April 9, 2020. Through April 15, 2020, the Network had received eight specific requests for information, and two conceptual inquiries. Questions have focused on housing for homeless individuals during the public health emergency, tele-health, isolation guidelines for residential care facilities and best practices for contacts in the field with individuals with serious mental illness. As we receive and respond to more inquires, we will work with our partners at Social Finance to synthesize and generalize information that can be distributed broadly.

Funding dedicated to this effort is $25,000 with substantial in-kind and financial contributions from a range of philanthropic and other partners.

Online Mental Health Resources

The Commission is working with the California Department of Health Care Services, UCLA, UC Davis and a range of community partners to establish a web-based resource that can support the mental health and wellbeing of Californians. This effort is in support of the Governor's COVID-19 response and intended to take pressure off the statewide warm lines and hot lines that have seen increases in call volume. If successful in the

COVID-19 environment, this resource could be sustained as part of the Commission's outreach and engagement strategy, stigma reduction efforts and broader work to improve public awareness of mental health and wellbeing and strategies for prevention and early intervention.

To date, $50,000 is set aside to support this effort with the potential for a second $50,000 in contributions. We are working with a number of partners to raise an initial $300,000 to support this effort.

Health Corps Behavioral Health Strategy
The Commission is supporting the Governor's efforts to recruit and deploy behavioral health volunteers to support Californians through the COVID-19 crisis. A number of states are pursuing or considering similar approaches but face challenges in connecting volunteers with individuals in need. We are talking with the State's IT sector to address this challenge.

No funding has been dedicated to this effort.

The Commission may wish to receive more information on these efforts.

Proposals for MHSA Flexibility
A number of mental health stakeholders have submitted letters to the Governor calling for increased flexibility or limitations in flexibility in how MHSA funding can be used during the COVID-19 crisis. Copies of the letters received by the Commission are attached.

Among the proposals are recommendations to:

- Establish a $100 million emergency behavioral health fund.
- Allow counties to transfer MHSA funding between the Community Services and Supports, Prevention and Early Intervention and Innovation components.
- Allow for more flexible use of MHSA revenues, including using these funds for services in locked facilities.
- Suspend data reporting and planning requirements.
- Suspend public posting and consultation requirements.
- Delay reversion deadlines.
- Access funding held in county Prudent Reserves.

There is not agreement among mental health stakeholders on these proposals.

The Commission may want to share its perspective on these issues.

Emerging Mental Health and Wellbeing Challenges. In addition to the immediate health threats associated with COVID-19 and the related isolation orders, research suggests Californians will face long-term mental health challenges when the immediate risk of viral infection is reduced or past. Although we are not fully aware of the range of those needs, we anticipate key areas where demand will be significant and there are opportunities to provide support.

- School Mental Health. The Commission has made progress in supporting school mental health, but we anticipate dramatic increases in school mental health needs as students, teachers and staff return to the classroom.

- Suicide Prevention. Research indicates that suicide rates will increase following the COVID-19 crisis. The Commission is working to establish an Office of Suicide Prevention and the leadership team to reduce suicide rates. (Please see the attached publications on suicide impacts of COVID-19.)

- Workplace Mental Health. Prior to COVID-19 many employers were investing in workplace mental health. The opportunity to support employees and families through workplace strategies can be an important approach to meeting mental health needs before and when they become severe and disabling.

- Homelessness. California's homeless crisis will be more challenging under the economic impacts of COVID-19.

- Criminal Justice Involvement. The economic impact of COVID-19 is likely to increase the number of mental health consumers who become involved with the criminal justice system.

- Increasing Racial and Ethnic Disparities. The impact of mental health challenges linked to COVID-19 and its economic effects are likely to exacerbate disparities in California's mental health systems.

The Commission should consider how best to inform and advise policymakers on these pending challenges.

Presenter: Toby Ewing, Executive Director

Enclosures (9): (1-7) seven letters from organizations or groups of organizations to the Administration regarding COVID-related recommendations concerning the MHSA; (8) "Increased Risk of Suicide Due to Economic and Social Impacts of Social Distancing Measures to Address the Covid-19 Pandemic: A Forecast" (draft; reprinted with author permission); (9) "Suicide Mortality and Coronavirus Disease 2019-A Perfect Storm" (JAMA Psychiatry April 10, 2020).

March 22, 2020

Dr. Mark Ghaly, Secretary
California Health and Human Services Agency
1600 Ninth Street, Room 460
Sacramento, CA 95814

Dr. Bradley P. Gilbert, Director
California Department of Health Care Services
1501 Capitol Avenue
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Re: County and Community Based Organizations Request COVID-19 Relief Funding to Ensure Critical Behavioral Health Safety Net Infrastructure

Dear Secretary Ghaly and Director Gilbert:

The County Behavioral Health Directors Association (CBHDA), California Council of Community Behavioral Health Agencies (CBHA), and the California Alliance of Child and Family Services (Alliance) are appreciative of the swift efforts on the part of the Administration and the Department of Health Care Services (DHCS) to respond to the unfolding COVID-19 public health crisis. We write to request the Administration take immediate action to salvage critical public behavioral health safety net infrastructure by requesting emergency relief funding available pursuant to Senate Bill 89 (Committee on Budget and Fiscal Review, Chapter 2, Statutes of 2020) as many of the effects of this pandemic are already threatening the core public behavioral health safety net which will be crucial during and after this crisis to ensure Californians have somewhere to turn for their mental health and substance use disorder needs.

Our organizations understand the high value that both Californians and this Administration place on our communities' behavioral health needs. We saw that prioritization reflected in your formation of a Behavioral Health Task Force, the visionary CalAIM proposal and subsequent time and substantial effort the Administration has invested, as well as in the Governor's recent State of the State Address. We know that the Newsom Administration is committed to doing what is right by Californians, and especially its Medi-Cal beneficiaries with mental health and substance use disorder needs.

As part of the crisis response, our organizations have worked closely with your Administration to prioritize the welfare of our public behavioral health safety net, by isolating those clients and providers who are sick and migrating as many of our services to phone and telehealth alternatives as possible to protect lives and allow for life-saving services to continue despite shelter-in-place mitigation efforts.

As a direct result of the public health emergency caused by the rapid spread of COVID-19, many providers of behavioral health services for children, adolescents, adults and older adults are experiencing significant service disruptions that are impacting cash flow and threatening the safety net of services for our clients. For example, throughout the state, providers with already thin margins are at immediate risk of closure due to the inability to bill when no services are rendered to clients or frontline workers isolated due to their illness. If we allow these providers to close during this early stage of the crisis, we will not have the necessary service capacity when it is most needed. We are particularly concerned about the potential to lose much of our residential substance use treatment provider capacity.

To compound the already devastating effects of COVID-19 by allowing for the loss of this public safety net infrastructure would be a mistake. We believe that in the days and weeks ahead more Californians will require behavioral health services and supports as a result of the immense individual and collective trauma we will all experience. In addition, with the significant economic impacts related to COVID-19, we, like the rest of the state, expect a significant decline in public behavioral health revenues, which are reliant on millionaires, sales and vehicle license fee taxes. MHSA funds are also not allowed to be used to save our substance use disorder residential treatment core infrastructure.

To address this crisis, our organizations request establishment of a $100 million dollar county and community-based behavioral health emergency relief fund to allow counties to access, administer and manage immediate funding to stabilize the public behavioral health safety net where funding is not already available, allowable, or sufficiently flexible, which would include preserving core infrastructure and COVID-19 emergency response needs. This amount represents one tenth of the $1 billion in possible funding for COVID-19 response under Senate Bill 89. Our system is arguably already in a dire situation with some providers unable to sustain services, and the risk of vulnerable clients being discharged to an already strained public safety net.

We also request any support the state can provide in directing personal protection equipment to our county behavioral health safety net, including its frontline providers. County and community-based behavioral health workers are key components of the critical infrastructure which continues to operate throughout this crisis. As we have moved more services to mobile and home-based services, we fear that many of our staff and contracted providers are working without the essential safety protection necessary to protect the workforce and our clients.

We appreciate your leadership in this moment and consideration of these requests. Together, our associations represent all California counties and over 200 nonprofit community-based organizations which serve individuals across the lifespan in the mental health, substance use disorder, child welfare, juvenile justice and education systems throughout California. The critical safety net services our collective members provide are an essential part of the health and well-being of thousands of clients in California. We must underscore, however, the urgency of this funding request. **We will lose providers within days, if not weeks, if we do not work together to find an expedited solution and welcome the opportunity to discuss these requests with you at your earliest convenience.**

Respectfully,

Michelle Doty Cabrera
Executive Director
CBHDA

Christine Stoner-Mertz, LCSW
CEO
California Alliance of Child and Family Services

Paul Curtis
Executive Director
and
Le Ondra Clark Harvey, Ph.D.
Director of Policy and Legislative Affairs
California Council of Community Behavioral Health Agencies

cbhda
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

cbha
California Council of Community Behavioral Health Agencies

California Alliance
Empowering lives. Enriching futures.

County Behavioral Health SB 89 Emergency Relief Fund Proposal

Problem Statement

The viability of California's public behavioral health delivery system is contingent upon the ability of providers – both county-operated as well as contracted providers, to bill for services. In the short two-week period since efforts to self-quarantine and mitigate the impacts of the COVID-19 pandemic started, county behavioral health systems and their contracted providers have already begun to experience fiscal impacts which threaten the viability and sustainability of the public behavioral health system at the very moment when we anticipate demand for public behavioral health services to skyrocket.

In the weeks and months ahead, as individuals experience the individual and collective trauma associated with this unprecedented global pandemic, the need for behavioral health services – both mental health and substance use disorder services, will increase. Many millions of Californians will be hit with devastating life changes associated with the pandemic – from life-threatening illness, to the death of loved ones, to job loss, and effects of prolonged isolation. Increases in anxiety, depression, and ultimately substance use disorders and suicide rates, will be felt across populations while at the same time, the economic devastation associated with the virus will also result in many millions more Californians qualifying for public behavioral health services under Medi-Cal.

Among one survey of county contracted behavioral health providers, 58% reported a decrease in service provision since the quarantining efforts were implemented. Among this cohort, approximately 33% reported that they had clients who were too sick to engage in treatment. Over 30% of survey respondents are considering massive staff layoffs or furloughs without immediate relief via emergency funding.

While DHCS has worked valiantly to identify and support the need to migrate as many services to telehealth as possible, this is a significant shift in culture and practice which will take time, as well as an investment of resources to effectuate. In the first week of telehealth offerings, approximately 20% of surveyed contracted providers reported that existing clients refused the offer of telehealth services. The underlying reasons for the refusals are unknown at this point, but if we have the opportunity to stabilize our provider networks, we can learn and innovate over the course of the upcoming weeks. Many of our services are grounded in psychosocial models of care which can be challenging to migrate to tech-based platforms. Whole lines of service delivery have been significantly disrupted, such as group therapy sessions. Perhaps most at risk are those substance use residential treatment providers with clients and/or staff in isolation due to illness. These providers are unable to bill for services, and their counties cannot draw from otherwise flexible funding sources, such as the Mental Health Services Act funds, to offset those losses.

Anecdotally, we know that the vast majority of our existing client base are individuals who qualify for Medi-Cal; as such, many of our clients are struggling to address the immediate basic needs for food,

shelter, and safety. While many of our behavioral health teams are at the same time adjusting to assist with these needs, individuals and families focus on their basic survival is taking precedence to making the leap to telehealth counseling or recovery services.

Counties as a whole are documenting extreme losses as well, which threaten our ability to sustain minimum service levels, given that county behavioral health is limited to cost in terms of reimbursement, and therefore have little to no margins. An analysis[1] of one of our mid-sized counties found a 42% reduction in county staff productivity since March 14th, and a 68% reduction in services by contracted providers. Due to the short amount of time that has elapsed and the evolving nature of this crisis, additional analysis of the impact to our broader system is forthcoming.

While county behavioral health and their contracted providers appreciate that there are many funding priorities before the administration for consideration, we would argue that the ability to address the mental health and substance use disorder needs of Californians should be among the state's top health and safety priorities.

While other sectors of the health care delivery system are heavily impacted, all of our systems will ultimately rely on our public behavioral health system to address the immediate crisis and long recovery that will be required. The public behavioral health system is as vital to our health and wealth as a state as it supports our workplaces, schools, courts, hospitals, and social services safety net.

The impending loss of significant portions of our provider capacity would be devastating and ill-timed. Unlike with other licensed professionals, much of our system is supported by paraprofessionals that would leave the profession and likely not return. Furthermore, without immediate relief funding, we estimate that many county behavioral health systems will be unable to bill for enough services to bring in the requisite Medicaid Federal Financial Participation (FFP) to support the sustainability of this crisis through to the end of the Spring. The crisis for county behavioral health and their contracted providers is now and requires swift action.

Proposal and Funding Criteria

Under this proposal, funds would be reserved for COVID-19 response and mitigation. Counties would use these funds to pay for immediate COVID-19 emergency response activities not otherwise fundable through existing county behavioral health resources, such as: the stabilization of our delivery system (e.g. stabilization of contractors who are unable to bill for services) and making necessary investments to adjust to the safe delivery of services in the context of COVID-19. Our goal would be to ensure continued access to behavioral health services through the county behavioral health safety net. While it is important to ensure maximum flexibility in the use of funds, as the state has with the homelessness funding allocated under SB 89, our groups hoped to provide some specific examples of the intended use of these funds:

- Capital investments in building up additional surge capacity;

[1] This county analyzed average service delivery levels from July 1, 2019-February 21, 2020 as baseline in production, then compared these service rates to the period of March 14-March 22, 2020.

- Investments to support the migration to phone-based and telehealth services, including the purchase of equipment, training, or service plans, end-to-end for clients and/or providers;
- Investments supporting the shift to more field and home-based services and fewer facility-based services, as appropriate;
- Contract enhancements for those contractors who agree to render services, unless and until the client(s) or worker(s) are in isolation due to suspected or tested COVID-19 illness;
- Payment of shift differentials to retain staff who agree to continue to provide essential services unless and until isolation measures are necessary to mitigate the impacts of COVID-19;
- Efforts to provide for the safety and wellbeing of clients and/or workers via Personal Protective Equipment or sanitization.

Distribution Formula

Our proposal would allocate funds to each county behavioral health plan as well as our two city operated plans and distribute funding based on the Mental Health Services Act distribution formula. The behavioral health plans would then allocate funding pursuant to the flexible COVID-19 funding criteria.

1121 L Street, Suite 300
Sacramento CA 95814
T 916.553.4167
steinberginstitute.org

STEINBERG INSTITUTE

ADVANCING BRAIN HEALTH POLICY & INSPIRING LEADERSHIP

March 26, 2020

Governor Gavin Newsom
California State Capitol
Sacramento, CA 95814

Dear Governor Newsom,

Thank you so much for the truly extraordinary leadership you are providing both the State and the nation during this unprecedented health and economic crisis. Your leadership has provided precisely the right needed calm and strength at a time of such uncertainty and challenge.

Given the breadth and intensity of the pandemic and its deleterious effects on the mental health of so many Californians, the Steinberg Institute is requesting that you issue an emergency Executive Order to temporarily waive certain requirements of the Mental Health Services Act (MHSA) to help create the flexibility and capacity counties currently need to focus on providing mental health services wherever and whenever they are needed most.

At this point in the pandemic, county mental health departments and their provider networks are actively reengineering care delivery systems just to keep critical services operating for the most seriously ill patients. The unprecedented scope of adjustments needed to care for patients during this crisis calls for funding flexibility. This flexibility is possible in the Community Service Supports (CSS) component of MHSA, but not in either Prevention, Early Intervention (PEI), Innovation (INN), or prudent reserve (PR) components. It also urges consideration of a reduction in administrative functions such as reporting and stakeholder process requirements as these draw capacity from the urgent need for care delivery.

Many of the County behavioral health departments are expecting to be asked to free up acute psychiatric hospital beds within weeks to secure adequate space for patients with COVID-19 who need life-saving ICU care. At the same time, these local behavioral health departments are needing to scramble to secure additional safe treatment beds and isolable housing where unsheltered mentally ill Californians can live, receive care, and minimize the risk of spreading the coronavirus. All the while counties are faced with the risk of an ever growing workforce shortage as some professionals are understandably concerned about their health and that of their families.

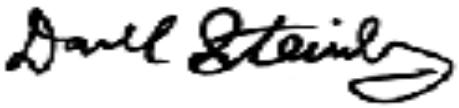
The Institute suggests that additional flexible funding, along with release from administrative processes during this time, could assist local agencies to manage these expanding mental health challenges.

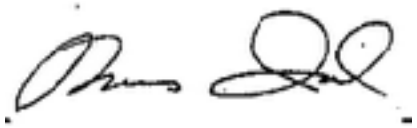
Based on the above, we request at this time of crisis that you temporarily consider permitting counties to:

1. Transfer local MHSA funds from PEI accounts, INN accounts and PR accounts into CSS accounts to optimize the amount of flexible funding available to support and care for those living with serious mental illness as well as those providing this care;
2. Use funds transferred into CSS to pay for the care of patients in much needed treatment facilities that cannot currently receive federal funds (MediCal) due to the IMD exclusion;
3. Place the MHSA reporting and stakeholder requirements on hold by extending the deadline for counties to submit 3-year plans until Q2 of next fiscal year in order to allow counties to focus on the provision of services; and,
4. Allow counties to utilize funds as they see fit to provide staff with the support they need to maintain their engagement in the provision of these vital services.

We are grateful for your consideration of these recommendations and thank you for your leadership during this daunting crises.

In partnership,





Darrell Steinberg
Founder

Tom Insel, MD
Chair

March 27, 2020

Dr. Mark Ghaly, Secretary
California Health and Human Services Agency
1600 Ninth Street, Room 460
Sacramento, CA 95814

Dr. Bradley P. Gilbert, Director
California Department of Health Care Services
1501 Capitol Avenue
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Toby Ewing, Executive Director
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Re: Request for Flexibility with Mental Health Service Act Requirements to Address COVID-19 Public Health Crisis

Dear Secretary Ghaly, Director Gilbert, and Mr. Ewing:

With an unprecedented and evolving public health crisis unfolding, all counties have focused on trying to do what is best for our clients in addressing the associated risks and impacts of COVID-19. This situation has presented county behavioral health with new fiscal and logistical challenges in ensuring we can meet the moment so that our clients – existing and new – can continue to access vital mental health and substance use disorder services through the public behavioral health safety net. The California Health and Human Services Agency (Agency), the Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (OAC) have been responsive partners in exploring solutions to the innumerable problems that have arisen. On behalf of our membership, CBHDA is requesting further collaboration to implement the orders, statutory and regulatory changes necessary to ensure we can leverage additional Mental Health Services Act (MHSA) funds, to more appropriately respond to the challenges associated with COVID-19.

Requests for urgent assistance:

- **Flexibility to Move Funds Between and Within Components:** Based on our experience the past couple of weeks, we anticipate that many counties will exhaust reserves in the upcoming

months and need to make difficult financing and programmatic decisions. These choices are still more difficult because of the rigidity in MHSA funding allocations for different MHSA components. MHSA dictates funding levels for each component including:

1. Community Services and Supports (CSS) - 76% of Revenue
2. Prevention and Early Intervention (PEI) - 19% of Revenue
3. Innovation (INN) - 5% of Revenue

Additionally, within many of the components existing funding mandates limit flexibility in responding to the expected economic crisis and maintaining core services for those most in need. For example, the MHSA places limits on: funding capital and workforce using only funds from CSS; requirements that the majority of CSS funds be used for full service partnerships; and requirements that 51% of PEI funds be used for those under the age of 25.

Unless counties are granted the flexibility to make funding decisions which align with the significant changes in our service delivery and overall funding needs, as MHSA funds decline, counties will be forced to make unreasonable funding decisions. Counties, for example, may be required to expend MHSA funding to implement a new innovation program, while at the same time, reducing services for CSS clients with serious mental illness, or counties may be unable to address critical workforce or capital needs directly related to the aftermath of COVID-19 response because diminishing CSS funds are unavailable.

- *CBHDA requests flexibility in distributing MHSA funds across different components and within components to ensure core services for those with serious mental illness are maintained as MHSA resources become more scarce.*

- **Flexibility on Deadlines:** Multiple MHSA deadlines related to funds subject to reversion are converging at the exact time the COVID-19 crisis hit. Counties are required to expend Assembly Bill (AB) 114 (Chapter 38, Statutes of 2017) reverted funds by July 1, 2020 and based on guidance issued in March 2019, counties are required to transfer any funds in excess of prudent reserve levels by June 30, 2020. In addition, some MHSA funds that counties planned to expend before the end of the fiscal year because these funds are subject to reversion cannot move forward due to COVID-19 related restrictions on public convenings and stakeholder engagement. Counties have been diligently working to meet these deadlines, but COVID-19 has impacted this situation in multiple ways, including the inability to secure mandated community approvals. Many counties intended to comply with deadlines through changes in existing plans or in newly developed Three-Year Plans. Plans must be approved by a variety of entities and are subject to a local review process as outlined in Section 3315 of Title 9 of the California Code of Regulations (CCR). Other counties cannot finalize bids and other processes because of statewide stay at home mandates. Many of the mandated approval and programmatic processes are not available at this time and will take time to reschedule once the current state of emergency is lifted.

  - *Because COVID-19 prevents counties from completing the mandated approval and programmatic processes to meet these deadlines, CBHDA requests the state extend the deadlines on funds subject to reversion at the end of this fiscal year by 6-12 months after the state of emergency has been lifted.*

- **Request to Suspend Certain Data Collection Requirements:** As county staff and contracted providers transition to telephone and telehealth services, Prevention and Early-Intervention (PEI) providers are unable to secure the comprehensive demographic information required by CCR Section 3560.010 and to meet requirements in CCR 3706(b). Contractors and county staff want to continue to provide services but are unable to comply with these Sections under these conditions. Phone calls and video conferencing do not provide adequate opportunity to ensure completion of surveys and other tools used to document demographic information. Contractors and staff can document contacts and services to ensure accountability.

    - *CBHDA requests the state waive demographic reporting requirements outlined in CCR Sections 3560.010 and 3706(b) or provide assurances that counties will not face adverse program review/audit findings or any other penalty for not complying with these Sections while services are being delivered primarily via telephone or telehealth.* Contractors and staff will continue to document contacts and services and report this information as required.

- **Request the Use of Discretion to Allow Performance Contract Amendments Without Requiring Three-Year Plan Updates:** Counties are using every resource at their disposal to combat COVID-19 and continue services for those in need. The financial strain is already evident as counties train staff and transition to new service delivery models. Counties are limited in their ability to use MHSA funds to support the response to COVID-19 because changes in an existing MHSA plan typically requires a 30-day comment period and a Performance Contract amendment. DHCS has the authority to amend a MHSA Performance Contract if a county requests funding for a new program/service that was not part of the County's MHSA Performance Contract, pursuant to CCR Section 3350. Under this Section, DHCS has the authority to allow this request for funding for a new program/service without requiring a county to submit an update to the Three-Year Plan.

    - *To allow for timely county response to COVID-19, CBHDA request that DHCS allow counties to secure MHSA funding for new programs or services to address COVID-19 challenges through a Performance Contract amendment without requiring a county to submit an update to the Three-Year Plan.*

- **Request to Extend Three-Year Plan Updates, Submission of RERs, and Suspend Engagement with Local Mental Health Boards:** As mentioned previously, to secure authorization to expend MHSA resources, counties must comply with various requirements involving approval and reviews from other local stakeholders such as Boards of Supervisors and community members. Counties had been in the process of finalizing Three-Year plans including securing the necessary approvals and reviews when California declared a state of emergency. Because of necessary public health initiatives including social distancing and stay at home orders, many counties are now unable to comply with all the requirements for a timely submission of their Three-Year Plan. Without an approved Three-Year Plan,

complying with other requirements such as timely submission of Updates and Revenue and Expenditure Reports (RERs) are also impacted.

- *For counties unable to complete the requirements to submit their Three-Year Plan because of COVID-19 related circumstances, CBHDA requests DHCS and the OAC extend the deadline for the Three-Year Plan submission and Updates. These counties should be allowed to use their existing approved Three-Year Plan and Updates to expend MHSA funds until a new plan can be approved.*

- *CBHDA also requests extended deadlines for RER submissions, PEI and Innovation Reports and all other MHSA reporting requirements impacted by the inability to secure an approved Three-Year plan or by staffing limitations associated with COVID-19 response.*

- *CBHDA requests DHCS suspend requirements counties are unable to meet because of COVID-19, such as newly enacted requirements related to local mental health boards outlined in AB 1352 (Chapter 460, Chapter of 2019).*

- *CBHDA requests assurances that counties will not face penalties, including adverse findings on program reviews/audits or the withholding of MHSA funds, for the inability to comply with MHSA timely submission requirements so long as delays are attributable to circumstances related to COVID-19.*

CBHDA is appreciative of DHCS' communication to directors that it intends to suspend all MHSA audits. We assume this includes data collection and data submission associated with MHSA audits, and desk reviews. CBHDA strongly supports this decision and thanks DHCS for this action.

I want to reiterate the tremendous support that we have received from Agency, the OAC and DHCS in this time of crisis, and respectfully request your consideration of these additional requests spurred by the extraordinary circumstances we are all experiencing.

Sincerely,

Michelle Doty Cabrera
Executive Director
County Behavioral Health Directors Association of California

CC: Dr. Kelly Pfeifer, Deputy Director, Behavioral Health, DHCS
Marlies Perez, Chief, Community Services Division, DHCS
John Connolly, Deputy Secretary, California Health and Human Services Agency
Richard Figueroa Jr., Office of Governor Newsom
Tam Ma, Office of Governor Newsom
Marjorie Swartz, Principal Consultant, Office of Senate pro Tem Atkins
Scott Ogus, Consultant, Senate Budget and Fiscal Review Committee

Kimberly Chen, Senate Committee on Health
Agnes Lee, Policy Consultant, Speaker's Office of Policy
Andrea Margolis, Consultant, Assembly Committee on Budget
Scott Bain, Assembly Committee on Health
Judy Babcock, Assembly Committee on Health

March 29, 2020

The Honorable Gavin Newsom
Governor, State of California
1303 10th Street, Suite 1173
Sacramento, CA 95814

Dear Governor Newsom:

We are a diverse coalition of state and local organizations representing consumers, family members, parents, caregivers, advocates, providers, and other stakeholders committed to preserving the goals and services provided by the Mental Health Services Act (MHSA). Our organizations include those working alongside state, county and local decision makers; individuals living with mental illness that are involved with the criminal justice system; and those who are homeless or at risk of becoming homeless. Together, we are dedicated to elevating the conversation around behavioral health to advance and preserve prevention, early intervention, treatment and recovery-based services and supports.

We recognize that the unprecedented and fast-moving nature of the COVID-19 outbreak has required a swift and flexible response on the part of state and local agencies, as it has for our organizations. We stand ready to work with the Administration to inform and guide any short-term changes in MHSA needed for the duration of this crisis, from our vantage point on the frontlines of affected communities. Given the impacts of COVID-19 on communities already facing significant barriers to accessing health care, the MHSA's guiding principle of client-and community- driven care matter now more than ever.

At the same time, we caution against making sweeping, long-term changes in the MHSA during this crisis without the stakeholder involvement and significant deliberation required to understand the lasting impact of such permanent changes on affected communities. **We are united and resolute that community-based, client-driven services and supports must remain in place for people living with behavioral health care needs who are receiving PEI, CSS, and INN services funded by the MHSA.**

Many of our coalition members, both entities and individuals, were instrumental in the passage of the MHSA. From drafting its language to rallying communities in a comprehensive ground-level campaign to gather support, the MHSA was a true grassroots effort driven by and for the voices of those it was designed to serve. More than 15 years after the passage of the MHSA, there have been numerous conversations about its effectiveness, its purpose, and whether it has delivered on its promise to transform California's mental health care system. However, too many of these discussions are taking place at the state level, without the full inclusion of consumers and families – the very populations that stand to be the most impacted by any changes to the MHSA.

We are united in the belief that the core values of the MHSA must be retained. As stated in the MHSA: *"with effective treatment and support, including client-centered, family-driven, and community-based services that are culturally and linguistically competent and provided in an integrated services system, recovery from mental illness is feasible. The MHSA, if adequately enforced, provides California with the ability to save lives and save money by committing to the provision of timely, adequate services"* (Excerpt from Section 2 (e,f))

Our Unified Guiding Principles are as follows:

- Diverse **stakeholders must be meaningfully involved** in discussions and decisions regarding any proposed changes to the MHSA.
- The MHSA must retain the **voluntary** nature of services that the Act is based upon.
- The local Community Planning Process is a **foundation** of the MHSA and must remain a key foundation of service planning and delivery.
- The MHSA must continue to be guided by the MHSA General Standards (Community Collaboration; Cultural Competence; Client Driven; Family Driven; Wellness, Recovery, and Resilience Focused and Integrated Service Experience) 9 CCR § 3320.
- Services must continue to be driven by **clients, family members, and those with lived experience**.
- California must support a public mental health system that is **not a fail-first system**.
- MHSA funds should not be utilized as a way to solve the homelessness issue in its entirety with the exception of utilizing funds to assist those who are homeless and also have a mental illness.
- People currently receiving services should not lose those services.

- The MHSA must continue funding **community-based services** (full-service partnerships) that meet people where they are at. These services are the foundation of the MHSA and they have proven to be successful.
- Local control and fund allocation are crucial to ensure programs and services are designed to meet the needs of the many unique and diverse populations across the state.
- Collection, analysis and dissemination of data and outcome measures are essential to ensure that MHSA funds are spent consistent with the intent of the Act.
- Strong enforcement and accountability are critical to the success and effectiveness of the MHSA.

We urge you to uphold the MHSA by including individuals with lived experience and all potentially affected client stakeholder groups in all discussions regarding any changes to the MHSA, **including temporary changes**. We also urge you to ensure that the vision, values and general standards of the MHSA, which we worked so hard to create, remain intact. **These include the foundational principles of stakeholder involvement at all stages of service planning evaluation and delivery, and prioritizing voluntary community-based services.**

Again, we are sensitive to the crisis our state is experiencing, and understand that the state and counties are examining myriad ways to bolster the safety net, but we also believe that any changes should ensure that the spirit and intent of the Act are upheld and that safeguards are put in place to protect the provisions of the MHSA that so many fought for. We stand ready, willing, and able to assist you with these efforts.

Sincerely,

Susan Gallagher, MMPA, Executive Director
Cal Voices

Christine Stoner-Mertz. LCSW, CEO
California Alliance of Child and Family Services

Sally Zinman, Executive Director
California Association of Mental Health Peer Run Organizations

Betty Dahlquist, MSW, CPRP, Executive Director
California Association of Social Rehabilitation Agencies

Le Ondra Clark Harvey, PhD, Director of Policy and Legislative Affairs
California Council of Community Behavioral Health Agencies

Linda Tenerowicz, Senior Policy Advocate
California Pan-Ethnic Health Network

Curtis Child, JD, Director of Legislation
Disability Rights California

Heidi Strunk, President and CEO
Mental Health America of California

Jessica Cruz, MPA/HS, Executive Director
NAMI California

Poshi Walker, MSW, Co-Director
#Out4MentalHealth

Stacie Hiramoto, MSW, Executive Director **Racial and Ethnic Minorities Health Disparities Coalition**

Pam Hawkins, Policy Analyst
United Parents

CC: Dr. Kelly Pfeifer, Deputy Director, Behavioral Health, DHCS
Marlies Perez, Chief, Community Services Division, DHCS
Mark Ghaly, Secretary, California Health and Human Services Agency
John Connolly, Deputy Secretary, California Health and Human Services Agency
Richard Figueroa Jr., Office of Governor Newsom
Tam Ma, Office of Governor Newsom
Marjorie Swartz, Principal Consultant, Office of Senate pro Tem Atkins
Scott Ogus, Consultant, Senate Budget and Fiscal Review Committee
Kimberly Chen, Senate Committee on Health
Agnes Lee, Policy Consultant, Speaker's Office of Policy
Andrea Margolis, Consultant, Assembly Committee on Budget
Scott Bain, Assembly Committee on Health
Judy Babcock, Assembly Committee on Health
Toby Ewing, Mental Health Services Oversight and Accountability Commission

NAMI California
National Alliance on Mental Illness

March 30, 2020

Jessica Cruz, MPA/HS
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Member

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Member

Andrew Bertagnolli, PhD
Member

Paul Lu
Member

NAMI California
1851 Heritage Lane # 150
Sacramento, CA 95815
916-567-0163

Governor Gavin Newsom
California State Capitol
Sacramento, CA 95814

Dear Governor Newsom,

Thank you for your outstanding leadership in the face of the unprecedented crisis faced by our state. In developing a proactive and strategic response to this crisis, the National Alliance on Mental Illness, California (NAMI CA) is urging state and local government leaders to continue to honor the values outlined in the Mental Health Services Act (MHSA) during this critical time for those living with mental illnesses and their families. NAMI CA represents 62 Affiliates across California who work every day to serve their communities as well as our more than 60,000 active advocates in California who care deeply about fixing the broken mental health care system in our great state.

We have recently reviewed ideas about how MHSA funds can be used as we meet the COVID-19 crisis head on while continuing to ensure services are getting to those in need. Some suggestions including eliminating stakeholder involvement, having flexibility in utilizing the "components" of funding, and extending the 3-year plan requirements, among others. We must be strategic in how we utilize MHSA funds. Therefore, NAMI CA suggests the following as strategies to be used:

- **Prudent Reserve Funds as a Spending Priority**

Any changes to funding streams or services must follow the use of the Prudent Reserve set-aside monies. When NAMI CA helped create and pass the original Prop 63, part of the intention was to ensure there were mechanisms in place to address crises and anticipate changes to funding levels. One of the ways we anticipated dealing with those changes was through the Prudent Reserves in which all counties hold up to 33% of funds in reserves. We must ensure that counties are able to access their prudent reserves immediately and any barriers to doing so must be eliminated.

We suggest that counties that need flexibility in MHSA component availability, first use their prudent reserves before making changes to the Act by allowing flexibility of funds used between categories. We fought for set asides to bend the cost curve through prevention and early intervention for example. We would hate to see the focus shift, albeit temporarily, away from programs that aim to intervene when a mental illness is first beginning to manifest.

- **Unspent Funds as a spending priority**

  In your 2020 State of the State address, you prescribed there to be a significant among in unspent MHSA funds. In the times of uncertainty and as a way of utilizing those funds accordingly, NAMI CA suggests counties utilizing this source of funding to offset any funds needed during the COVID-19 crisis.

- **Flexibility must come with documentation**

  Any use of MHSA funds outside their original purpose or designation must be documented and posted for public comment. Transparency from governmental leaders is critical in maintaining public confidence in the processes by which we are governed. This documentation should be robust and clearly connect to how the COVID-19 crisis requires changes to programing and service requirements under the current law.

- **Changes must be time limited**

  In addition to robust documentation, any changes to funding streams must be time limited with 60-90 day limit with the sole purpose of meeting this moment for Californians. As we continue to adjust to this new reality as a state, we expect our processes and funding will do the same, but we cannot overreach and destroy the systems of care that families depend on in order to do so.

- **Encourage innovation in both county and state processes**

  Public processes must evolve to meet this moment in California. Part of that evolution must incorporate the use of online platforms by government entities to communicate with stakeholders, including broadcast of accessible meeting and hearings as well as methods by which stakeholders can provide public comment to our government officials. Some counties such as San Bernardino have exemplified how to work with

stakeholders remotely to ensure all voices can be on the record. We can no longer rely on antiquated models of engagement where resident must come to one location for information and public engagement. Further, to best serve the needs of our great and diverse state, we must adapt to and embrace available technologies designed to enhance and support better health outcomes for all residents. Exploring how technology can serve to increase access could be an excellent MHSA Innovation project for example, and NAMI CA would like to work and support counties in this endeavor.

Stay true to our core values, listen to stakeholders including families and consumers first.

It is important that we do not let this crisis deter us from the core values we've set forth as a state. Crisis must be a time that we cling closer to our values, not abandon them. MHSA has a strong core value in being driven by those it serves, which includes families and consumers. We must put partnerships above politics as we move through this time. Those partnerships must include the stakeholders that are most impacted by the policy decisions being made.

Our core values exist to guide us in uncertain situations and serve as a north star to light our path forward. The core values of the MHSA tell us that in this critical moment, it is of utmost importance to be led by the voices of the families and individuals we serve. We must increase all efforts to provide transparency and trust in order to truly meet this moment as a state for all Californians.

We stand ready to help do our part, our fervent hope is that families won't be left behind in this time of greatest need.

In partnership,

Jessica Cruz, MPA/HS
Chief Executive Officer
NAMI California

CC: Dr. Mark Ghaly, Secretary, California Health and Human Services Agency
Dr. Bradley P. Gilbert, Director, DHCS
Toby Ewing, Executive Director, MHSOAC
Michelle Cabrera, Executive Director, California Behavioral Health Directors Association

Dr. Kelly Pfeifer, Deputy Director, Behavioral Health, DHCS
Marlies Perez, Chief, Community Services Division, DHCS
John Connolly, Deputy Secretary, California Health and Human Services Agency
Richard Figueroa Jr., Office of Governor Newsom
Tam Ma, Office of Governor Newsom
Marjorie Swartz, Principal Consultant, Office of Senate pro Tem Atkins
Scott Ogus, Consultant, Senate Budget and Fiscal Review Committee
Kimberly Chen, Senate Committee on Health
Agnes Lee, Policy Consultant, Speaker's Office of Policy
Andrea Margolis, Consultant, Assembly Committee on Budget
Scott Bain, Assembly Committee on Health
Judy Babcock, Assembly Committee on Health

California Behavioral Health Planning Council

CHAIRPERSON
Lorraine Flores

EXECUTIVE OFFICER
Jane Adcock

April 7, 2020

Governor Gavin Newsom
California State Capitol
Sacramento, CA 95814

Dr. Mark Ghaly, Secretary
California Health and Human Services Agency
1600 Ninth Street, Room 460 Sacramento, CA 95814

Dr. Bradley P. Gilbert, Director
California Department of Health Care Services
1501 Capitol Avenue
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: Recommendations for Mental Health Service Act Requirements Flexibility to Address COVID-19 Public Health Crisis

➢ Advocacy
➢ Evaluation
➢ Inclusion

Dear Governor Newsom, Secretary Ghaly, and Director Gilbert:

The California Behavioral Health Planning Council thanks all of you for your leadership and compassion as we navigate this public health crisis.

Pursuant to state law, the Council serves as an advisory body to the Legislature and Administration on the policies and priorities that this state should be pursuing in developing its behavioral health system. Our membership includes persons with lived experience as consumers and family members, professionals, providers, and representatives from state departments whose populations touch the behavioral health system. Their perspectives are essential to our view on the challenges and successes of behavioral health services and best practices in California.

Over the past couple of weeks, each of you has received a number of letters requesting certain accommodations to current laws and regulations governing the use of Mental Health Services Act (MHSA) funds. The Council, in fulfilling its advisory role to you, is submitting our recommendations on those requests.

Processes for use of funds:

Under the MHSA, counties are required to develop 3-Year Plans and Annual Updates, stakeholders are to be engaged, Mental Health Boards are to conduct public hearings and Boards of Supervisors are to approve the plans.

MS 2706
PO Box 997413
Sacramento, CA 95899-7413
916.323.4501
fax 916.319.8030

The Council supports the following accommodations for processes:

Allow counties to continue following existing 3-Year Plan until able to go through update process.

Allow counties to complete a Performance Contract change for new programs or services to address COVID-19 needs without an update to 3-Year Plan.

Allow counties to post information as soon as possible, rather than 30 days prior, to inform stakeholders when use of MHSA funds differs from original purpose and require counties to maintain documentation for reporting after the state of emergency is lifted.

Rules for use of MHSA funds

There are restrictions on how and when MHSA funds can be used. Limitations are governed by component designation and by time/budgetary considerations such as permissible access to Prudent Reserve funds and reversion calculations.

The Council supports the following accommodations for use of MHSA funds:

Allow counties flexibility for use of funding within and between components to meet local needs in response to COVID-19.

Allow immediate access to Prudent Reserves if monthly distributions are significantly below anticipated levels.

Allow counties more time to expend funds, extending deadlines for funds subject to reversion, until 6 months after the state of emergency is lifted.

The Council opposes the following accommodations for use of MHSA funds:

To pay for involuntary inpatient care, such as in an Institute for Mental Disease (IMD).

Transfer of funds from one component to another without a county decision/need identified.

Rules for Stakeholder Involvement

Counties are required to comply with requirements to receive input and approval from local stakeholders including Boards of Supervisors prior to implementing the programs presented in their 3-Year Plans.

Community engagement is a core value of the MHSA. The motto of the Act has always been “nothing about us, without us,” in recognition that it is the consumers and family members who are the ones most affected by policy decisions. Thus, transparency, information and inclusion are mandates under the MHSA.

The Council supports the following accommodations for the inclusion of stakeholders:

Allow online/virtual meetings for stakeholders to provide input in place of in-person meetings or hearings.

Allow counties to post proposed plan information as soon as possible, rather than 30 days prior, to inform stakeholders and maintain transparency during this state of emergency.

Rules for Data Collection and Reporting

County staff and contracted providers are required to secure comprehensive demographic information, including but not limited to age, race, ethnicity, primary language, sexual orientation, gender identity, disability and veteran status.

The Council supports the following accommodations for Data Collection and Reporting:

Allow demographic data collection and reporting requirements for Prevention and Early Intervention services to be suspended when individuals refuse to respond via telephone or telehealth during the COVID-19 public health crisis.

Ensure that counties will not face adverse program review/audit findings or penalties for not complying with the reporting requirements while services are being delivered primarily via telephone or telehealth.

Overall Recommendation:

While California is enduring its worst public health crisis in decades, the Council asks that your decisions promote and honor the vision and values of the MHSA. That you support the principles of consumer and family member-direction, community collaboration, cultural and linguistic responsiveness, service integration and wellness/recovery.

The Council appreciates the myriad of issues you are all faced with and the multitude of decisions that must be made during this crisis. We hope that our recommendations are helpful in sorting through the requests for accommodations submitted by organizations seeking to

promote access and quality outcomes for Californians living with severe mental illness.

If you have any questions, please contact Jane Adcock, Executive Officer at (916) 750-1862 or Jane.Adcock@cbhpc.dhcs.ca.gov.

Sincerely,

Original signed by

Lorraine Flores
Chairperson

Cc: Dr. Kelly Pfeifer, Deputy Director, Behavioral Health, DHCS
Jim Kooler, Assistant Deputy Director, Behavioral Health, DHCS
Marlies Perez, Chief, Community Services Division, DHCS
John Connolly, Deputy Secretary, Health and Human Services Agency
Richard Figueroa Jr., Office of Governor Newsom
Tam Ma, Office of Governor Newsom
Marjorie Swartz, Principal Consultant, Office of Senate pro Tem Atkins
Scott Ogus, Consultant, Senate Budget and Fiscal Review Committee
Kimberly Chen, Senate Committee on Health
Agnes Lee, Policy Consultant, Speaker's Office of Policy
Andrea Margolis, Consultant, Assembly Committee on Budget
Scott Bain, Assembly Committee on Health
Judy Babcock, Assembly Committee on Health

April 10, 2020

The Honorable Gavin Newsom
Governor, State of California
State Capitol
Sacramento, CA 95814

Re: Suspension of Requirements of the Mental Health Services Act (MHSA)

Dear Governor Newsom:

The organizations signing this letter are non-profit organizations located throughout the state of California that specialize in serving racial, ethnic, LGBTQI2-S, and other vulnerable communities. We are in strong support of the letter attached dated March 29, 2020, that you received from statewide mental health organizations cautioning against making long-term changes in the MHSA during the COVID-19 outbreak without stakeholder involvement and significant deliberation to understand the lasting impact of such changes on affected communities.

In addition, there is one issue in particular that we wish to bring to your attention that we believe affects our communities more than others. We know that both the County Behavioral Health Directors Association and the Steinberg Institute have requested

permission to transfer local MHSA funds between components. In essence, they want to allow counties to transfer Prevention and Early Intervention (PEI) and Innovation (INN) funds to the Community Services and Supports (CSS) programs.

We strongly disapprove of this proposal as it would disproportionately affect communities of color, the LGBTQI2-S community, and other unserved, underserved, and inappropriately served communities. Decreasing PEI funding would be a "double hit" to our communities because:

1. PEI programs are often ***more effective*** in serving our communities and are often ***preferred*** by members of our communities.

2. Community-based organizations that are located in our underserved communities and/or specialize in serving our communities are funded more often through PEI than CSS.

Furthermore, communities of color are disproportionately affected by the COVID-19 situation. The African American/Black population has the highest death rates from the COVID-19 virus; therefore, stress and trauma will definitely increase for this community. PEI programs could address and mitigate these disparities. Our own Surgeon General, Nadine Burke Harris said as much when she referenced church leaders in the community as helping get the message out.

We have seen in the past that programs that serve our communities are the last to be funded but the first to be cut in times of need. Allowing counties or the state to deplete

PEI funds would appear to repeat this discriminatory pattern. Programs such as those under the California Reducing Disparities Project (CRDP) are just beginning to establish themselves in counties. Transferring PEI funds to CSS would undercut these programs and be a step backwards by promoting the very discriminatory practices that create disparities again, leaving vulnerable communities unserved.

Although Innovation funds could be used for new programs that target our communities and reduce disparities, historically this has not been done nearly as often as we hoped. Transferring these funds would further diminish the possibility of creating programs that showed promise for underserved communities, including continuation of CRDP projects at the local level.

While we might support a delay in overall reporting requirements, we do not support the request for counties to suspend demographic data collection (of PEI) at this time. If PEI funding is reduced, how else would it be documented whether or not our communities were adequately served? More important, we believe it is possible to collect demographic data over the telephone or other means, if in-person intake meetings were temporarily halted.

One of the most important principles of the MHSA is that government authority is not to be exercised without communication and collaboration with consumers, family members, and the community. We want to be supportive of your extraordinary efforts in managing this unprecedented public health crisis. We also do not want unexpected consequences to befall our communities ***that remain unserved, underserved, inappropriately served, and more vulnerable at this time.*** We are most willing to meet to discuss our concerns and consider alternative proposals for assisting you in overcoming this COVID-19 emergency.

Sincerely,

Stacie Hiramoto, MSW, Director
Racial and Ethnic Mental Health Disparities Coalition

Janet King, MSW, Project Director
Native American Health Center

Le Ondra Clark Harvey, PhD, Director of Policy and Legislative Affairs
California Council of Community Behavioral Health Agencies

Sonya Young Aadam, CEO
California Black Women's Health Project

June Lee, Executive Director
Korean Community Center of the East Bay

Pastor Horacio Jones, Chair
African American Steering Committee for Health and Wellness

Vanetta Johnson, Executive Director
Peers Envisioning & Engaging in Recovery Services (PEERS)

Seng S. Yang, Director
Hmong Cultural Center of Butte County

Eba Laye, Director
Whole Systems Learning

Gulshan Yusufzai, Executive Director
Muslim American Society – Social Services Foundation

Mel Mason, LCSW, Executive Director
The Village Project, Inc.

Dr. Darling Richiez, DNP, MSPH, CHES
Chief Nursing Officer
Health Education Advocacy Leadership (HEAL), Inc.
HEAL Community Health Promotion Center

Cymone A. Reyes, Executive Director
San Joaquin Pride Center

Rebecca Gonzales, Director of Government Relations & Political Affairs,
National Association of Social Workers (NASW) - CA Chapter

Carolyn Chadwick, Chief Operating Officer
Tessie Cleveland Community Services

Richard L. Zaldivar, Executive Director
The Wall – Las Memorias

Leva Zand, Development Director
Center for Empowering Refugees and Immigrants

Gigi R. Crowder, L.E., Founder and CEO
Black Minds Matter 2!

David Kakishiba, Executive Director
East Bay Asian Youth Center

Beatrice Lee, Executive Director
Diversity in Health Training Institute

Elizabeth Lou, President/CEO
Nile Sisters Development Initiative

Tony Jackson, PhD
Bay Area Chapter, President
Association of Black Psychologists, Inc.

Josefina Alvarado Mena, Esq.
Chief Executive Officer
Safe Passages

Karen Skultety, Executive Director
Open House

Heidi L. Strunk, President and CEO
Mental Health America of California

Susan Gallagher, Executive Director
CalVoices

cc: Dr. Kelly Pfeifer, Deputy Director, Behavioral Health, DCHS
Michelle Doty Cabrera, County Behavioral Health Directors Association
Darrell Steinberg, Steinberg Institute
Nadine Burke Harris, California Surgeon General
Marlies Perez, Chief, Community Services Division, DHCS
Mark Ghaly, Secretary, California Health and Human Services Agency
John Connolly, Deputy Secretary, California Health and Human Services Agency
Richard Figueroa Jr., Office of Governor Newsom
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Marjorie Swartz, Principal Consultant, Office of Senate pro Tem Atkins
Scott Ogus, Consultant, Senate Budget and Fiscal Review Committee
Kimberly Chen, Senate Committee on Health
Agnes Lee, Policy Consultant, Speaker's Office of Policy
Assemblymember Joaquin Arambula, Chair Assembly Budget Subcommittee #1
Andrea Margolis, Consultant, Assembly Committee on Budget
Scott Bain, Assembly Committee on Health
Judy Babcock, Assembly Committee on Health
Toby Ewing, Mental Health Services Oversight and Accountability Commission

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Increased Risk of Suicide Due to Economic and Social Impacts of Social Distancing Measures to Address the Covid-19 Pandemic: A Forecast

Preprint · April 2020

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Increased Risk of Suicide Due to Economic and Social Impacts of Social Distancing Measures to Address the Covid-19 Pandemic: A Forecast

Carl F. Weems PhD

Professor and Chair

Human Development and Family Studies

Co-Director, ISU Translational Research Network (UTuRN)

Iowa State University

Victor G. Carrion, MD

Professor and Vice Chair of Child and Adolescent Psychiatry, Department of Psychiatry and Behavioral Sciences,

School of Medicine, Stanford University

Bethany H. McCurdy, BS & Mikaela D. Scozzafava, MA

Research Associates, ISU Translational Research Network (UTuRN)

Human Development and Family Studies

Iowa State University

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Correspondence To: Carl F. Weems, Professor and Chair, Department of Human and Family Studies, 4380 Palmer, Iowa State University, Ames, IA 50011. E-mail: cweems@iastate.edu

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Abstract

Background. Due to the Covid-19 pandemic there have been unprecedented increases in unemployment and social isolation nationally and globally. Predicting suicide rates as a result of this pandemic can provide information about the potential mental health ramifications and supports that may be needed. This article aims to forecast the potential increased incidence of suicide due to the economic and social impacts of the social distancing measures in place to address the Covid-19 pandemic. ***Methods***. Authors identified available evidence to develop a statistical forecast using previous estimates of the impact of unemployment and social isolation on suicide rates as well as predicted unemployment data and social isolation data. ***Findings***. The increased rate of suicide worldwide due to increased unemployment and social isolation could be close to 50,000 individuals based on initial estimates of these collateral impacts. ***Interpretation***. Policy, funding, and interventions to address the mental health impact of the Covid-19 pandemic is needed. The model can be applied to predict additional localized or regional effects. The efforts to stop the spread of Covid-19 can be weighed against these potential collateral mental health effects. ***Funding.*** The authors received no financial support for the research, authorship, and/or publication of this manuscript.

Research in Context

Evidence before this study

Along with the health devastation of the coronavirus pandemic and Covid-19 related disease, it is apparent that there will be traumatic stress wrought by the human loss, severe stress, and global fear. The collateral economic and social impacts are also likely to have a deep effect on the mental health of many throughout the entire world. According to the World Health Organization, suicide accounts for approximately 800,000 deaths per year globally with 79% of suicides occurring in low- and middle-income countries. World suicide incidence is 10·6 persons dying from suicide per 100,000 people with an estimate of 7·7 for females and 13·5 for males. Being male, low socioeconomic status, and being from low-income countries have increased rates and increased risk. In the USA, rates were 22·4 for males and 6·1 per 100,000 for females as reported by the US Office of Disease Prevention and Health Promotion. Social isolation/loneliness and unemployment are well established factors associated with increased risk of suicide. Due to the Covid-19 pandemic there have been unprecedented increases in unemployment and social isolation nationally and globally. Predicting suicide rates as a result of this pandemic can provide information about the potential mental health ramifications and supports that may be needed.

Added value of this study

This article provides a forecast the potential increased incidence of suicide due to the economic and social impacts of the social distancing measures in place to address the Covid-19 pandemic. Authors identified available evidence to develop a statistical forecast using previous estimates of the impact of unemployment and social isolation on suicide rates as well as predicted unemployment data and social isolation data. The model can be applied to predict additional localized or regional effects. The efforts to stop the spread of Covid-19 can be weighed against these potential collateral mental health effects.

Implications of all the available evidence

The increased rate of suicide worldwide due to increased unemployment and social isolation could be close to 50,000 individuals based on initial estimates of these collateral impacts. Policy, funding, and interventions to address the mental health impact of the Covid-19 pandemic is needed.

Increased Risk of Suicide Due to Economic and Social Impacts of the Social Distancing Measures to Address the Covid-19 Pandemic: A Forecast

Along with the health devastation of the coronavirus pandemic and Covid-19 related disease, it is apparent that there will be traumatic stress wrought by the human loss, severe stress, and global fear. The collateral economic and social impacts are also likely to have a deep effect on the mental health of many throughout the entire world. The mental health impact of the disintegration of the typical social and economic world will have effects of which the full toll will not be fully understood for years via retrospective analysis of data to be collected. However, this paper examines the future potential of the negative psychosocial consequences on suicide rates. The study is prompted by the need to estimate the mental health needs in the coming months/years and recent calls to better understand the broader implications of the efforts to stem the spread of the virus. Brooks et al.[1] conducted a review of studies examining the effects of quarantine measures and identified several psychological impacts that include post-traumatic stress symptoms, confusion, and anger with longer quarantine duration, infection fears, frustration, boredom, inadequate supplies, inadequate information, financial loss, and stigma contributing to psychological stress. In addition, the Center for Disease Control (CDC)[2] warns about feelings of guilt that may be associated with not performing work or parenting duties. In this study, we examine the potential impact on USA and worldwide suicide rates using estimates from existing research and public data, focusing on two factors which have estimates of the initial impact of the pandemic and are also known to increase risk for suicide - social isolation/loneliness and unemployment.

The adverse conditions precipitated by the effects of the pandemic as well as the social distancing measures threaten positive self-evaluations among the entire population of the world in multiple ways, including the disruption of esteem-supporting relationships (e.g., with co-workers, teachers, friends, neighbors). After disaster, adverse conditions for positive self-evaluation exist and the context in which many individuals find themselves are thwarting the use of strategies to maintain positive self-evaluations[3,4]. This may be particularly true for disadvantaged communities and families, and in those whose identities rely on work or performance[5]. In terms of social relatedness, the social distancing measures are seriously disrupting social ties and one's ability to access not only his or her extended community, but with family members as well. Indeed, loneliness and related mental health impacts are a very common outcome of social distancing measures[1]. For example, Reynolds et al.[6] found that loneliness was reported in 38·5% (95% CI 35·5–41·5) and social isolation in 60·6% (95% CI 57·6 – 63·6) of a large sample (n=1,057) of individuals quarantined during the 2003 severe acute respiratory syndrome (SARS) outbreak in Canada.

In addition to social isolation, US jobless claims exceeded 3,200,000 on March 21, 2020 according to the US Department of Labor[7], which was over 3 million more newly unemployed for each of the two prior weeks as well as the same week one year ago. This number jumped to well over 6 million on April 2nd [7]. According to International Labour Organization[8] estimates the pandemic could result in 24·7 million jobs lost worldwide. Their analysis indicates that this may be a worst-case scenario for global unemployment with estimates of a "low" unemployment scenario of 5·3 million (already surpassed by the US alone) and "mid" scenario of 13 million jobs lost [8]. Supporting relationships at the family, neighborhood, church, school, and work have been interrupted - threatening the amount or the stability of contact with social ties, financial resources, and a sense of meaning [3,4,5]. Reasoning from these considerations on social isolation and employment loss, there is a need to examine the potential for these effects to impact the overall death rate via suicide. Using two well established factors associated with suicide, namely social isolation and unemployment, allows for a somewhat conservative estimate of one of the most severe mental health impacts.

According to the World Health Organization (WHO) [8], suicide accounts for approximately 800,000 deaths per year globally with 79% of suicides occurring in low- and middle-income countries in 2016. Suicide accounted for 1·4% of all deaths worldwide, making it the 18th leading cause of death in 2016. World suicide incidence is 10·6 persons dying from suicide per 100,000 people with an estimate of 7·7 for females and 13·5 for males[9]. Being male, low socioeconomic status, and being from low-income countries have increased rates and increased risk[8]. In the USA, rates were 22·4 for males and 6·1 per 100,000 for females as reported by the US Office of Disease Prevention and Health Promotion[10].

In terms of increased risk of suicide associated with unemployment, review of the literature and analysis by Gunnell and Chang[11] suggests a consistent association that has been well established for some time. In terms of risk

estimates, Kposowa[12] used a cohort analysis of social factors predicting suicide in the US National Longitudinal Mortality Study. The sample was 471,922 individuals 15 years and above at the beginning of the study, of whom 545 had committed suicide. Unemployed men were twice (2·12, 95% CI = 1·16–3·88) as likely to commit suicide as those employed with unemployed women 3.8 times more likely to kill themselves as their employed counterparts (3·85, CI 1·45–10·2).

It's also long been understood that social isolation increases risk of suicide[13]. A recent review by Calati[14] suggests that the objective condition (e.g., living alone) and the subjective feeling of being alone (i.e., loneliness) are strongly associated with suicidal outcomes with these associations found transculturally. In terms of estimates of increased risk, Stickley and Koyanagi[15] used the US National Longitudinal Mortality Study with data from 7403 persons. Attempted suicide was dichotomous: "Have you ever made an attempt to take your life, by taking an overdose of tablets or in some other way?". Loneliness was assessed by subjectively asking if they felt 'lonely and isolated from other people' in the past two weeks with 4 options: very much, sometimes, not often, and not at all. Odds ratio controlling for age, sex, educational qualifications, ethnicity, marital status, wealth, employment status, alcohol dependence, social support, physical health conditions, stressful life events, and common mental disorders for those in the very much loneliness category was 3·45.

In addition to unemployment and loneliness, the pandemic is expected to impact negative mental health outcomes in multiple ways, and these are also predictive of suicide. Common reactions to the stress of the disaster like pandemic are substance abuse, mood disorders, anxiety and post-traumatic stress. A meta-analysis of this literature by Yoshimasu[16] reports that substance-related disorders [OR = 5·24; 95% CI = 3·30–8·31] and mood disorders [OR = 13·42; 95% CI = 8·05–22·37] are associated with suicidal risk. Lin et al.[17] reported that depressed mood increased suicide risk by a factor of 2·11 (adjusted risk ratio).

Drawing from the theoretical considerations above and data on the increased risk for suicide engendered by mental health problems, unemployment, and social isolation, each of which are increasing in incidence as a result of the pandemic, this paper calculates the potential increases in death associated with the Covid-19 pandemic due to suicide.

Method

A literature search identified estimates for developing a statistical model to predict increased suicide rates.

Data from the WHO and US Office of Disease Prevention and Health Promotion were used to estimate existing suicide rates. World suicide incidence is 10·6 persons dying from suicide per 100,000 people with estimates being 7·7 (·000077) for females and 13·5 (.000135) for males[9]. In the USA, existing rates were estimated as 22·4 for males (·000224) and 6·1 (·000061) for females per 100,000[9].

Unemployment

Estimates for unemployment were taken from the US jobless claims which hit 3,283,000 on March 21, 2020 and over 6 million on April 2nd [7]; reported were over 3 million more unemployed. The US workforce is 47% female[7]. To provide a conservative estimate for those effected, we used the April 2nd number of 6 million additional[7] unemployed as the theoretical population impacted in the US. According to International Labour Organization[8] estimates, the pandemic could result in 24·7 million jobs lost, with a "low" unemployment scenario of 5·3 million and "mid" scenario of 13 million jobs lost. Given these numbers, a conservative estimate for those effected, the theoretical population impacted for women and men of 10 million individuals, was used with the gender distribution of 38·96% of the workforce being female[18]. Estimates for the increased risk of suicide for unemployment were taken from Kposowa[12] predicting suicide in the US National Longitudinal Mortality Study. For unemployed men, the risk ratio of 2·12 was used and for unemployed women, the risk ratio was 3·8.

Social Isolation

Estimates for the number affected by increased social isolation were taken from public reports of stay at home orders for the USA on March 25th, which was estimated to be 50% of the US population. As of March 25th, 15 states and 30 municipalities had ordered 166 million people to stay home, according to data compiled by Regan et al.[19] using US Census population estimates. For the world, the estimate of increased movement restriction was estimated

at 2·6 billion people. As noted, Reynolds et al.[6] estimated loneliness in 38·5% and social isolation 60·6% of those quarantined. As a conservative estimate of 10% of those effected by stay at home orders as of March 25th was used as a theoretical population of those impacted by loneliness in the US which would be 16·6 million of whom 50·8% are female, according to the US Census Bureau[20] as of 2019. For the world, we used an estimate of 5% or 130 million for the worldwide theoretical population of those effected by loneliness of whom there is a total population ratio of 1·01 males to every 1 female[21].

Estimates for suicide risk associated with social isolation and loneliness were estimated from two sources - the Stickley & Koyanagi[15] analysis of the US National Longitudinal Mortality with odds ratios for suicide attempts for those in the most severe loneliness category ranged from 3·45 (lifetime suicide attempt) to 17·37 (past 12-month suicide attempt), however these were not broken down by sex and the data for calculating relative risk was not available. Kposowa[12] predicting suicide in the US National Longitudinal Mortality Study also reported relative risk ratios for those living alone with estimates ranging from 1·4 to 1·55 for males and 1·93 to 2·4 for females. Taken together, our models used an estimate of 1·5 for males and 2·0 for females.

Mental Health

The statistical models added a negative mental health multiplier. Drawing from the broader literature and data in Lin et al.[17] reporting that depressed mood may increase suicide risk by a factor of 2·11, this number was used in the models as a mental health multiplier. This addresses the fact that our model cannot estimate those who both lost their job and became severely lonely and cannot estimate incidence of mental disorder impacts on the general population resulting from the pandemic.

Statistical model

The estimate was based on the following: The estimate of existing incidence establishes the baseline number of individuals that increased risk will exacerbate. The estimated increased risk is the multiplier that either unemployment or loneliness adds to the estimate of additional cases of suicide. The estimate of those affected is the theoretical population of those impacted by the risk factors of unemployment or loneliness. The mental health multiplier is added to the equation to acknowledge the additional risk added by the increased risk associated with mood disorders and substance abuse and is theoretically a conservative estimate for all the various mental health factors that may increase risk among the theoretical population of those affected by unemployment and loneliness, while recognizing error in the estimates of the population impacted. Thus the equation was: Estimate of existing incidence * Estimate of Increased Risk (Risk Ratio) * Estimated number of Those Effected * Mental health multiplier 2·11 = Number of Suicides. These analyses were stratified by sex differences in base rates, risk estimates and workforce and population estimates. Base rates (existing incidence times the theoretical number effected) are then subtracted from these totals to give an estimate of the increased rate. Data were calculated in MS Excel and the spreadsheet is available in the online supplement.

Results

Unemployment

Results of the estimates for unemployment are presented in Table 1 and these are broken down by gender. US suicide incidence stratified by gender, times the increased risk estimate by gender, times the mental health multiplier, times the theoretical number impacted and then subtracting out the base rate estimate suggest the USA may see over 3,800 additional suicides and that the world may see as more than 5,100 additional due to unemployment.

Loneliness

Results of the estimates for loneliness are also presented in Table 1and these are broken down by gender. US suicide incidence stratified by gender, times increased risk estimate, times the mental health multiplier, times the theoretical number impacted and then subtracting out the base rate estimate suggests the USA may see over 5,600 additional suicides and that the world may see as more than 35,000 additional suicides due to loneliness/isolation.

Discussion

The results of the estimations suggest that overall more than 49,000 additional suicides could be seen based on conservative estimates of those impacted by initial effects on employment and social isolation. The estimated numbers could be compounded by the expected limited work force and resources to address mental health. Governments may consider establishing funding sources throughout the forecast of the pandemic in order to procure needed operations of all systems providing mental health care. Brooks et al.[1] suggests that in situations where physical isolation/distancing is required – the goals might be to do so for no longer than required, provide a clear rationale for the efforts, and provide information ensuring sufficient supplies are available. They also suggest that appealing to a sense of altruism about the benefits of quarantine to the wider society may also help.

The dire warning of this data is one we hope will not come to fruition. This is one theoretical predictions the authors hope will not be worn out by future analysis. However, this paper provides a contribution by drawing attention to the future mental health needs and is a prompt for proactive measures. Important to note though not explored thoroughly here is the psychological effect of social stigma that may precipitate suicide in individuals with a viral infection. Theories of stigma suggest that stigmatization significantly influences its targets' mental health[22,23]. Previously, research has found associations between suicide and social stigma in patients diagnosed with HIV/AIDS[24] and Ebola[25]. Little is known about health effects of social stigmatization regarding viral infections and requires further exploration.

In terms of the archival contribution of this paper, our estimates of the number of individuals impacted, while based on the available data, are liable to wide variation if we revise them down words we could have as few as 5,000 additional suicide and revise them upwards we could easily see 100,000 more cases worldwide. This fact shows both the power of intervention to prevent the loss of life, and also points to the utility of the model developed for regional, state or other country wide efforts. That is, the model developed here is probably more accurate for the USA estimates. Yet, the model can be applied at regional, state, country levels where and when more specific data emerges. Analyzing the data by regional, state, or country planners may supply more localized estimates for mental health preparedness efforts. Similar models might be developed for predicting the increased incidence of substance abuse and mental disorders.

Identifying the results of previous quarantine efforts is also beneficial to understand what to anticipate after a pandemic. A positive impact can result from marketing campaigns highlighting the benefits of being responsive together through physical distancing while maintaining social and emotional connectedness. Hawryluck et al.[26] suggested that distress among those quarantined during the SARS epidemic in Toronto might have been lessened by thorough education, detailing and reinforcing the importance of quarantine, while also providing outreach to increase individuals' stress management. These efforts can be led by any organization, their government, or different communities. The media and health organizations provided the majority of information about disease control measures to quarantined individuals in Toronto[26]. Employers might also allow time for adaptation and grief of loss while providing supportive resources and innovative approaches that allow individuals the capability of continuing to contribute to their work-related mission and efforts.

In partnership with national leadership, health systems should probably attend not only to acute care, but take preventive measures, such as the implementation of loan forgiveness programs, reduce the cost of postgraduate training, shorten the duration of training, and other approaches that incentivize individuals to seek a career in mental health. This may take rethinking current disaster aid funding from a short term to longer term focus[27]. Building the work force, the employers and the health care of tomorrow requires utilizing this time as an opportunity to be free from traditional constraints and evolve into a society that is more adaptive to current and future needs. Above all, let us not avoid reality, let us approach it. The goal of this article is to face the problem head on and develop intervention measures that can ameliorate this pandemic's impact on health.

Author contributions:

CFW conceptualized the ideas for this article with help from VGC. CFW, BHM, and MDS conducted literature searches. CFW wrote the first draft of the manuscript. VGC, BHM, and MDS contributed to the writing after the first draft. BHM and MDS verified data, figures, and analysis from the first draft.

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Table 1 *Estimates of Increased Suicide Risk Due to Covid-19 Collateral Effects on Unemployment and Loneliness/Social Isolation*

	Estimate of Existing Incidence	Estimate Increased Risk (Risk Ratio)	Theoretical Number of Those Impacted	Mental Health Multiple	Suicide N	Subtotal	Minus Base rate	Increase Subtotals
Unemployment								
	USA							
Males	0·000224	2·2	3,180,000	2.11	3,306·59		712·32	
Females	0·000061	3·85	2,820,000	2.11	1,397·40		172·02	
	World					4,703.99		3,819·65
Males	0·000135	2·2	6,140,000	2·11	3,847·75		828·90	
Females	0·000077	3·85	3,860,000	2·11	2,414·47		297·22	
						6,262.22		5,136·10
Loneliness								
	USA							
Males	0·000224	1·5	8,167,200	2·11	5,790·22		1,829·45	
Females	0·000061	2	8,432,800	2·11	2,170·77		514·40	
	World					7,960.99		5,617·14
Males	0·000135	1·5	65,650,000	2·11	28,050·60		8,862·75	
Females	0·000077	2	64,350,000	2·11	20,909·89		4,954·95	
						48,960.49		35,142·79
								Total Increase
				Total =	67,887·70		18,172·01	49,715·68

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VIEWPOINT

Suicide Mortality and Coronavirus Disease 2019—A Perfect Storm?

Mark A. Reger, PhD
VA Puget Sound Health Care System, Seattle, Washington; and Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle.

Ian H. Stanley, MS
VA Puget Sound Health Care System, Seattle, Washington; and Department of Psychology, Florida State University, Tallahassee.

Thomas E. Joiner, PhD
Department of Psychology, Florida State University, Tallahassee.

Corresponding Author: Mark A. Reger, PhD, VA Puget Sound Health Care System, 1660 S Columbian Way (S-116), Seattle, WA 98108 (mark.reger@va.gov).

Suicide rates have been rising in the US over the last 2 decades. The latest data available (2018) show the highest age-adjusted suicide rate in the US since 1941.[1] It is within this context that coronavirus disease 2019 (COVID-19) struck the US. Concerning disease models have led to historic and unprecedented public health actions to curb the spread of the virus. Remarkable social distancing interventions have been implemented to fundamentally reduce human contact. While these steps are expected to reduce the rate of new infections, the potential for adverse outcomes on suicide risk is high. Actions could be taken to mitigate potential unintended consequences on suicide prevention efforts, which also represent a national public health priority.

COVID-19 Public Health Interventions and Suicide Risk

Secondary consequences of social distancing may increase the risk of suicide. It is important to consider changes in a variety of economic, psychosocial, and health-associated risk factors.

Economic Stress

There are fears that the combination of canceled public events, closed businesses, and shelter-in-place strategies will lead to a recession. Economic downturns are usually associated with higher suicide rates compared with periods of relative prosperity.[2] Since the COVID-19 crisis, businesses have faced adversity and laying off employees. Schools have been closed for indeterminable periods, forcing some parents and guardians to take time off work. The stock market has experienced historic drops, resulting in significant changes in retirement funds. Existing research suggests that sustained economic stress could be associated with higher US suicide rates in the future.

Social Isolation

Leading theories of suicide emphasize the key role that social connections play in suicide prevention. Individuals experiencing suicidal ideation may lack connections to other people and often disconnect from others as suicide risk rises.[3] Suicidal thoughts and behaviors are associated with social isolation and loneliness.[3] Therefore, from a suicide prevention perspective, it is concerning that the most critical public health strategy for the COVID-19 crisis is social distancing. Furthermore, family and friends remain isolated from individuals who are hospitalized, even when their deaths are imminent. To the extent that these strategies increase social isolation and loneliness, they may increase suicide risk.

Decreased Access to Community and Religious Support

Many Americans attend various community or religious activities. Weekly attendance at religious services has been associated with a 5-fold lower suicide rate compared with those who do not attend.[4] The effects of closing churches and community centers may further contribute to social isolation and hence suicide.

Barriers to Mental Health Treatment

Health care facilities are adding COVID-19 screening questions at entry points. At some facilities, children and other family members (without an appointment) are not permitted entry. Such actions may create barriers to mental health treatment (eg, canceled appointments associated with child restrictions while school is canceled). Information in the media may also imply that mental health services are not prioritized at this time (eg, portrayals of overwhelmed health care settings, canceled elective surgeries). Moreover, overcrowded emergency departments may negatively affect services for survivors of suicide attempts. Reduced access to mental health care could negatively affect patients with suicidal ideation.

Illness and Medical Problems

Exacerbated physical health problems could increase risk for some patients, especially among older adults, in whom health problems are associated with suicide. One patient illustrated the psychological toll of COVID-19 symptoms when he told his clinician, "'I feel like (you) sent me home to die."[5]

Outcomes of National Anxiety

It is possible that the 24/7 news coverage of these unprecedented events could serve as an additional stressor, especially for individuals with preexisting mental health problems. The outcomes of national anxiety on an individual's depression, anxiety, and substance use deserve additional study.

Health Care Professional Suicide Rates

Many studies document elevated suicide rates among medical professionals.[6] This at-risk group is now serving in the front lines of the battle against COVID-19. A national discussion is emerging about health care workers' concerns about infection, exposure of family members, sick colleagues, shortages of necessary personal protective equipment, overwhelmed facilities, and work stress. This special population deserves support and prevention services.

Firearm Sales

Many news outlets have reported a surge in US gun sales as COVID-19 advances. Firearms are the most common

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method of suicide in the US, and firearm ownership or access and unsafe storage are associated with elevated suicide risk.[7] In this context, issues of firearm safety for suicide prevention are increasingly relevant.

Seasonal Variation in Rates

In the northern hemisphere, suicide rates tend to peak in the late spring and early summer. The fact that this will probably coincide with peak COVID-19 prevention efforts is concerning and deserves additional study.

Suicide Prevention Opportunities

Despite challenges, there are opportunities to improve suicide prevention efforts in this unique time. Maintenance of some existing efforts is also possible.

Physical Distance, Not Social Distance

Despite its name, social distancing requires physical space between people, not social distance. Efforts can be made to stay connected and maintain meaningful relationships by telephone or video, especially among individuals with substantial risk factors for suicide. Social media solutions can be explored to facilitate these goals.

Tele–Mental Health

There is national momentum to increase the use of telehealth in response to COVID-19. Unfortunately, tele–mental health treatments for individuals with suicidal ideation have lagged far behind the telehealth field. Opportunities to increase the use of evidence-based treatments for individuals with suicidal thoughts have been noted for years, especially in rural settings, but fear of adverse events and lawsuits have paralyzed the field. Disparities in computer and high-speed internet access must also be addressed. Research, culture change, and potentially even legislative protections are needed to facilitate delivery of suicide prevention treatments to individuals who will otherwise receive nothing.

Increase Access to Mental Health Care

As COVID-19 precautions develop in health care settings, it is essential to consider the management of individuals with mental health crises. Screening and prevention procedures for COVID-19 that might reduce access to care (eg, canceled appointments, sending patients home) could include screening for mental health crises; clinical staff would be needed to some degree in settings that may currently relegate COVID-19 symptom screening to administrative staff. Also, rather than sending a patient with a child home, alternative treatment settings could be considered (eg, a private space outside).

Distance-Based Suicide Prevention

There are evidence-based suicide prevention interventions that were designed to be delivered remotely. For example, some brief contact interventions (telephone-based outreach)[8] and the Caring Letters intervention (in which letters are sent through the mail)[9] have reduced suicide rates in randomized clinical trials. Follow-up contact may be especially important for individuals who are positive for COVID-19 and have suicide risk factors.

Media Reporting

Because of suicide contagion, media reports on this topic should follow reporting guidelines and include the National Suicide Prevention Lifeline (1-800-273-TALK). The hotline remains open.

Optimistic Considerations

There may be a silver lining to the current situation. Suicide rates have declined in the period after past national disasters (eg, the September 11, 2001, terrorist attacks). One hypothesis is the so-called pulling-together effect, whereby individuals undergoing a shared experience might support one another, thus strengthening social connectedness. Recent advancements in technology (eg, video conferencing) might facilitate pulling together. Epidemics and pandemics may also alter one's views on health and mortality, making life more precious, death more fearsome, and suicide less likely.

Conclusions

Concerns about negative secondary outcomes of COVID-19 prevention efforts should not be taken to imply that these public health actions should not be taken. However, implementation should include a comprehensive approach that considers multiple US public health priorities, including suicide prevention. There are opportunities to enhance suicide prevention services during this crisis.

ARTICLE INFORMATION

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