WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Teleconference Meeting
September 24, 2020
PowerPoint Presentations and Handouts

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Tab 3:	• **PowerPoint:**	**Suicide Prevention Funding Allocation**
Tab 5:	• **Handout:**	**MHSOAC Memo: Sharing Research Findings within Transparency Dashboard Framework**
	• **Handout:**	**Cal Voices Help@Hand Issues and Concerns**
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SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MHSA Innovation Proposal:
County Addiction Medicine Fellowship

MHSOAC Meeting – September 24, 2020

Overview

1. INN General Requirements
2. Primary Problem
3. Proposed Innovation & Learning Goals
4. Budget Request

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General Requirements

General Criteria:

- Introduces **a new practice or approach** to the overall mental health system by…

providing *specialized, public-sector focused* *training to physicians in integrated psychiatric and substance use disorder treatment* by means of an Addiction Medicine Fellowship sponsored by a county.

Primary Purpose:

- **Increases the quality** of mental health services, including measured outcomes by…

creating an integrated workforce of physicians with specialized training in the treatment of clients with co-occurring substance use disorders in a county/community setting where it is needed the most.

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Primary Problem

The current addiction treatment workforce in many California counties is severely under-equipped to meet the complex needs of clients with co-occurring mental health and substance use disorders.

- **Public Sector Workforce** – Addiction Medicine Fellowships are primarily at University settings. County services are on the ground in the community providing safety net services and early intervention for some of the most vulnerable communities. An addiction fellowship sponsored by the County will support a public sector workforce pathway.

- **Behavioral Health Equity and Cultural Humility** – These are core principles for the County. An addiction fellowship sponsored by the County will be integrated into the active teaching of structural humility and reducing health disparities.

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Proposed Innovation

- An accredited Addiction Medicine Fellowship sponsored by San Mateo County Health tailored to addressing the needs and priorities of the public sector including;
    1. treating the most vulnerable with co-occurring mental health and substance use disorders,
    2. working with peer substance use counselors,
    3. advancing equity including contributing to equity projects in clinical and community settings, and
    4. collaborating remotely with academic Addiction Medicine programs on scholarly activities to leverage academic resources for widespread application in non-academic county settings.

Learning Goal #1

Does an Addiction Medicine fellowship improve workforce capacity to serve vulnerable co-occurring mental health and substance use clients?

Learning Goal #2

Does an Addiction Medicine fellowship sponsored by a county government entity increase capacity for fellows to engage in meaningful community advocacy?

Learning Goal #3

Does an Addiction Medicine fellowship in a county/ community setting improve behavioral health outcomes for co-occurring mental health and substance use clients?

Budget Request

- Requesting $663,125 for 4 years allocated out as follows
  - Service: $536,000; Admin: $76,625; Evaluation: $50,000
  - Year 1 is focused on start-up activities
  - Year 2-4 will include one fellow per year (3 total fellows)

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**TOTAL**
1.	Salaries	$10,000	$160,000	$160,000	$160,000		$490,000
2.	Direct Costs						
3.	Indirect Costs						
4.	**Total Personnel Costs**	**$10,000**	**$126,000**	**$194,000**	**$160,000**		**$490,000**
OPERATING COSTS		**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**TOTAL**
5.	Direct Costs		$15,500	$15,500	$15,500		$46,500
6.	Indirect Costs	$9,579	$19,156	$19,156	$19,156	$9,578	$76,625
7.	**Total Operating Costs**	**$9,579**	**$34,656**	**$34,656**	**$34,656**	**$9,578**	**$123,125**
NON-RECURRING COSTS (equipment, technology)		**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**TOTAL**
8.							
9.							
10.	**Total Non-recurring costs**						
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**TOTAL**
11.	Direct Costs						
12.	Indirect Costs	$6,250	$12,500	$12,500	$12,500	$6,250	$50,000
13.	**Total Consultant Costs**	**$6,250**	**$12,500**	**$12,500**	**$12,500**	**$6,250**	**$50,000**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 20/21**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**TOTAL**
14.							
15.							
16.	Total Other Expenditures						
BUDGET TOTALS							
Personnel (line 1)		$10,000	$160,000	$160,000	$160,000		$490,000
Direct Costs (add lines 2, 5 and 11 from above)			$15,500	$15,500	$15,500		$46,500
Indirect Costs (add lines 3, 6 and 12 from above)		$15,829	$31,656	$31,656	$31,656	$15,828	$126,625
Non-recurring costs (line 10)							
Other Expenditures (line 16)							
TOTAL INNOVATION BUDGET		**$25,829**	**$207,156**	**$207,156**	**$207,156**	**$15,828**	**$663,125**

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Thank you!

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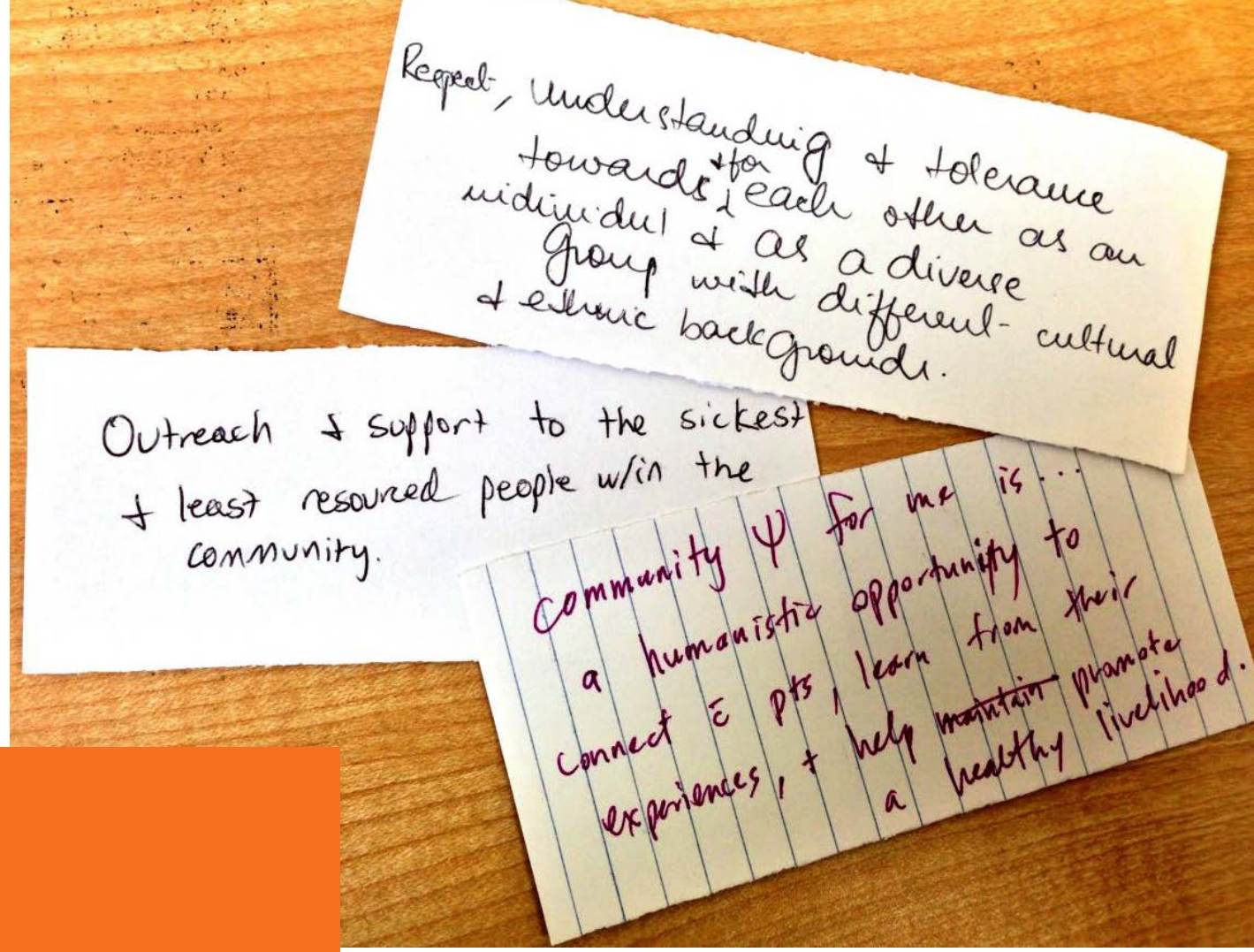

smchealth.org/mhsa

mhsa@smcgov.org

Proposed Motion

The Commission approves San Mateo County's Innovation Plan as follows:

- Name: County Addiction Medicine Fellowship
- Amount: Up to $663,125 in MHSA INN funds
- Project Length: Four (4) Years

SAN MATEO COUNTY HEALTH
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Mental Health Services
Oversight & Accountability Commission

Suicide Prevention Funding Allocation

MHSOAC Meeting on September 24, 2020
Ashley Mills, M.S.
Research Supervisor

Overview

- The Commission was authorized to allocate $2 million of its budget over the next two fiscal years to begin implementing the state's suicide prevention plan.
- The Commission approved several initiatives to address critical statewide gaps in strategic planning, data, safety, training, and support during its meeting on August 27, 2020.
- The Commission will consider funding allocations to support the approved suicide prevention initiatives.

Initiatives and Budgets

Initiative	Budget (not to exceed)
Advance Local Strategic Planning and Implementation	$535,000
Increase Lethal Means Safety	$200,000
Accelerate Standardized Suicide Risk Assessment and Management Training and Technology Support	$215,000
Deliver Standardized Suicide Risk Screening Training	$150,000
Create a Suicidal Behavior Research Agenda and Action Plan and Begin Implementation	$500,000

Proposed Motion

Allocate funding and authorize the Executive Director to enter into contracts to support the five (5) initiatives with the key activities presented in aggregate not to exceed $2,000,000.

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

LYNNE ASHBECK
Chair
MARA MADRIGAL-WEISS
Vice Chair
TOBY EWING
Executive Director

September 24, 2020

The Commission has directed staff to increase and improve communication relating to the Commission's community engagement efforts and data analytics, as well as broader communications about the state of knowledge in the field of community mental health.

Efforts are underway to provide diverse communication tools for sharing our research findings, including data briefs, videos, infographics, and data dashboards published within the Commission's Transparency Dashboard framework. Staff, under the leadership of Chief of Research and Evaluation Dr. Dawnté Early and Research Supervisor Ashley Mills, currently is developing the first of many informational briefs to share what we are learning from our data analysis, literature reviews, and community engagement.

Topics and titles under development include the following:

Criminal Justice and Mental Health

Immigrant and Refugee Mental Health

Prevention and Early Intervention

- The High Cost of Adverse Childhood Experiences
- Prevention and Intervention in Early Childhood for Parent and Baby
- Closing the Gap to Increase Timely Access to Mental Health Supports
- Identification and Intervention at First Break of Psychosis
- Continuing Care to Prevent Relapse in Mental Health

Workplace Mental Health

- Recent changes in the workplace and impacts on mental health
- Impacts of the pandemic on the mental health of racial and ethnic groups and employment
- Designation of essential workers and challenges to mental health

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Help@Hand Issues and Concerns

Stakeholders continue to raise concerns regarding the Help@Hand project, particularly since the project is emerging in ways that fail to recognize the counties' primary purposes for the program, lacks sufficient evaluation and transparency, lacks sufficient peer involvement, and may not meet several of the General Standards of the MHSA.

Background

In Spring of 2017, the Mental Health Services Oversight and Accountability Commission (MHSOAC) convened a meeting at Google-Verily headquarters in South San Francisco on technology-mental health partnerships, in an attempt to bring together certain stakeholders, technology leaders, and government officials[1]. The goal of the day was to create innovation incubators, and potential technological prototypes, as an example of how counties could spend down their large sums of unused Innovation funds. These conversations led Los Angeles and Kern Counties to develop Innovation (INN) proposals, disseminate them for minimal stakeholder feedback and post the proposals for 30-day public comment[2] [3]. In October, 2017 the MHSOAC approved these first two counties to begin the Tech Suites (now called Help@Hand) Innovation project with the goal of increasing access to mental health services utilizing technology applications (apps). Initially, the project involved only two apps, Mindstrong (created by Google Verily), and 7 Cups. The Board of Directors of The California Mental Health Services Authority (CalMHSA), a Joint Powers Authority (JPA), voted to administer the Tech Suite project, pending project approval by the MHSOAC, at their October 12, 2017 Board of Directors Meeting[4].

By September, 2018, 14 counties/cities were participating in the Help@Hand project[5]. Los Angeles had anticipated the launch of virtual services on their website by February 2018, however by May 2019, the "primary focus of CalMHSA and the Counties…was to build capacity in the Tech Suite in order to establish minimally viable products for the two Tech Suite Apps."[6] In the first two years of the project, significant learning took place, as challenges were discovered with both of the apps[7]. 7 Cups was removed from the project for unknown reasons in September 2019[8], but it is known that serious issues arose with that app which had the potential to impact user safety and security[9] [10].

After experiencing numerous delays, 12 of the participating counties voted to approve a Help@Hand request to the MHSOAC (with no stakeholder input) to extend the Help@Hand project from a three-year project to a 5-year project[11]. This follows efforts by CalMHSA, Counties and CBHDA to develop and pass budget trailer bill language (SB 79) in July 2019, which extends reversion and allows counties more time to spend down their funds.[12]

In 2019, after having spent over $20 million[13], CalMHSA (without any stakeholder input or MHSOAC review), significantly changed the project into a rapid pilot model approach, with each county launching a small number of time-limited pilots. The goal of this is for counties to learn from these pilots and share that knowledge with other counties to inform future local agency decisions about which apps to offer within their mental health system[14].

The original timeline of the "new" pilot model estimated that 8-12 apps would be completed and become accessible to the PMHS by June 30, 2020[15]. However, by that date at least $22 million had been spent[16] we are not aware of any county pilots that had been completed, and most counties had not yet begun to pilot any apps. While Help@Hand may point to COVID 19 for these most recent delays, these apps, if implemented as promised, could have significantly helped clients in the PMHS during COVID 19.

Is Help@Hand Meeting the Counties' Primary Purposes?

The table below lists the original primary purpose and target populations of each participating county, along with the app(s) each county is considering piloting.

County	Primary Purpose from original proposal	Target Populations as of 6/30/20	Apps they are considering piloting[17]
City of Berkeley	Increase access to mental health services to unserved and underserved groups; and to increase the quality of mental health services, including better outcomes [18]	Youth, TAY, all Berkeley residents	None
Inyo	Increase access to mental health services to underserved groups[19]	Perinatal mothers and transition age youth	Withdrew from project
Kern	Increase access to mental health services to underserved groups[20]	Those with sub-clinical mental health symptom presentation; those at risk of mental illness or relapse, socially isolated individuals	None
Los Angeles	Increase access to mental health care and support and to promote early detection of mental health symptoms, or even predict the onset of mental illness[21]	Current target populations[22]: Transition age youth and college students, **county employees**, complex needs individuals, existing mental health clients	1. Launched Headspace: Guided meditation and mindfulness 2. Credible Mind: Self-guided connection to online resources for information 3. Uniper: Telehealth and social engagement for older adults 4. MindLAMP: A research app that collects information about your health through surveys, brain games, and phone sensor data
Marin	Increase access to mental health services to underserved groups; provide support and linkage to mental health resources[23]	Isolated older adults	1. myStrength: Online tools (interactive programs, in-the-moment coping tools, inspirational resources, and community support) to improve and sustain health and well-being 2. Uniper: Telehealth and social engagement for older adults
Modoc	Increase access to mental health services for underserved groups[24]	Those with sub-clinical mental health symptom presentation; those at risk of	Not participating in pilots

		mental illness or relapse, socially isolated individuals	
Mono	Increase access to mental health services to underserved groups; increase the quality of mental health services, including measurable outcomes[25]	Transition age youth	None
Orange	Increase access to mental health services to underserved groups; increase access to mental health care, promote early detection and predict the onset of mental illness[26]	Individuals with sub-acute mental health symptoms; social isolated individuals, clients in rural areas, high utilizers	Launched Mindstrong: Digital phenotyping, virtual therapy and psychiatric care through a smartphone
Riverside	Early detection and suicide prevention, improve outcomes for high risk populations, Improve service access for rural regions and underserved communities[27]	Transition age youth, underserved communities	Launched Take My Hand: Developed by Riverside County, provides online peer chat
San Francisco	Utilize a new approach to overall public mental health service delivery in order to use technology to increase access to mental health care and support [28]	Transition age youth and socially isolated transgender adults	TBD
San Mateo	Connect transition age youth in crisis, older adults experiencing isolation, and the Spanish and Chinese monolingual communities to in-person services; improve access to mental health services and supports; and improve wellness and recovery outcomes for those who engage with the mobile apps[29]	Transition age youth Older adults experiencing isolation Spanish and Chinese monolingual communities	Headspace: Guided meditation and mindfulness
Santa Barbara	Increase engagement of underserved, hard-to-reach and marginalized communities, improving communications and increasing access to services[30]	Adults discharged from psychiatric hospitals/recipients of crisis services; transition age youth who are students at colleges and universities; individuals 16 and over living in geographically isolated communities	Headspace: Guided meditation and mindfulness
Tehama	Provide comprehensive information about local mental health and behavioral services; serve as a support platform for rural youth and TAY; identification of onset of mental illness among youth, transition age youth and seniors[31]	Transition age youth and individuals living in remote, isolated areas	MyStrength: Online tools (interactive programs, in-the-moment coping tools, inspirational resources, and community support) to improve and sustain health and well-being
Tri-City	Increase access to mental health services to underserved groups[32]	Transition age youth, older adults, non-English speaking clients and community members	Wysa: Digital therapy and therapy avatar

Does Help@Hand increase access to mental health services to underserved groups?

As noted in the above table, the primary goal of every participating county is to increase access to mental health services to underserved groups. The Help@Hand project underwent a major pivot in 2019 after CalMHSA and the counties determined that the initial two apps were not ideal. 7 Cups was removed from the project entirely, and Mindstrong is being used by only one county[33]. The original vision of the project, and of the county INN plans, anticipated full integration of the applications with county behavioral health services and incorporation of specific county services within applications[34]. However, after spending almost $20 million on the project, much of which went to development of the initial two apps with the goal of integrating them into county systems, CalMHSA and the counties determined that this approach was not feasible and the project was switched to a pilot model in late 2019[35].

CalMHSA launched a second Request for Statement of Qualifications (RFSQ) in fall 2019, with the goal of approving several new applications that would require minimal development, and thus be able to launch quickly[36]. The tradeoff with this is that the applications do not interface with county systems, and thus are generally not able to provide crisis response or referral to community services. The access to services provided by the current apps is generally limited to meditation and mindfulness, access to general mental health information, and coping tools. With the exception of Mindstrong, Take My Hand, and Wysa, the apps being piloted do not appear to provide any direct mental health services, and were readily available to any member of the public prior to the existence of the Help@Hand Program.

In their Innovation plans, all counties identified underserved groups as their broad priority population for the Help@Hand project. Increased access to mental health services to underserved groups is a complex issue that requires commitment and forethought. There are a number of reasons that an individual or group of individuals may be underserved. Some of these include[37]:

- Geographic Isolation
- Lack of culturally responsive services
- Lack of staff who reflect their culture, ethnicity, and/or sexual orientation and gender identity
- Lack of continuity of available programs
- Low income
- Speak a language other than English
- Face economic barriers to accessing care
- Stigma

To effectively increase services to underserved groups, and to ensure that an INN project is culturally competent, these factors must be addressed. Although the transparency of the Help@Hand project is limited (discussed in more detail below), there is little evidence that addressing the challenges of underserved populations is a priority of the project. This is evident by the following:

- Stakeholders have expressed concerns that the individuals who are most in need of services do not have basic access to a computer with internet, or even a telephone with unlimited minutes and data, and are therefore unable to use mental health apps
- There are no publicly available Help@Hand plans or other guidance to assist counties in reaching out to individuals in remote areas, or providing them with technology to access mental health apps
- The Help@Hand website does not have translation options which would allow the content to be understood by non-English speakers
- There have been challenges getting available apps translated into languages other than English
- Consumers surveyed by the Help@Hand evaluation team have also expressed distrust of technology and mental health apps, which threatens to limit the expansion of apps to some of the hardest to reach populations
- The CalMHSA grievance process is only available to English speakers

The challenges encountered during the first two years of the project caused significant delays, and cost over $20 million[38], yet there has yet to be any documented increase in access to services for any consumers, including those from underserved groups.

Is Help@Hand Meeting the MHSA General Standards?

Counties are required to adopt the MHSA's six General Standards when planning, implementing, and evaluating all programs[39]. These six General Standards are:

1. Community Collaboration
2. Cultural Competence
3. Client-Driven
4. Family-Driven
5. Wellness, Recovery, and Resilience Focused
6. Integrated Service Experience

If we examine Help@Hand through the lens of each of these General Standards, it is not clear that the project is meeting any the first four General Standards.

General Standard #1: Community Collaboration

Community Collaboration is the process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill a shared vision and goals[40]. In its Innovation Resource Paper[41], the MHSOAC recommends:

> ***Proposed innovations are developed at the grass-roots level*** *with inclusive participation of potential and actual service users, their families and caregivers and service providers or other representatives; these stakeholders reflect the demographics of the community.*

Community collaboration within the Help@Hand project should take place at all levels of the project, including with CalMHSA at the project management level, and with counties at the local level. There is little evidence that community collaboration has been a focus or priority of the project, and the project was clearly not developed at the grass-roots level with inclusive participation of potential and actual service users. True community collaboration requires demonstrated transparency, shared learning, and broad participation by community members and stakeholders.

From its inception, the project has lacked both transparency, and broad community collaboration. Transparency has been minimal from the beginning, with the project having been conceived at a non-public meeting hosted by the MHSOAC at Google-Verily headquarters and then presented to counties for buy-in with little to no involvement in *development* of the project by the stakeholders who would be using the products.

While CalMHSA shared some of their documents with Cal Voices in response to Public Records Act requests, neither CalMHSA, nor the counties have made any of the project's evaluation reports, budget documents, or other documents which demonstrate progress and challenges widely available to the public. In addition to concerns by stakeholders about transparency, several participating counties have also raised concerns about CalMHSA's transparency in the management of the project.[42]

A second public records act request, and conversations with stakeholders indicate that CalMHSA has begun to label most documents as "draft" documents which appears to be an attempt to limit public dissemination. Project budget documents, evaluation reports, and pilot process documents all remain in draft form indefinitely. UC Irvine has completed at least three quarterly evaluation reports which document some of the successes and challenges with the project, and while Cal Voices received these reports from CalMHSA after Public Records Act requests, these valuable reports are not disseminated widely to the public or, as far as we know, to the MHSOAC. The Year 2 Quarter 1 Evaluation Report[43], still labeled "confidential draft", appears to be highly formatted and looks like a professional document, not a working draft. UCI has also completed an Annual Evaluation Report, which is not labeled "draft", but it has not been publicly disseminated or posted on the Help@Hand website.

There are a large number of documents, many also labeled "draft", that Cal Voices has requested via the Public Records Act but has not received, including, but not limited to:

- Help@Hand draft budget revision-Jan 9, 2020; July 2020
- A full accounting ledger of collaborative payments
- INN Tech Suite Road Map
- Full meeting packets (Leadership Committee, Change Control Board, Tech Lead Meetings)
- Pilot Process Summary
- Collaborative Pilot Planning Summary
- Pilot Goals and Roadmap

In addition, although CalMHSA is a public entity subject to the Ralph M. Brown Act[44], there are very few state level public meetings related to the Help@Hand project, and no state level public meetings which allow public comment on app selection, budget documents, or peer involvement.

Community Collaboration by interested stakeholders appears to be almost entirely lacking at the state project management level of Help@Hand, which is indicated by the lack of transparency and the lack of public meetings. Community collaboration at the county level varies by county, but there is no indication of community collaboration prior to development of the project.

General Standard #2 Cultural Competence

Cultural Competence requires counties to incorporate and work to achieve nine specific goals for cultural competency into all aspects of policy-making, program design, administration and service delivery[45]. As previously discussed, there is little evidence that cultural competence has been a focus of the Help@Hand project.

General Standard #3, #4 Client and Family-Driven

MHSA programs and services must use clients' input as the ***main factor*** for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes[46].

The Help@Hand project was conceived at a meeting hosted by the MHSOAC at Google Verily. Although the MHSOAC is subject to the Bagley-Keene Act, there is no record that this meeting was publicized, agendized, or open to the public. Thus, there is no indication that clients or family members were involved in the planning of the project.

Following this meeting, counties, with assistance from CalMHSA, initially developed their INN plans without any documented stakeholder involvement, and then requested stakeholder feedback and public comment. The MHSA states:

> *Each [county MHSA] three-year program and expenditure plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness[…]. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations.*[47]

The Act makes clear that stakeholders, including clients and consumers, must actively participate throughout the process, from initial program conception and project development all the way to the final evaluation. Clearly, consumers were not involved with the initial planning of the Help@Hand project, and they are not being included throughout the process.

More recently, CalMHSA has been hosting between one and three stakeholder listening sessions within each county to obtain information from stakeholders about the challenges, barriers, and needs of consumers related to mental wellness apps. These sessions have resulted in common needs and barriers expressed by stakeholders,

including: the lack of access to quality mobile phones with data, lack of access to a computer, internet service, and the need for the most basic computer skills training, including how to read an email or create a password. However, many of the concerns reported by stakeholders at these meetings are not addressed by CalMHSA in their management of the project.

The following table summarizes the needs and concerns expressed by stakeholders in each county:

	Los Angeles	Riverside	Orange	Kern	Santa Barbara	San Mateo	Marin	Tehama
Dislike of video chats	x							
Language/literacy barriers	x	x			x			
Privacy/safety concerns	x	x	x	x	x	x	x	x
Lack of access to equipment/internet/ sufficient data	x	x	x	x	x	x	x	x
The need for basic computer skills and cell phone training	x	x	x		x	x	x	
Education about apps, digital safety, and cyber security	x	x	x	x	x	x	x	x
The need for disability accommodations	x	x	x			x	x	
Additional challenges for older adults	x	x				x	x	
Support in other languages		x	x	x	x			
The desire for apps that reduce anxiety and stress	x	x	x	x	x		x	x
The desire for apps that link people to crisis intervention services			x	x	x	x		x
The desire for apps that provide linkage to services				x	x	x		x

Clients surveyed indicated a need for disability accommodations, support in other languages, linkage to crisis supports and other services, and a lack of access to basic technology and internet. Yet, it does not appear that this stakeholder input has been the main factor for Help@Hand planning, policies, procedures, service delivery, or evaluation. This is evident by the following:

- The project does not provide for access to technology for underserved groups
- Current apps do not provide support in other languages

- The apps being piloted do not link consumers to crisis intervention services
- The apps being piloted do not link consumers to mental health services
- Consumer input was collected during a small number of small meetings held within counties

True community collaboration and incorporation of client needs would require the Help@Hand project to demonstrate broad and meaningful participation by consumers and other stakeholders throughout the entire Help@Hand project, from initial app selection until final evaluation. True community collaboration would also have eliminated many of the early problems which occurred within the project, including:

- Poor fit between Tech Suite products and client needs and resources[48]
- Evaluators felt that the 7 Cups interface was overwhelming, overloaded, unorganized and confusing[49]
- 7 Cups' ability to detect a user's location raises issues with privacy[50]
- Mismatch between the apps and clients' clinical needs or presentations[51]
- Frequent changes in project direction may result in inefficiency, lack of clarity for project staff and counties and decreased participation[52]

If an effort had been made, prior to counties drafting their Innovation Plans, to include stakeholders from the target populations in developing the Help@Hand project from the ground up, it is likely that the project would look very different than it does today.

Other Concerns:

Insufficient Peer Involvement

According to CalMHSA, "Peers are not just central to the success of these applications, they are and will be the driving force. As such, they will be the largest component of the workforce supporting the use and advancement of the apps."[53] Yet, the state level project manager, CalMHSA, employed a single peer on the project between November 2018 and March 2020. That peer left CalMHSA and, at the time of this writing, has yet to be replaced.

Peer involvement is also an essential component of community collaboration, yet the peer component of the Help@Hand project has struggled for a number of reasons. Innovation plans are required to promote consumer-operated services, such as direct peer support provided by clients with shared lived experience and reflective of the cultural makeup of local communities. Yet, peers working at the county level on Help@Hand consistently report that the peer voice is minimized, that peers are not involved at all levels of the project, and they are not invited to key Help@Hand meetings. In addition, the peer outreach component of the project is apparently not active yet, and has been further delayed due to the challenges posed by the current pandemic[54].

Counties have reported challenges in hiring peers, including restrictive hiring practices or requirements of local behavioral health systems, high turnover, and a shortage of peers[55]. Addressing this challenge should be a priority. When peers are valued for their expertise, hiring and retention are not be a problem.

Evaluation

Innovation projects, while designed to discover innovative service delivery approaches, are also intended to produce learning. Robust data collection and evaluation activities are a key element in furthering learning, and a requirement for INN plans[56]. The collaborative encountered numerous challenges during its first two years which caused significant delays and resulted in the project pivoting dramatically. It is not clear what processes are in place to not only learn from these challenges, but to share that learning with other counties in the future.

To date, at least $2,385,000 has been paid to UCI for evaluation activities, yet no evaluation reports have been publicly disseminated. There has not been a cross-collaborative information exchange process developed to aid in learning[57]. Furthermore, the collaborative process evaluation, which evaluates the learning taking place in the collaborative, and the effectiveness of Help@Hand at the organizational level, was paused indefinitely in October, 2019[58] and, as far as we know, has not yet resumed.

CalMHSA has only recently implemented a grievance process whereby consumers can express their concerns directly to CalMHSA[59], yet the state level grievance process is available only to English speakers. Counties have existing grievance processes which can also be utilized by consumers to communicate their concerns directly to their county, but there is no process for county grievances to be shared with the collaborative.

Nearly three years into the project, the determination of which data (baseline, demographic, and outcomes) will be collected, and how counties can effectively collect that information has not yet been made. In addition, there has been some talk about limiting UC Irvine's evaluation role as the project moves forward[60].

Safety and Privacy

The Help@Hand project encountered several challenges related to the safety and privacy of users during the first two years of the project. These include:

- Issues with 7 Cups listeners (one had a Confederate Flag as a symbol).
- Safety and privacy guidelines were not begun until February, 2019. It is unclear whether they have been completed.
- Clients expressed privacy concerns about sharing their mental health experiences within their small communities.
- Another unknown serious issue with a user resulted in 7 Cups being placed on hold.
- 7 Cups was ultimately removed from the project.
- It wasn't until two years into the project (December 2019) that CalMHSA determined an informed consent should be obtained from participants

Despite the challenges encountered during the first 2 years of the project, there is little indication that safety and privacy of users has been a focus of the preparation for these new pilots. When the Tech Suites project began with the initial two apps in 2017, it took nearly 1.5 years to discover the serious concerns with 7 Cups

that caused it to be removed from the project. Yet, the new pilot process involves very quick turn-around pilot launches, with public mental health system consumers, of a small number of apps. There is no indication that the apps have been thoroughly vetted for privacy, safety and security before being piloted on consumers. In addition, most of the apps being piloted do not have a mechanism to link consumers to any form of crisis response, or even a mechanism to link consumers to county-provided services. Despite several CPRA requests, Cal Voices has not obtained any privacy documents or informed consent materials.

Fiscal Accountability

The MHSOAC approved the first two counties in October, 2017. Since then, over $22 million has been spent, including at least $6.7 million paid to 7 Cups (which has been removed from the project prior to launch) and $3.7 million paid to Mindstrong, which is now being considered by a single county. Both of these companies are private technology companies, and the public money they received went largely towards product development, for a product that was never produced. Where is the taxpayers return of investment?

The collaborative project budget (the portion of the full budget managed by CalMHSA), which totals approximately $38 million for all 5 years of the project, pays for all project management, technology fees, a project peer, evaluation, and outreach activities. As of 01/2020 it is estimated that $19.9 million has already been spent of this collaborative project budget, leaving only $18 million remaining of the full collaborative project budget. To date, there have been no evaluation reports publicly released, and there is not yet a process in place to evaluate the collaborative process or further interagency learning.

While the first 3 years of the project demonstrated excessive spending on product development, there are concerns that the project has recently pivoted too far in the other direction, with too little money spent on customizing apps so that they are relevant to the goals of the project and the needs of the communities. CalMHSA and the Counties restarted the project into a pilot model around Dec, 2019, with counties quickly launching apps as pilot projects with minimal resource investment. The original goal was to begin launching pilots after 1 month of product development, with a 2 month pilot length. If 7 Cups received $6.7 million before being removed from the project after nearly two years without achieving a minimal viable product, and Mindstrong has received at least 3.7 million without yet being officially launched, is the project's new pilot model fiscally responsible?

Project Management

Stakeholders continue to raise concerns about the effectiveness of the Help@Hand project management. There have been reports of unclear lines of communication and governance within CalMHSA and between CalMHSA, contractors and counties. The project also involves a large number of contractors who have unclear and sometimes overlapping duties. Through June 30, 2019, which is the latest complete financial accounting we have been able to receive, even after three Public Records Act requests, CalMHSA paid $2,500,443 to subcontractors. Excessive staff turnover at CalMHSA has been cited as another concern, with their Executive Director, Associate Director and Peer all leaving the organization in recent months.

Stakeholders express that CalMHSA has focused on internal processes and meetings at the expense of results. The collaborative, which includes CalMHSA and Help@Hand county leads, holds several different phone meetings every week, yet there is no public access to or documentation of these meetings, and no evidence of cross-collaborative learning or evaluations being conducted.

The project has been beset with continued delays: As of June, 2020, an estimated total of 3 apps were being actively piloted by 3 counties (1 app/county). The project is already several months behind their new pilot process timeline which estimated that 12-15 apps would be in pilots by this date.

Digital Divide

Although a goal of the Help@Hand project is to increase services for underserved populations, client stakeholders from every county who participated in Help@Hand stakeholder sessions reported that a lack of access to computers/smart phones and/or a lack of internet access was a barrier to accessing these apps. Underserved populations often represent some of the lowest socioeconomic communities, including those from rural populations, the very same groups who report a lack of access to the technology necessary to access wellness apps.

In September, 2019, A-Z Techs conducted an examination of California Lifeline's free phone plans and determined that these plans provided between .1 and 3 gigabytes of data per month for low income consumers. This report concluded that consumers on Lifeline plans may not have sufficient data to access wellness apps on their phones. Consumers with Lifeline phones, often referred to as "Obamaphones", also report that the phones are older and less capable of running many of these apps.

While CalMHSA and the counties have begun some local digital literacy training, providing access to apps for underserved groups will not be realized until low income and geographically isolated individuals have access to devices and unlimited high speed internet.

Conclusion

Cal Voices and other community mental health advocates brought many of these issues to the attention of the MHSOAC and counties prior to the approval of this project. Some 3 years into the implementation timeline, nearly all of our concerns have come to fruition.

Innovation projects are intended to create learning. With this learning is always the possibility that an Innovation project will ultimately not result in improved services or programs. However, the fact that the ultimate goal is learning does not negate the requirements of the MHSA, or the stated goals of the counties. Innovation projects utilize public taxpayer money which necessitates abundant levels of transparency and fiscal accountability.

Effective Community Collaboration and stakeholder involvement during the initial development of the project would have eliminated or minimized many of the challenges that the project faces today. Stakeholder feedback would have revealed at the outset that individuals within the target population lack devices and internet access,

many consumers experience distrust of technology, and it would have educated planners about the types of digital wellness that stakeholders are seeking. Broad community collaboration and project transparency would also have been likely to minimize the excessive spending that took place during the first two years of the project.

Learning also requires robust evaluation activities throughout the process to continually identify and correct weaknesses and challenges. This evaluation must examine both county level and state level (CalMHSA) successes and challenges, and be shared publicly to encourage learning, growth and transformation.

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September 17, 2020

Mental Health Services Oversight and Accountability Commission
State of California

Madam Chairwoman Ashbeck and Commissioners:

Please consider the following request for adopting and sending a Governor's Office Action Request (GOAR) asking Governor Newsom to proclaim Post-Traumatic Stress Injury Awareness Day in California.

The diagnostic term Post-traumatic Stress Disorder (PTSD) was crafted in 1980 by the American Psychiatric Association to commonly describe and categorize the psychological aftermath of severe traumatic distress. However, it has since been scientifically demonstrated that post-traumatic stress causes physical changes within the brain which more accurately describe an injury than a disorder. To continue to refer to this injury as a disorder today, needlessly, and wrongfully fosters the stigma adding to the adversity of the wound and fomenting suicide.

The Mental Health Services Oversight and Accountability Commission's *Strategic Plan for Suicide Prevention 2020-2025 - Striving for Zero* approaches this issue already with its emphasis on the need to address stigma as a major obstacle to preventing suicide - "Stigma not only discourages people from seeking help, but also can prevent people, families, and communities from becoming connected with meaningful support."

Your Plan goes so far as to assert in the first pages - "to demonstrate one tactic that can combat stigma, the Commission uses non-stigmatizing language throughout this plan." Previously accepted phrases such as "committed suicide", "suicidal person", and "mentally ill" are methodically avoided in the succeeding 97 pages.

We ask that MHSOAC take this definitive step to add the phrase "post-traumatic stress disorder" to its list of harmful and antiquated stigmatizing terms, replacing it with the much more positive phrase "post-traumatic stress injury". Removing the word "disorder" takes away from the stigma, which is good. Adding the word "Injury" introduces honor, which is better!

With this subtle but effective move you can provide evolutionary advancement - without concern of financial burden. It can also, as you state in your recent letter to the Governor and Legislature, “help flatten the next curve of COVID-19”.

Thank you for your consideration,

Thomas Mahany
Executive Director
Honor for ALL

Proclamation -

Whereas all citizens deserve the investment of every possible resource to ensure their lasting physical, mental, and emotional well-being;

Whereas all citizens living with mental health needs from post-traumatic stress deserve our compassion and consideration;

Whereas the brave men and women who risk their lives to protect our freedom, health, and welfare deserve our special recognition of their gallantry, fidelity, and sacrifice;

Whereas post-traumatic stress can result from any number of stressors to include combat, rape, sexual assault, battery, torture, confinement, child abuse, car accidents, train wrecks, plane crashes, bombings, or natural disasters;

Whereas indirect exposure to others’ pain and injury can cause post-traumatic stress and increased capability for self-injury and suicide among groups such as veterans, physicians, nurses, and first responders;

Whereas**,** it has been shown though electro-magnetic imaging that severe post-traumatic stress causes physical changes within the brain which are more accurately described as an injury than a disorder;

Whereas referring to post-traumatic stress as a disorder can disparage the injured and discourage them from seeking proper and timely care;

Whereas increased understanding of post-traumatic stress can help eliminate the stigma attached to this mental health issue; and

Whereas timely and appropriate treatment of post-traumatic stress responses can diminish complications and avert suicides;

Now, therefore**,** be it resolved, that I, Gavin Newsom, Governor of California do hereby proclaim (*month*) 27, 2020 Post-Traumatic Stress Injury Awareness Day and encourage all Californians to join me in this worthy observance.