WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Teleconference Meeting
June 24, 2021
PowerPoint Presentations and Handouts

Agenda Item 3:	• **PowerPoint:**	**Multi-County Collaborative Psychiatric Advance Directives**
	• **Handout:**	**Position Letter**
Agenda Item 4:	• **PowerPoint:**	**Physician Committed**
	• **Handout:**	**Physician Committed Toolkit**
Agenda Item 5:	• **PowerPoint:**	**Transformational Equity Restart Program**
Agenda Item 6:	• **PowerPoint:**	**Resident Engagement and Support Team (REST)**
Agenda Item 7:	• **PowerPoint:**	**H.O.P.E. - Holistic Outreach Prevention and Engagement**
	• **Handout:**	**Letters of Support**
Agenda Item 8:	• **PowerPoint:**	**Mental Health Student Services Act**
Miscellaneous:	• **Handout:**	**Article – "California connects datasets to show how mental health services can reduce arrests" (gcn.com)**

CONCEPTSFORWARD
CONSULTING

Multi-County Collaborative Psychiatric Advance Directives

MHSA Innovations Project

Kiran Sahota, MA

June 24, 2021

What is the Problem to address?

What are Psychiatric Advance Directives?

Psychiatric Advance Directives (PADs) are used to support treatment decisions for individuals who may not be able to consent to or participate in treatment decisions because of a mental health condition. The psychiatric advance directive allows the individual's wishes and priorities to inform mental health treatment. Psychiatric Advance Directives are created in a voluntary setting with full consent of the participant.

They are not: forced treatment and do not require a Power of Attorney.

- No "voice" for Individuals in crisis.
- Unnecessary hospitalization and incarceration.
- Lack of understanding an acceptance of PADs
- PADs are not accessible in a crisis

What is not working?

“Since the 1990’s, 27 states have enacted instructional PADs statues. However, the expected widespread use of PADs never came to fruition (SAMHSA).”

- Thinking a PAD is just part of an Advance Directive
- Misunderstanding the purpose of PADs
- Mental illness = limited decision-making capacity
- Lack of access to PADs in a crisis
- Silos of efforts within California counties

Stakeholder engagement and CPPP

- Fresno's prior MHSOAC approval 2019
- USC Saks Institute county engagement 2019
- Stakeholder planning as reported in county Three-year Planning 2020-2023.
- Local county planning, stakeholders and BHAB meetings
- Five statewide informational sessions and three Peer listening sessions between March and June 2021
- USC Saks Institute Symposium May 2021

What are we hoping to learn and how will it be evaluated?

Expanded Project Core Components- to be created by Peers, consumer and stakeholders.

- **Standardized training** on the usage and benefits of PADs by stakeholders – *Evaluation of process and understanding.*
- Peer created **standardized PAD template** with the facilitation of peers with lived experience- *Evaluation of process and utilization ease.*
- Development of a **training toolkit** (in 9 Languages) to be used throughout various counties while maintaining reliability and consistency- *Evaluation of understanding and utilization.*
- Creation and implementation of a **cloud-based technology platform** to utilize PADs- *Evaluation of process, utilization and impact.*

What is the Technology Platform?

"A major hindrance is the lack of a single portal for the storage, access to, and retrieval of a PAD- Joint Commission"

- A fundamental aspect of the PADs Innovation
  - It is not an Electronic Health Record; it will not store HIPAA protected data.
  - PAD is individually created with consent to upload and consent to share.
  - 100% Peer and Stakeholder created.
- Technology market does not build for individuals with SMI
  - Custom build- meaning not having to "back" a project into a generic program.
    - Easily adoptable and sustainable for all counties.
    - Avoids challenges encountered with previous MHSA technology projects.
- Participatory Technology Development
  - A process to create with Peers and stakeholders, rather than just for them.
  - Process is iterative and collaborative across design, engineering, project management and stakeholder voice
  - Aim is to avoid common pitfalls of tech development to improve:
    - Usefulness, effectiveness, and relevance
    - Addresses community concerns and inclusion of community strengths and wisdom.
- Innovation process to determine
  - Licensing cost and future funding
  - Legislation

Budget

- To include experts in the area of PADs training, MHSA project management, Fiscal Intermediatory, Evaluation, Peer Advocacy, Technology and Media.

COUNTY	Total INN Funding Requested	Local Costs - Admin and Personnel	Contractor/ Evaluation	Peer funding*
Fresno	$500,000	-	$500,000	$200,000
Mariposa	$517,231	$437,614.13	$79,660	$166,453
Monterey	$1,978,237	$759,411	$1,218,826	$400,000
Orange	$12,888,948	$1,043,478	$11,845,470	$584,602
Shasta	$630,731	$423,000	$207,731	$48,000
Total	**$16,515,147**		**$13,851,687**	**$1,399,055**

- Peer funding in addition to current county funded peer positions or community peer contracts.

CONCEPTSFORWARD
CONSULTING

Thank You

FROM CONCEPT TO COMPLETION

Proposed Motion (5):

The Commission approves each of the following County's Innovation plans, as follows:

COUNTY	TOTAL INN FUNDING REQUESTED (each amount is reflected in MHSA INN funding)	DURATION OF INN PROJECT
Mariposa	Up to $517,231	4 Years
Orange	Up to $12,888,948	4 Years
Shasta	Up to $630,731	4 Years
Monterey	Up to $1,978,237	4 Years
Fresno	Additional funding up to $500,000	5 Years
	TOTAL: $16,515,147.00	

From:	Reedy, Grace@MHSOAC
To:	Reedy, Grace@MHSOAC
Subject:	FW: Innovation plans for Imperial County and Multi-County Collacorative
Date:	Thursday, June 17, 2021 10:16:34 AM

From: [redacted] <[redacted]@gmail.com>

Sent: Friday, June 11, 2021 2:24 PM

To: MHSOAC <MHSOAC@mhsoac.ca.gov>

Subject: RE: Innovation plans for Imperial County and Multi-County Collacorative

HOPE Program

I have been really fascinated on this topic for a while actually. And was looking to research more about it. I think there should be alternatives and or just more choices for mental health consumers out there. I feel that this going to be really beneficial and ais needed and so I recommend the approval to this proposal.

PAD-Multi County Collaboration

I have recently attended listening sessions regarding PADS. I want to know more about the actual accountability measures for situations where the PAD isn't honored or a check system that they are active and not misplaced, neglected or lost. What are the legalities of them not being actually implemented or not?

Thank you

[redacted]

CLCC-Member

Physician Committed

Danelle Campbell, Program Manager
Mental Health Services Oversight & Accountability Commission
June 24, 2021

Butte County
BEHAVIORAL HEALTH

- Early identification and intervention of behavioral health issues among youth.
- Collaboration among our partners in behavioral health, physical health, and education to strengthen and expand our safety net for our youth.
- Primary care system will embrace and feel empowered to integrate behavioral health screenings as part of overall adolescent health care.

The Need

What is the problem we are trying to solve?

- Increase the **capacity and comfort** of medical providers to efficiently and effectively integrate behavioral health screenings into physical health settings and situations.
- Increase **early identification** of adolescent mental health and substance use issues.
- **Provide seamless referral** to brief intervention and clinical navigation to ensure warm hand off for long term support when appropriate.

Why do we need the extension?

1. Program implementation timeline was significantly impacted

2018 Camp Fire

153,335 acres
18,804 structures
-8 of 9 schools in Paradise were lost
85 fatalities

2020 COVID

Worldwide Pandemic

2020 North Complex Fire

318,935 acres
2,471 structures
15 fatalities

1. Increased need for interventions – trauma, isolation, suicides
2. Meet the increased demands and expand the reach:
   - 8th Grade – Hearing & Vision Screenings
   - Alternative Schools –
   - Town of Paradise School Nurses & Health Aids
     - *Not only a new geographical location but a community that experienced significant trauma*
   - Middle School and High School Nurses and Health Aids
   - Community Based Providers – clinics, private practice, orthodontist, orthopedist, etc.

Proposed Extension

What is not working? How will this extension address that problem?

Butte County is requesting an additional 2 years and additional funding in the amount of $1,252,631 to meet the high demands from their community and respond to the increased demands as a result of COVID-19 with **no changes to the project goals or purpose**:

- Year 4: $620,834
- Year 5: $631,797

Program implementation and expansion into new settings, situation and geographical locations was significantly impacted and delayed by local wildfires and COVID-19.

This extension will allow the opportunity to regain efforts with existing sites, meet increased demands and expand to:

- New Communities
- New School Setting
- New Age Demographic
- Expanded Opportunities Within Existing Sites
- Expansion to Community Based Clinics, Providers, Hospitals, and Specialty Physicians

External Controls and Impacts on the Community

- Significant impacts in the community environment (i.e., fire, disaster, pandemic) have impacted our ability to consistently collect reliable and valid data. Constant interruptions to data collection metrics has impacted our ability to reliably demonstrate that this project can be successful across sectors

This extension will allow for continued study and evaluation of the project.

Community Contribution

How has our community contributed to the extension of this project?

- **Butte Youth Now Coalition** – community coalition made up of 13 diverse sectors, members advocate for and support the extension
- **Butte Glenn Medical Society** – physician group dedicated to the development and implementation of this initiative
- **Provider/Partner Agency Support** - Younger age, school nurses, alternative sites, new geographical locations, more community based medical providers
- **Youth Peer Advocates** - 15 youth led focus groups identified increased youth stress, anxiety, depression, isolation, feelings of hopelessness.
  - 76% of high school youth know someone who is struggling right now.
  - Youth requested more safe and supportive opportunities to express their struggles and get support.
- **Letters of Support** – MHSA Steering Committee, Paradise School District, PV High School, California Health & Wellness, Anthem, Butte Glenn Medical Society
- **MHSA Steering Committee**
- **Behavioral Health Advisory Board**
- **30-Day Public Comment Period**

"The aftermath of trauma suffered by the Camp Fire, as well as the isolation and stress experienced by youth during the COVID pandemic have only increased the need for this service."

Goals & Evaluation

What are we hoping to learn with this extension and how will we measure it?

Learning Goal	Extension Study
Can behavioral health screenings be effectively and efficiently integrated into the comprehensive adolescent health physical?	Extension will allow for services to resume/continue providing further testing the effectiveness/efficiency with a younger age, new settings/situations, new partners, etc.
Did the evaluation show that behavioral health screenings were effectively and efficiently integrated into the physical?	Yes, however the extension will allow testing/evaluation in new settings/situations/populations.
Does this project provide the physician/primary care provider with more confidence and capacity in regard to screening for behavioral health issues?	Yes, 93% report felt it was “effective”. Implementation at this level was stalled due to the fires and COVID. Expansion will allow for further implementation, testing and evaluation to occur.
Will physicians’ comfort levels with discussing behavioral health and adolescents increase with comprehensive training and the implementation of a standardized tool?	Yes, 77% of medical providers reported they are “very comfortable” asking the screening questions. As we resume implementation and expansion efforts, we can provide additional training and support to all of the new partners to improve comfort levels.
Do adolescents feel more capable of managing early symptoms of behavioral health issues?	Of the 44 youth who completed the survey, 100% felt safe and trusted the staff member providing the intervention, 91% overall average in mental health/well being. Youth reported a 90% increase in coping skills and 54% of youth were connected to a supportive service (youth group, school club, program etc.)

Budget

- 4 FTE Behavioral Health Education Specialists
- Extra Help Peer Providers
- Program Supplies
- Training for medical providers
- Production of toolkits
- .25 FTE Analyst dedicated to Evaluation
- Administrative costs

$1,252,631

Two *Additional* Years

Proposed Motion: The Commission approves Butte County's Innovation plan extension, as follows:

Name:	Physician Committed
Amount:	Up to $1,252,631 in additional MHSA Innovation funds, to a total authority of $2,484,955
Project Length:	Five (5) years with this Extension

WHY WE SCREEN FOR MENTAL HEALTH ISSUES?

The Importance of Mental Health in Primary Care

Encourage Open Communication

Take Action to Support Families

Physical Symptoms and Signs Suggestive of Mental Health and Substance Abuse Concerns

Sleep Problems

- Excessive sleep
- Significant change in sleep patterns
- Difficulty falling or staying asleep
- Nightmares

Chronic, Recurrent, or Unexplained Physical Symptoms

- Abdominal pain
- Joint pain
- Headache
- Fatigue or low energy
- Loss of appetite
- Epigastric pain or gastritis (alcohol use)
- Chest pain or difficulty breathing (panic/anxiety attacks)
- Oligomenorrhea or amenorrhea, especially in women of low weight (anorexia, teen pregnancy)
- Irregular menses (anorexia, bulimia)

Neurologic Symptoms

- Legs weak
- Limb paralysis (conversion reaction)
- Pseudoseizures
- Non-physiologic neurologic symptoms
- Difficulty concentration, inattention in school
- Irritability, restlessness

Physical Findings

- Excess weight gain or loss
- Parotid gland enlargement, dental enamel erosion, calluses or erosions on knuckles (purging)
- Cigarette burns, multiple linear cuts or patterns (self-harm, maltreatment)
- Metabolic abnormalities such as hypochloremic metabolic alkalosis, low potassium, or elevated amylase (purging)
- Recurrent injuries (maltreatment, Self-harm)
- Isolated systolic hypertension (alcohol use)
- Chronic nasal congestion (cocaine use)
- Chronic red eyes (marijuana use)

Other

- Worsening symptoms of previously well-managed chronic illness
- School absences

Providing support to parents and families with teens in Butte County

PHYSICIAN COMMITTED

TO SCREENING AND EARLY IDENTIFICATION OF HEALTH ISSUES

5 SIMPLE QUESTIONS

Alcohol

1. Do you have any friends who drink?

2. Have you ever had more than a few sips of alcohol?

Mental Health

3. In general, how do you think things have been going for you lately?

4. What are the things that are more stressful for you?

5. What changes have you noticed in your sleep lately?

FOR ALL PATIENTS

STEP 1: ASK THE TWO SCREENING QUESTIONS

High School (ages 14 –18) Ask the patient question first.

Patient: How many days?
"In the **past year, on how many days** have you had more than a few sips of beer, wine, or any drink containing alcohol?"

LOWER MODERATE or HIGHEST RISK

Friends: How much?
"If your friends drink, **how many drinks** do they usually drink on an occasion?"

Binge drinking by friends HEIGHTENS CONCERN.
(3 to 5+ drinks)

DO FRIENDS DRINK?

NO

Neither patient nor patient's friends drink

- **Praise choices** of not drinking and of having nondrinking friends.

YES

Patient does not drink, but friends do

- **Praise choice** of not drinking.
- **Consider probing a little** using a neutral tone: "When your friends were drinking, you didn't drink. Tell me a little more about that." If the patient admits to drinking, go to Step 2 for Patients Who Do Drink; other wise, continue below.

- **Reinforce healthy choices with praise and encouragement.**
- **Elicit and affirm reasons to stay alcohol free.**
- **Educate,** if your patient is open about drinking risks related to brain development and later alcohol dependence.

- **Rescreen next year** at the latest.

- **Explore how your patient plans to stay alcohol free when friends drink.**
- **Advise against riding in a car with a driver who has been drinking or using other drugs.**
- **Rescreen at next visit.**

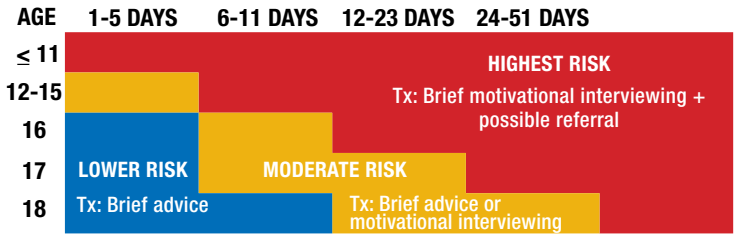
Screening complete for nondrinkers

STEP 2: ASSESS RISK

For patients who DO drink ...

For a broad indicator of your patient's level of risk, start with the chart below, which provides empirically derived population-based estimates. Then factor in what you know about friends' drinking and other risk factors, ask more questions as needed, and apply your clinical judgment to gauge the level of risk.

On how many DAYS in the past year did your patient drink?



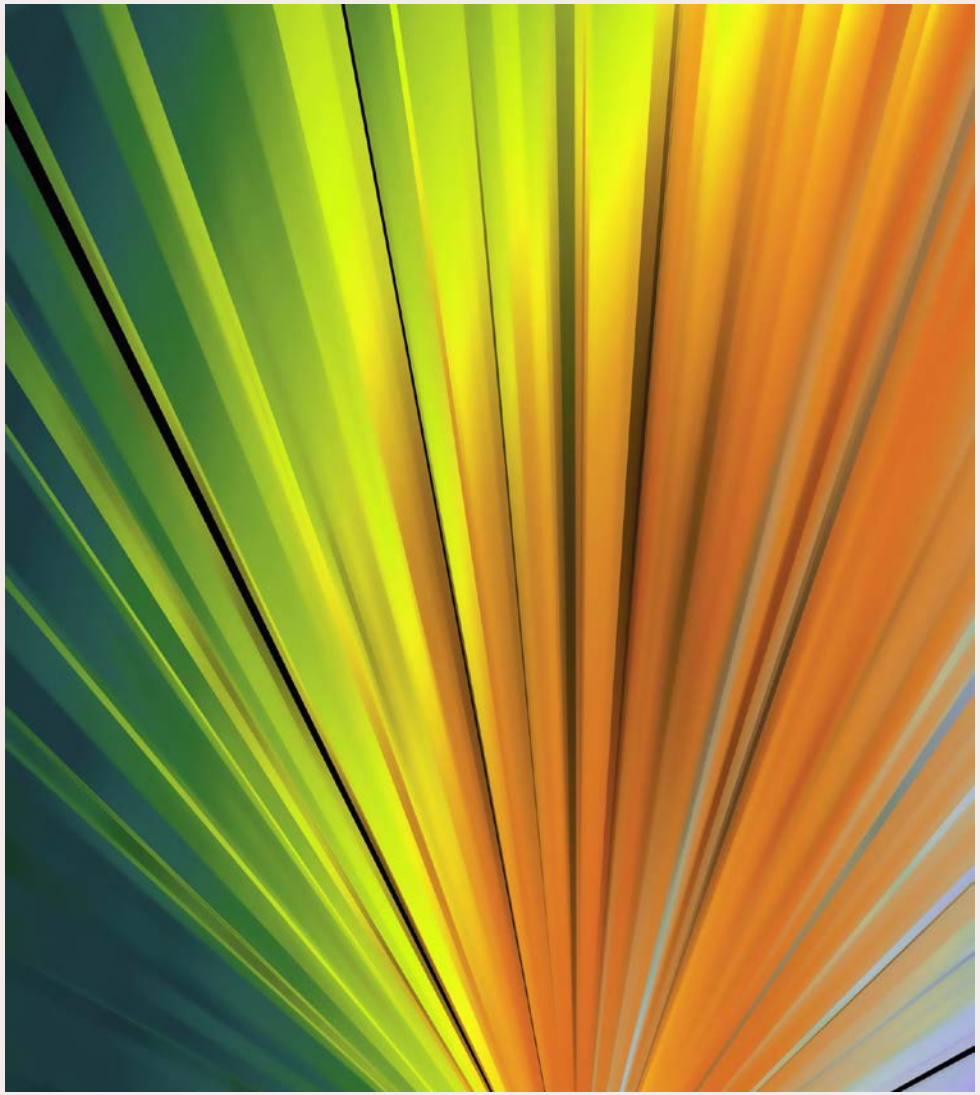
Factor in friends:

- **For high school students:** Having friends who binge drink heightens concern. Recent research estimates that binge drinking levels for youth start at 3 to 5 drinks, depending on age and gender

Include what you already know about the patient's physical and psychosocial development in your risk evaluation, along with other relevant factors such as the level of family support, drinking and smoking habits of parents and siblings, school functioning, or trouble with authority figures.

For moderate and highest risk patients:

- **Ask about their drinking pattern:** "How much do you usually have? What's the most you've had at any one time?" If the patient reports bingeing, ask: "How often do you drink that much?"
- **Ask about problems experienced or risks taken:** "Some people your age who drink have school problems like lower grades or missed classes. Some do things and feel bad about them later, like damaging or stealing property, getting into fights, getting sexually involved, or driving or riding in a car driven by someone who has been drinking. Others get injured, have memory blackouts, or pass out. What not-so-good things related to drinking, if any, have you experienced?"
- **Ask about other substance use** ("Have you used anything else to get high in the past year?") and consider **using other formal tools to help gauge risk**. The majority of your lower risk patients will not have used illicit drugs (NIAAA, 2011), but ask them, too, about past-year use, time permitting.



Transformational Equity Restart Program

MHSOAC Innovation Project Presentation

What is the problem you are trying to solve in your county?

Individuals involved with the justice system face many obstacles as they transition out of incarceration and probation, and return to the community.

In Merced County, there is a significant need for a coordinated, culturally responsive network of care for individuals involved in probation services and the justice system in order to reduce recidivism.

Behavioral Health populations involved with the justice system need a unique, individualized approach to treatment that is coordinated between systems that look at reducing length of time in custody in addition to increasing support around treatment for mental health treatment and co-occurring disorder treatment.

What is not working? How does the INN project address that problem?

Although Merced County has some services for the forensics population (MH Court, Jail services), these are siloed approaches to treatment. There are no specific forensics behavioral health services available for clients as they are released from jails back to the community, nor are there specific services for clients who are in the community **and** receiving probation services.

Information/data sharing between probation, law enforcement, jails, and behavioral health is significantly limited, and disjointed at best.

The Transformational Equity Restart Program/Data Driven Recovery Project will be incorporated into the Innovations program; this program will assist Merced County in developing analytic tools, asset maps, and data sharing agreements to identify strategies for reducing the incidence, duration, and recurrence of arrests and incarcerations of people with behavioral health conditions. The program will also improve care coordination, integration, and culturally responsive services for clients with behavioral health issues who are justice involved or at risk of justice involvement.

How has your community contributed to the creation of this project?

MULTIPLE VENUES	The Merced community informed the Innovation Project by providing feedback at the following venues:	Cultural Humility Forums
MHSA Three Year Plan Community Program Planning Process	Current MHSA Annual Update and Innovation (CPPP)	Focus groups
Stakeholder Comment Cards	Key informant emails and interviews	MHSA Ongoing Planning Council monthly meetings
Cultural Humility, Health Equity and Social Justice Committee meetings	Community Survey	Behavioral Health Board Public Hearing May 5, 2021

What are you hoping to learn and how will you measure it?

The Transformational Equity Restart Program will provide services and care for our underserved communities in a way that addresses cultural humility, health equity, social justice and provide information and data sharing between probation, law enforcement, jails, and behavioral health.

Merced County is seeking to build a culture of hope, inclusion, trust and cultural humility and responsiveness for families and individuals living with mental health issues who are in a continuous cycle of jail, hospitalization, homelessness, with no support system.

Behavioral Health populations involved with the justice system face many obstacles as they transition out of incarceration and return to communities.

Data collection will include:

of clients connected to behavioral health service upon release from jail/prison

Demographics, # of referrals, Length of time in treatment

# of justice involved individuals linked to behavioral health services

# of clients with a reduction in mental health symptoms and/or improved health

Recidivism rates, # of days incarcerated, violations of probation

Client satisfaction surveys

Proposed Budget

Project Budget	$3,124,323.39
Evaluation	$500,000
5-year Expenditure (Budget + Evaluation)	$3,624,323.39

Job Classification	Number of FTEs	Annual Position Salary Costs	Annual Position Benefits Costs
BHRS Program Manager (.50 FTE will be funded with Medi-Cal and .50 FTE Innovation funds	.50 FTE	$ 49,680.80	$ 44,376.78
Mental Health Clinician II	1.00 FTE	$ 96,969.60	$ 78,507.54
Dual Diagnosis Specialist /Mental Health Worker	1.00 FTE	$ 63,668.80	$ 59,524.68
Peer Support Specialist	2.00 FTE	$ 81,952.00	$ 94,964.94
Evaluation (Contract)		$ 100,000.00	
Total Program Positions	4.5 FTE		

Proposed Motion:

The Commission approves Merced County's Innovation plan, as follows:

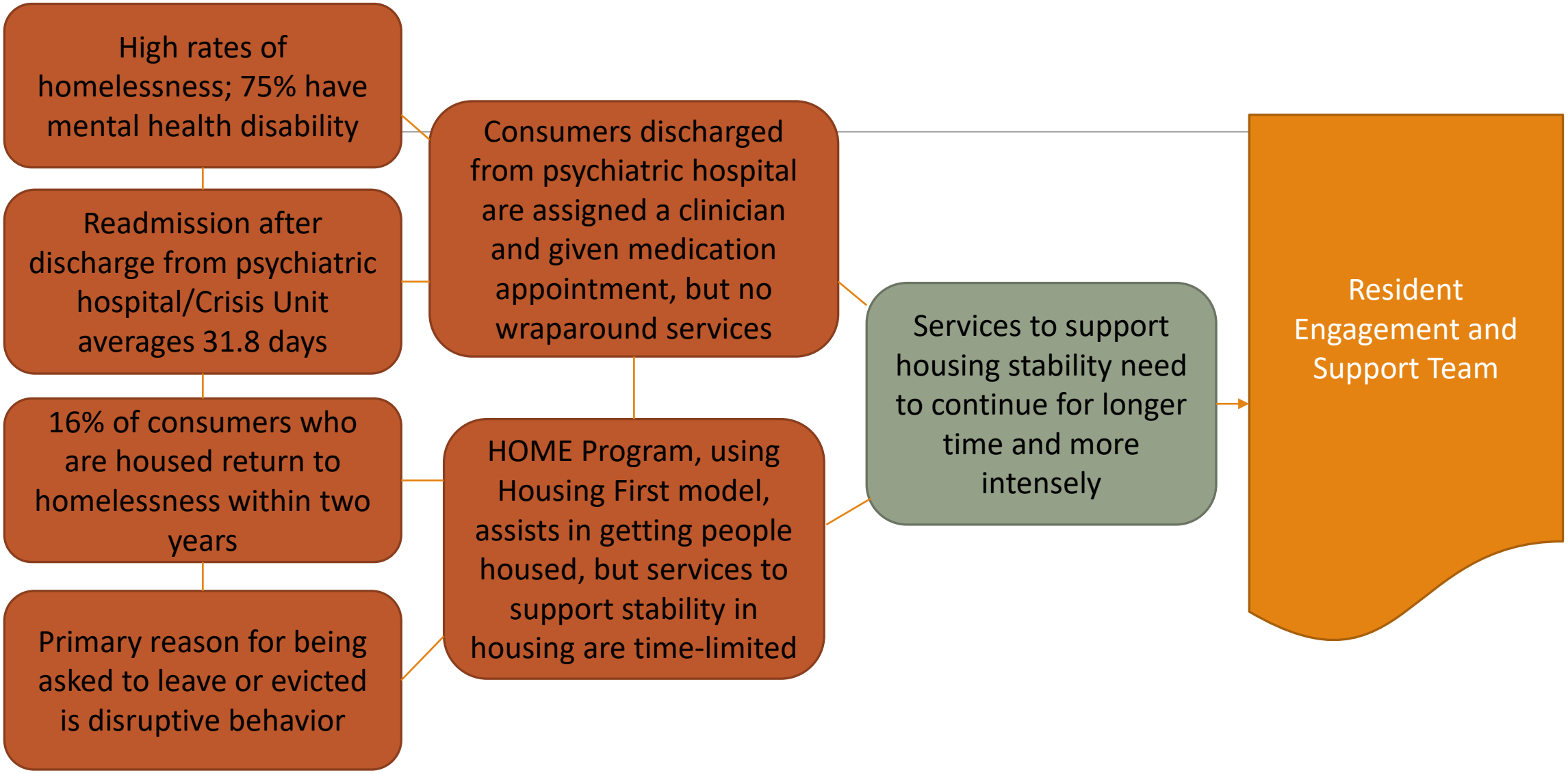
- Name: Transformational Equity Restart Program (TERP)
- Amount: Up to $3,624,323.39 in MHSA Innovation funds
- Project Length: Five Years

Resident Engagement and Support Team (REST)

HUMBOLDT COUNTY BEHAVIORAL HEALTH INNOVATION PROPOSAL

JUNE 24, 2021

The Problem


High rates of homelessness; 75% have mental health disability
Readmission after discharge from psychiatric hospital/Crisis Unit averages 31.8 days
16% of consumers who are housed return to homelessness within two years
Primary reason for being asked to leave or evicted is disruptive behavior
Consumers discharged from psychiatric hospital are assigned a clinician and given medication appointment, but no wraparound services
HOME Program, using Housing First model, assists in getting people housed, but services to support stability in housing are time-limited
Services to support housing stability need to continue for longer time and more intensely
Resident Engagement and Support Team

REST addresses this problem

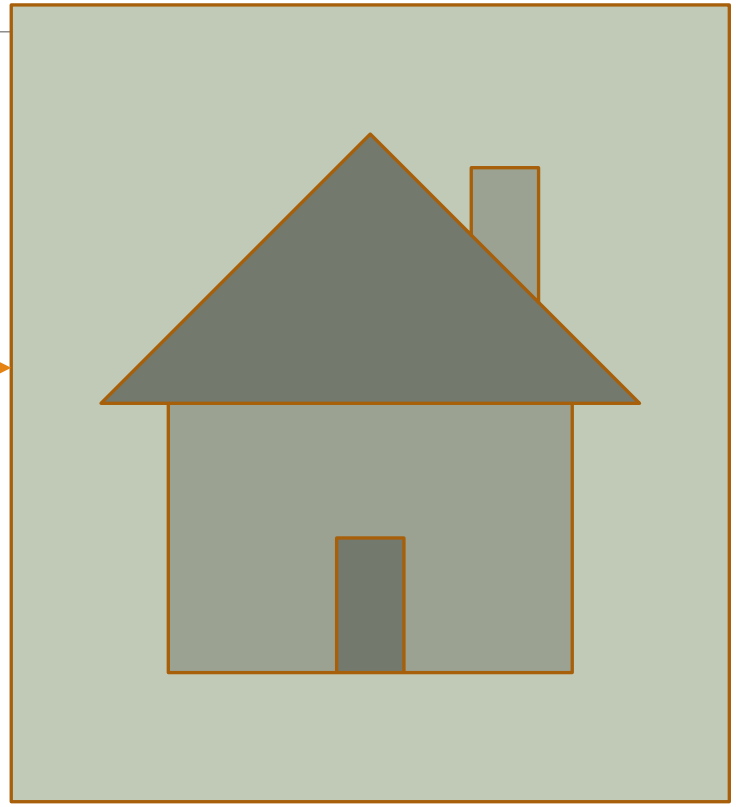
Another option for those not meeting criteria of Full Service partnership or who are resistant to BH services

Uses “Housing First” principles

Staffed by case managers and peer coaches to increase engagement and help meet goals

Fills an identified gap in the continuum of care through helping individuals remained housed

Individualized services and supports to newly housed to promote successful transition to housing stability



Community Contribution to REST

Fall/Winter 2019-20, Three Year Plan CPP:

- 700 participants rank housing, supportive services for housing, and more case managers as top priorities
- Participants rank persons experiencing homelessness as #1 population not being adequately served in the community

Winter 2020-21, Annual Update CPP:
Participants continue to place addressing homelessness as a top priority

Spring 2021, 30 day public comment and public hearing:
Support expressed for services to be provided by REST

"Support teams need funding so that they can help keep people housed once they get housed. This is so vital. Lease violations and behavioral concerns get folks kicked out of housing quickly, and with more support team members to address these issues people can keep housing and not re-enter houselessness."

"Often times homeless patients…have a history of debt, poor rental history…I propose that this be a focus of the recovery program, to offer guidance on how to do things like apply for an apartment, how to set up a bank account, etc."

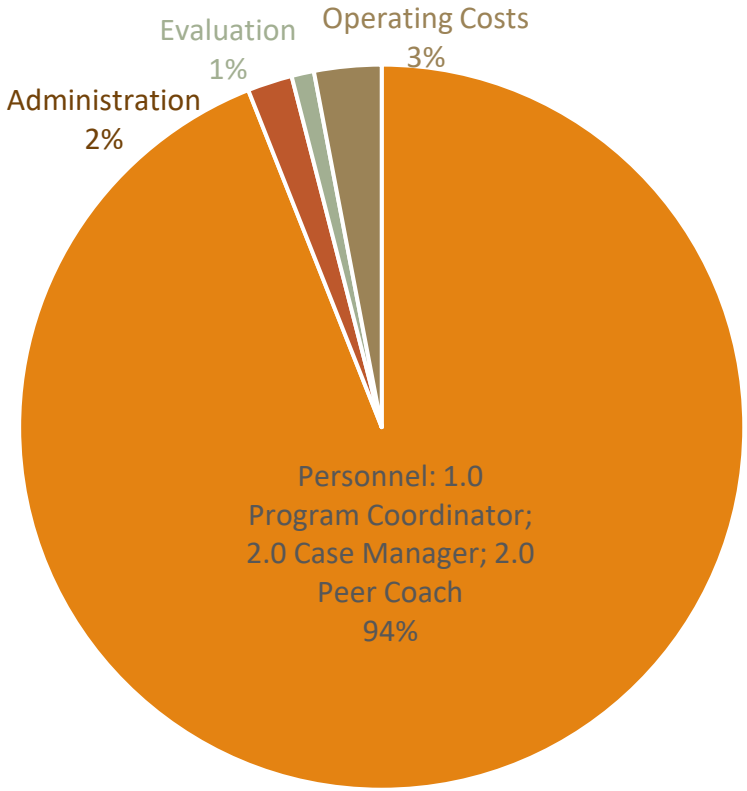
Learning and measures

Learning Question	Measures
1. How effective is ongoing case management and peer support for those discharged from SV or CSU, or exiting from a Full Service Partnership (FSP) or HOME services, to maintain housing?	Well-trained case managers and peers will increase engagement of consumers in appointment-based outpatient care. Clients will remain housed as measured by EHR, DCR, HOME, Activate Care reports
2. Will increased case management and peer support services facilitate recovery as indicated by a reduction in the number of emergency service episodes?	Consistent and consumer-driven interventions by REST team will promote successful outcomes. Number of emergency service episodes reduced as measured by EHR and MORS reports
3. Will educating landlords about recovery increase the number of landlords who accept our consumers as tenants?	Increased capacity for housing and landlord forbearance for consumers. Consumers remain housed as measured by landlord survey, HOME dashboard
4. Will REST help us learn what services and supports are most utilized by newly housed individuals?	Clients will maintain treatment compliance as measured by targeted consumer survey; show rates; appointment compliance rate; consumer survey/focus group
5. Will REST services contribute to improved physical health outcomes for consumers served?	Better health for consumers as measured by physical health and urgent care appointments; emergency room visits
6. How long do consumers remain housed?	Higher rate of consumers remaining housed as measured by length of time in housing

Budget: $1,617,598 in Innovation funds over five years

Funding Source	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY 25/26	Total
Innovation Funds	$300,196	$314,832	$324,955	$335,339	$342,276	$1,617,598
Medi-Cal FFP	$166,826	$166,826	$166,826	$166,826	$166,826	$834,132
5 Year Budget	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**Total**
Personnel	$440, 606	$454,645	$464,128	$474,096	$480,594	$2,314,069
Administration	$8,373	$8,671	$8,991	$9,199	$9,418	$44,652
Evaluation	$4,814	$5,112	$5,432	$5,640	$5,859	$26,857
Operating Costs	$13,230	$13,230	$13,230	$13,230	$13,230	$66,150
TOTAL	$467,023	$481,658	$491,781	$502,166	$509,102	$2,451,730

Projected Expenditure Percentages



Proposed Motion: The Commission approves Humboldt County's Innovation Project, as follows:

Name:	**Resident Engagement and Support Team (REST)**
Amount:	**Up to $1,617,598 in MHSA Innovation funds**
Project Length:	**Five (5) Years**

H. O. P. E.

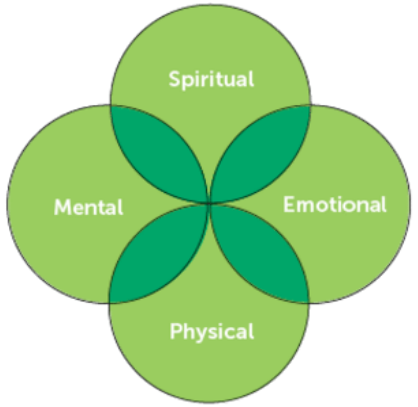
Holistic Outreach Prevention and Engagement

Innovation Plan

IMPERIAL COUNTY Behavioral Health Services Systems of Care

WHAT IS THE PROBLEM

- **Increase in psychiatric emergencies but decrease in admission to services for youth and young adults, ages 13-25**
  - Enrollment in mental health services decreased 26% from April-December 2019 and April-December 2020
- **More acute mental health conditions resulting in longer hospital stays**
  - Average length of hospitalization in FY 18-19, 10 days vs. 14 days in FY 19-20
  - During FY 19-20, 55% were not actively enrolled in mental health services
  - Of the 45% enrolled in mental health services; most had recurrent hospitalizations
- **Lack of engagement in mental health services**
  - Treatment adherence challenges that contributes to psychiatric emergencies
  - Clients do not follow-up with services after experiencing a psychiatric emergency
  - High no-show rates to mental health appointments ranging between 25-34%
- **Traditional outreach and engagement efforts to engage youth and young adults in mental health services have not worked**

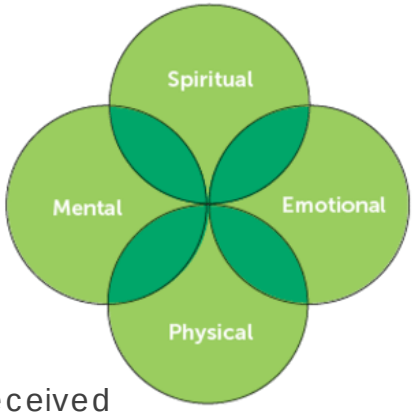


HOW THE PROBLEM WILL BE ADDRESSED

- **Inclusion of Wellness Activities to provide a Holistic Approach**
  - Focus on the individual's overall well-being - mind, body, and soul - instead of mental health symptoms
  - Facilitate engagement and reduce stigma associated with receiving mental health services
  - Bring a balance of emotional, physical, spiritual, and mental health by providing wellness activities including mindfulness, fitness, nutrition, and artistic forms of expression such as music and art
  - Implement individual wellness plan that will be client-centered, client-driven, and strength-based that will motivate the individual to stay engaged in services
- **Integration of Peer Support Specialists**
  - Act as a role model for Recovery
  - Provide a warm hand-off to help mitigate stigma associated with mental health
  - Provide navigation to supplemental services
  - Provide introduction to other more youth-friendly modalities

- **This two-level approach will help reduce stigma and motivate youth and young adults to participate in mental health services, reducing the current 'no-show' rate, improving treatment adherence, and reducing psychiatric emergencies**

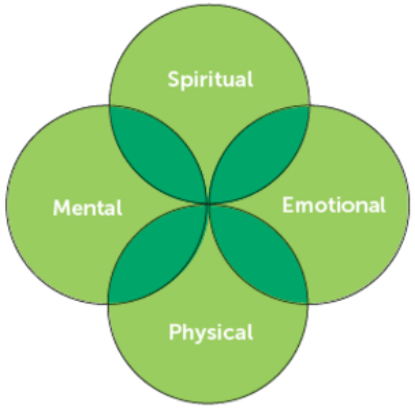
COMMUNITY CONTRIBUTION



- **Community Program Planning Process (CPPP)**
  - 16 Zoom forums between Feb-Mar 2021, 8 in English and 8 in Spanish
  - Meetings were advertised in 3 local newspapers and posted on ICBHS' Facebook page
  - Additional input from stakeholders and community members was received via survey monkey; 389 surveys were received
  - Two main areas of consideration: 1) Increase mental health access to unserved groups 2) Increase quality of mental health services
  - Population of Focus: Youth and young adults, between the ages 13-25
  - Key program elements: Adapting the current practice by Integrating peer support specialist and Incorporating a *Wellness* component to provide a holistic approach to treatment
  - The 30-day public comment period was from May 1, 2021 through May 31, 2021
  - Mental Health Board hearing was conducted on June 1, 2021

LEARNING OBJECTIVES & EVALUATION

- **Quantitatively**, Imperial County hopes to learn if:
  - Having peers support specialists will increase enrollment in services and retention rate
  - Implementing a holistic approach to treatment facilitates an increase of participants and will that help them to remain engaged
  - Having these two methods of engaging youth and young adults will reduce psychiatric emergencies/admissions
- **Qualitatively**, Imperial County hopes to learn if:
  - Having peer supports helps to decrease stigma related to mental illness
  - Having a holistic approach to recovery will motivate them to participate and stay engaged in mental health services
  - Does this innovation help reduce symptoms of mental illness and give the person an overall sense of wellbeing
- **Evaluation**
  - Performance outcome measurement tools
  - Behavior and Symptom Identification Scale (BASIS-24)
  - Youth Outcome Questionnaire Self Report (YOQ-SR)
  - Data will be gathered from electronic health record
  - Staff and participant interviews and surveys



BUDGET

Total Project: $3,455,605 for three years

($1,578,342 are funds subject to reversion on June 30, 2021)

- Personnel costs: $1,919,318
  - Non direct administrative staff ($547,522)
  - Direct service staff ($1,324,048)
  - Indirect staff ($47,748)
- Operating Costs: $767,473
  - Program and administrative costs
- Non-recurring costs: $52,314
  - 2 Vehicles to transport participants to and from activities
- Consultant/Contract costs: $716,500
  - Evaluation Contractor and wellness vendors and contractors

Budget and Source Revenue & Expenditure FY 2021-22 THROUGH FY 2023-24

REVENUE		2021-2022	2022-2023	2023-2024	TOTAL
(Revenue by Allocation Fiscal Year)					
	INN Re-allocated Funds *(Potential for Reversion)*	$ 1,080,871	$ 219,967	$ -	$ 1,300,838
	FY 2015-2016 *(Contigent MHSA ARER- Potential for Reversion)*	$ -	$ 277,504	$ -	$ 277,504
	FY 2016-2017 *(Contigent MHSA ARER)*	$ -	$ 452,181	$ -	$ 452,181
	FY 2017-2018 ""	$ -	$ 217,535	$ 270,457	$ 487,992
	FY 2018-2019 ""	$ -	$ -	$ 505,245	$ 505,245
	FY 2019-2020 ""	$ -	$ -	$ 431,845	$ 431,845
	Total Revenue	$ 1,080,871	$ 1,167,187	$ 1,207,547	$ 3,455,605
PERSONNEL COSTS		**2021-2022**	**2022-2023**	**2023-2024**	**TOTAL**
(Salaries, wages, benefits)					
1.	Salaries (Program Supervisor, Office Asstnt.)	$ 178,893	$ 181,471	$ 187,158	$ 547,522
2.	Direct Salaries (MHRT, MHW, CSW)	$ 419,886	$ 441,077	$ 463,085	$ 1,324,048
3.	Indirect Salaries (Director,Deputy Director, Admin. Sec)	$ 15,402	$ 16,173	$ 16,173	$ 47,748
4.	Total Personnel Costs	$ 614,181	$ 638,721	$ 666,416	$ 1,919,318
OPERATING COSTS		**2021-2022**	**2022-2023**	**2023-2024**	
5.	Direct Costs	$ 97,893	$ 105,724	$ 113,125	$ 316,742
6.	Indirect Costs	$ 140,983	$ 152,242	$ 157,506	$ 450,731
7.	Total Operating Costs	$ 238,876	$ 257,966	$ 270,631	$ 767,473
NON-RECURRING COSTS		**2021-2022**	**2022-2023**	**2023-2024**	
(Equipment,Technology)					
8.	Direct Costs (Vehicle)	$ 52,314	$ -	$ -	$ 52,314
9.	Indirect Costs	$ -	$ -	$ -	$ -
10.	Total Non-Recurring Costs	$ 52,314	$ -	$ -	$ 52,314
CONSULTANT/CONTRACT COSTS		**2021-2022**	**2022-2023**	**2023-2024**	
(Clinical, training, facilitator, evaluation)					
11.	Direct Costs *(Wellness Providers, etc.)*	$ 110,000	$ 220,000	$ 220,000	$ 550,000
12.	Indirect Costs *(Project Evaluation Contract)*	$ 65,500	$ 50,500	$ 50,500	$ 166,500
13.	Total Consultant Costs	$ 175,500	$ 270,500	$ 270,500	$ 716,500
OTHER EXPENDITURES		**2021-2022**	**2022-2023**	**2023-2024**	
(Please explain in budget narrative)					
14.	Direct Costs	$ -	$ -	$ -	$ -
15.	Indirect Costs	$ -	$ -	$ -	$ -
16.	Total Other Expenditures	$ -	$ -	$ -	$ -
BUDGET TOTALS					
PERSONNEL COST (Line 1)		$ 178,893	$ 181,471	$ 187,158	$ 547,522
DIRECT COST (Add 2 ,5, 8 & 11)		$ 627,779	$ 766,801	$ 796,210	$ 2,190,790
INDIRECT COST (Add 3, 6 & 12)		$ 221,885	$ 218,915	$ 224,179	$ 664,979
NON-RECURRING COST (Line 10)		$ 52,314	$ -	$ -	$ 52,314
OTHER EXPENDITURES (Line 16)		$ -	$ -	$ -	$ -
TOTAL INNOVATION BUDGET		**$1,080,871**	**$1,167,187**	**$1,207,547**	**$ 3,455,605**

Proposed Motion

The MHSOAC approves Imperial County's Innovation plan, as follows:

- Name: Holistic Outreach Prevention and Engagement (HOPE)
- Amount: Up to $3,455,605 in MHSA INN Funds
- Project Length: Three (3) Years

NAMI San Diego and Imperial County

National Alliance on Mental Illness

June 11, 2021

Re: Support for the HOPE Program (Innovations Project)

Dear MHSOAC Members,

I am writing to enthusiastically support Imperial County Behavioral Health Service's Innovations Project proposal for the program entitled: "Holistic Outreach Prevention and Engagement (HOPE)"

The National Alliance on Mental Illness in San Diego & Imperial County (NAMI San Diego) is the community's voice on mental illness. We were thrilled to find that the HOPE Program clearly addresses the most pressing needs identified by stakeholders and community members in Imperial County; namely, effectively engaging youth and young adults who are in need of behavioral health services yet are not connected or are not participating in their treatment/services. Furthermore, HOPE will accomplish this goal by allowing peer support specialists to utilize innovative strategies to successfully engage our youth and young adults.

When this bid is awarded, NAMI San Diego is commited to supporting Imperial County Behavioral Health Services (ICBHS) to ensure the project's success. Specifically, given our organization's extensive experience training and leading teams of peer support specialists in San Diego and in Imperial County, we can support ICBHS by hiring, training and leading the team of Peer Support Specialists.

Sincerely,

Cathryn Nacario 06/11/2021

Cathryn Nacario, RN, MHA
Chief Executive Officer
NAMI San Diego
5095 Murphy Canyon Road, Suite 320
San Diego, CA 92123

COUNTY OF IMPERIAL

DAN PRINCE
Chief Probation Officer

ELIZABETH V. SAIS
Assistant Chief Probation Officer

PROBATION DEPARTMENT
JUVENILE HALL

324 Applestill Rd.
El Centro, CA 92243

(442) 265-2400
(442) 265-2376 fax

PROBATION DEPARTMENT

June 16, 2021

Leticia Plancarte-Garcia, Director
Imperial County Behavioral Health
202 N. Eighth Street
El Centro, CA 92243

Dear Ms. Plancarte-Garcia,

On behalf of the Imperial County Probation Department, we write to express our organizational support to Imperial County Behavioral Services in their application for the Mental Health Services Act Innovation Project, Holistic Outreach Prevention and Engagement (HOPE) program. We strongly support this plan that focuses on engaging youth and young adults with specialized services that include Peer Support Specialists to assist in navigating mental health services. We believe using this approach can assist in decreasing psychiatric emergencies and motivate youth and young adults to access mental health services.

The Imperial County Probation Department continues to work collaboratively with Imperial County Behavioral Health Services in a wide range of services for both our youth and young adult populations. One such program is the Youth and Young Adults (YAYA) program, which provides adolescents a combination of mental health and educational services. Another program is the Substance Use Disorder program, which provides outpatient services to individuals experiencing drug abuse. This collaboration has been most beneficial to our vulnerable and at risk community by helping them meet their treatment goals.

Through the continuous collaboration with Imperial County Behavioral Health Services, both entities will be able to work on engaging youth and young adults in accessing mental health treatment and other supportive services.

The vision and implementation offered in this plan will reinforce our collaborative efforts and assist each entity in providing services to the mentally ill. I give this plan my full support.

Dan Prince,
Chief Probation Officer
danprince@co.imperial.ca.us
(442) 265-2401

Imperial Valley Regional Occupational Program

687 State Street • El Centro, California 92243
(760) 482-2600 • Fax (760) 482-2750
www.ivrop.org

Preparing Students For Work: It's Our Business

Edwin P. Obergfell
Superintendent

June 16, 2021

Imperial County Behavioral Health Services
Behavioral Health/ Administration
202 N. 8th Street, Third Floor (EC)

Dear Leticia Plancarte- Garcia:

As the Imperial Valley Regional Occupational Program Community Foundation's (IVROPCF) ReadyforLIFE Program Manager, it is my pleasure to confirm strong institutional support for the 2021 Holistic Outreach Prevention and Engagement program. In my capacity as the program manager, I am responsible for overseeing the ReadyforLIFE youth program that provides services to vulnerable high-school aged youth within our community.

The ReadyforLIFE Program is a partnership between the Imperial Valley ROP Community Foundation and Imperial Valley ROP (contracted agency). ReadyforLIFE utilizes a holistic approach to case management and services making our partnership an anchor in the community that empowers students by providing organized educational activities needed to prepare students for careers, college, and life. Along with various programs within our organization, we focus on creating paths of opportunities for students of all ages by empowering them to achieve their career, academic, and life goals. As such, our program aligns with Imperial County Behavioral Health Service's (ICBHS) mission to provide holistic treatment options to motivate youth/ older youth to participate in mental health services and reduce stigma of mental health services. ReadyforLIFE is in support of the HOPE program and looks forward to referring our youth to benefit from the great services ICBHS's HOPE program will be offering.

Through this grant opportunity HOPE, ICBHS and IVROP-CF ReadyforLIFE are working to transform the youth populations in our communities by preventing, guiding and supporting them through their mental health journey by delivering the aforementioned interventions. We look forward to witnessing the great outcome this program will offer to our community's youth/ older youth population.

Sincerely,

Chantelle Gerardo
IVROP-CF ReadyforLIFE Program Manager

Adriana Hernandez
IVROP-CF ReadyforLIFE Program Director

From: Reedy, Grace@MHSOAC
To: Reedy, Grace@MHSOAC
Subject: FW: Innovation plans for Imperial County and Multi-County Collacorative
Date: Thursday, June 17, 2021 10:16:07 AM

From: [redacted] <[redacted]@gmail.com>
Sent: Friday, June 11, 2021 2:24 PM
To: MHSOAC <MHSOAC@mhsoac.ca.gov>
Subject: RE: Innovation plans for Imperial County and Multi-County Collacorative

HOPE Program

I have been really fascinated on this topic for a while actually. And was looking to research more about it. I think there should be alternatives and or just more choices for mental health consumers out there. I feel that this going to be really beneficial and ais needed and so I recommend the approval to this proposal.

PAD-Multi County Collaboration

I have recently attended listening sessions regarding PADS. I want to know more about the actual accountability measures for situations where the PAD isn't honored or a check system that they are active and not misplaced, neglected or lost. What are the legalities of them not being actually implemented or not?

Thank you

[redacted]

CLCC-Member

From:	Reedy, Grace@MHSOAC
To:	Reedy, Grace@MHSOAC
Subject:	FW: INN_Imperial County_HOPE Program
Date:	Thursday, June 17, 2021 10:22:39 AM
Attachments:	image001.gif

From: [redacted] <[redacted]com>
Sent: Friday, June 11, 2021 4:27 PM
To: Reedy, Grace@MHSOAC <Grace.Reedy@mhsoac.ca.gov>
Cc: Robancho, Lester@MHSOAC <Lester.Robancho@mhsoac.ca.gov>; Orrock, Tom@MHSOAC <Tom.Orrock@mhsoac.ca.gov>; Lieberman, Matthew@MHSOAC <Matthew.Lieberman@mhsoac.ca.gov>
Subject: INN_Imperial County_HOPE Program

June 11, 2021

Good Afternoon,

The above innovation project for Imperial County would be both worthwhile and beneficial to the community because it is using peer support specialists IN CONJUNCTION WITH wellness activities for TAY and youth ages 13-26 with two goals:

1. a goal of increasing mental health access to underserved groups and
2. increasing the quality of mental health services.

Additionally, stakeholders indicated they wanted the Innovation Project to include Wellness as a component of this innovative project.

It has been noted that adding the “wellness component”, which is a combination of exercise, yoga, meditation, and good/healthy nutrition can provide the patient with new coping skills which will translate into a greater sense of control over their lives.

This is a wonderful opportunity for those in the age range of 13-25 in Imperial County and I concur with The Plans.

In Service,

[redacted]

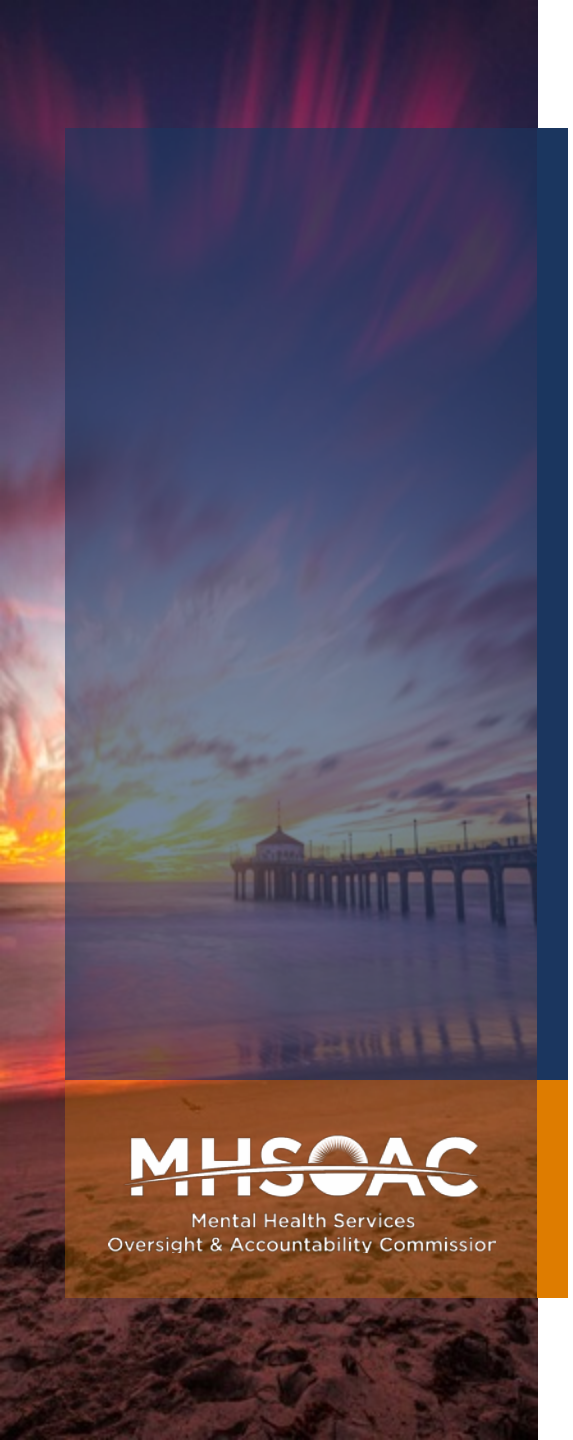
MHSOAC - Client Family Leadership Committee Member

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Mental Health Student Services Act

June 24, 2021

Tom Orrock, Chief of Stakeholder Engagement and Grants



Previous Commission Action

In December 2019, the Commission authorized a Request for Applications (RFA) for Mental Health Student Services Act grants, resulting in 18 awards for 75 million dollars.

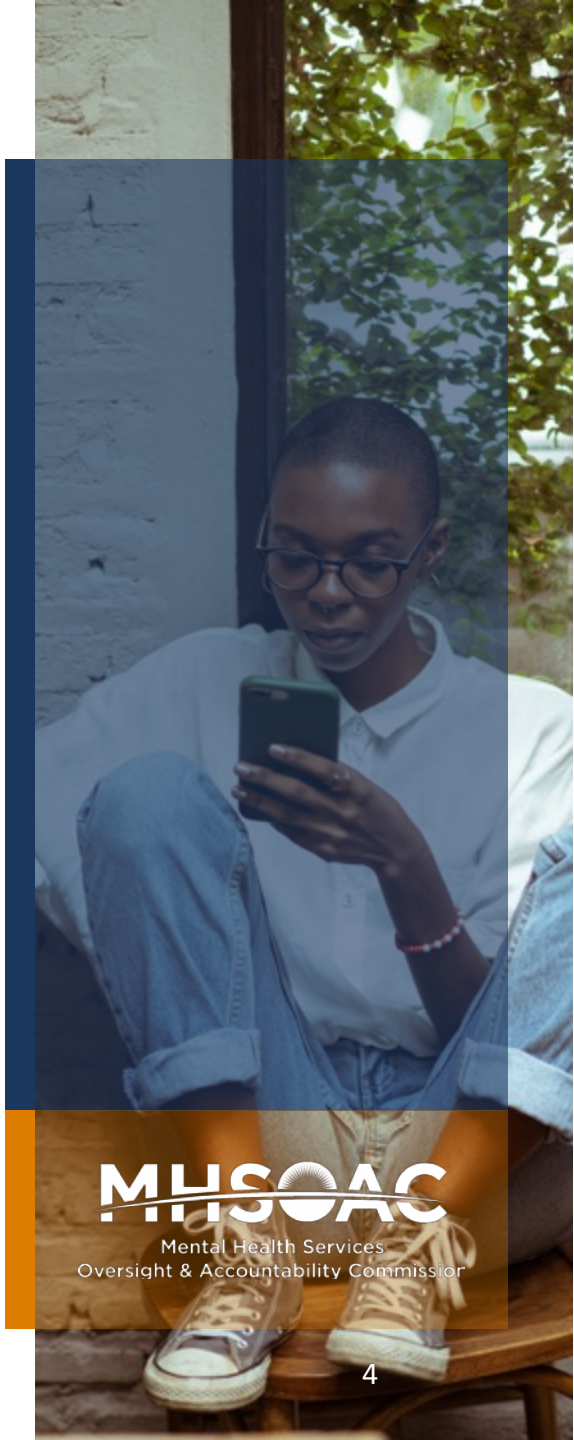
Anticipated MHSSA Funding in 2021-22 Budget

The Governor's Proposed 2021-22 Budget included $55 million in additional funding for the MHSSA.

- $5 million to support MHSSA by conducting a statewide evaluation
- $50 million to fund twelve additional school-county partnerships

Additional MHSSA Grants ($50 million)

$2.5 million (Small)	$4 million (Medium)	$6 million (Large)
Amador	Marin	Contra Costa
Glenn	Monterey	Riverside
Imperial	Santa Cruz	Sacramento
Lake	Sonoma	San Diego



Potential MHSSA Funding in 2021-22 Budget

Additional funding for school-county partnerships if approved in the final budget would:

- Fund 8 remaining MHSSA applicants
- Fund grants for additional applicants.

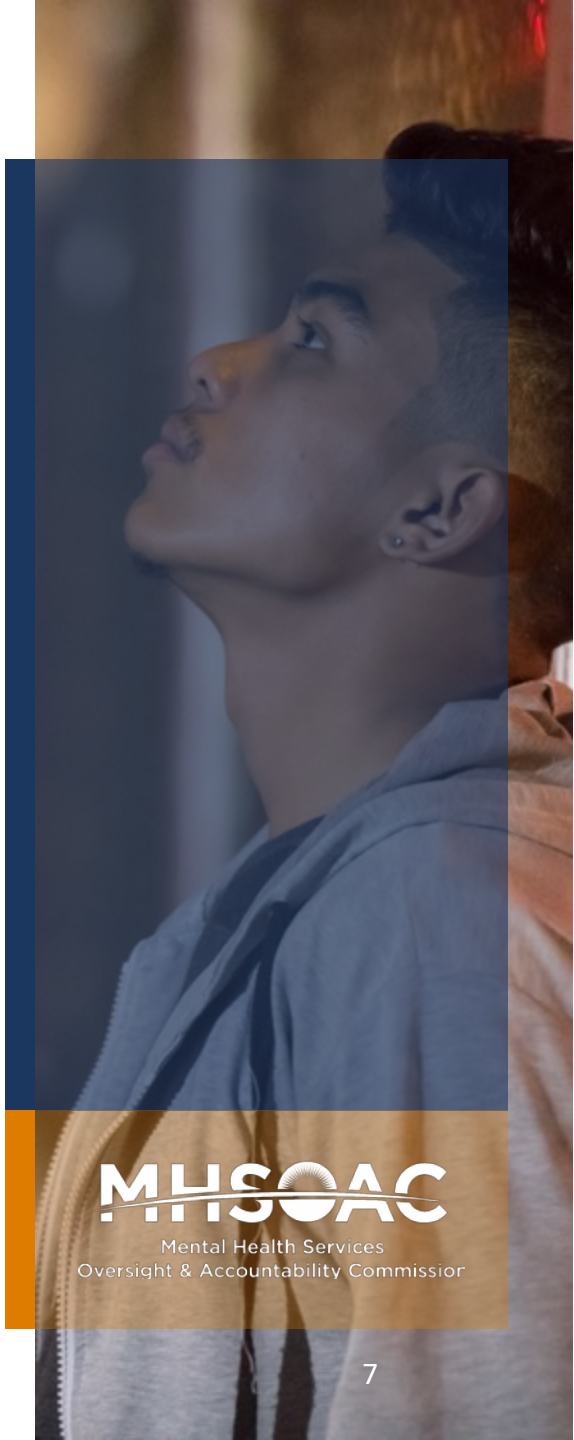
Proposals from Remaining Eight Applicants

$2.5 million (Small)	$6 million (Large)
Mariposa	Los Angeles
Nevada	San Bernardino
Shasta	San Francisco
Sutter-Yuba	
Tuolumne	

Proposed Motion

1. The Commission authorizes the Executive Director to allocate funding up to $5 million to support the MHSSA including executing contracts as needed to conduct a statewide program evaluation.

2. The Commission authorizes the Executive Director to allocate funds as appropriate, and to execute MHSSA grant agreements with all applicants under the 2019 Request for Applications.



California connects datasets to show how mental health services can reduce arrests

BY STEPHANIE KANOWITZ
JUN 09, 2021

Linking disparate datasets and applying customized analytics to them have helped California better map the relationships between mental health services and arrests.

In 2017, the California Mental Health Services Oversight and Accountability Commission partnered with the California Justice Department and received more than 20 years' worth of criminal justice records that it linked to data from its Full Service Partnership program, which aims to help people experiencing or at risk of institutionalization, homelessness, incarceration or in-patient psychiatric services. As a result, MHSOAC connected data on about 64,000 FSP participants who receive mental health services with 81,000 arrests at three time periods: 12 months before the arrest, during their participation in FSP and one year after exiting FSP.

"We saw a 69% reduction among clients who had three or more arrests prior to participating in the Full Service Partnership program. This is a really, really big deal," said Dawnté Early, chief of research and evaluation at MHSOAC. "The linked data is helping not only the commission validate that mental health programs can drastically reduce arrests among mental health consumers, but what it's also showing is that when we invest in the community, going more upstream, that we can reduce contact with the criminal justice system and that's what we want."

The research also found that of the 64,000 participants, 70% had no arrests before, during or after participation. For the others, arrests dropped 47% from before to during participation in FSP and 29% from before to after.

https://gcn.com/articles/2021/06/09/california-mental-health-arrest-data.aspx

The data from FSP is mostly respondent based. Participants answer a series of questions with follow-ups about every three months. Other datasets include key events such as arrests, hospitalizations, hirings, firings, acquiring housing and deaths. From the state Justice Department, the commission gets what Early calls administrative data such as arrests, convictions and whether the defendant was deemed competent to stand trial.

By linking the data, MHSOAC can verify participants' first-person responses with the DOJ information. That's because someone who was handcuffed and put in a police car but not actually placed under arrest may say they were arrested because in their mind they were.

"One of the things that we saw when linking these data together that had never touched before was that the positive rates – meaning the rate at which you said, 'Yes, I was arrested' – [and] what we actually saw in the system were really different," Early said. "One of the things that we were able to do was validate what we were seeing in our respondent data to what was actually in the system."

To combine the datasets and perform the analytics, the commission is using SAS, which helped create the algorithms MHSOAC is using. The idea behind it is called whole-person care, which brings together information from different aspects of someone's life to have meaningful insight.

Data management, not the analytics, is the hardest part, said Jennifer Robinson, SAS' director of local government. That's because entities use different data formats, making governance and usage and sharing policies crucial to have in place before any analytics can happen.

"One of the aspects that's very difficult in whole-person sharing is ensuring that the person in one system is the same person in another system, so if you're matching records, making sure you're matching the records that relate to the right person," Robinson said. "To accomplish that, SAS analytics uses entity resolution. That concept is scoring the information to be able to give confidence ratings to how accurate we think the match is."

Data is anonymized before it's analyzed and arranged into reports for customers such as MHSOAC, she added.

The commission creates data dashboards to share their results and engage the community on what they are doing. They also produce policy reports and MHSOAC adopts recommendations based on what the research shows. Additionally, they write briefs and provide infographics, Early said.

"There are different audiences for this information and so for us, if the information is not being used or isn't understandable, then we're not doing our job," she said.

The commission recently began integrating data with other California state agencies that intersect with mental health consumers. For instance, this year it started using

quarterly wage data from the Employment Development Department. Because the respondent data captures information on whether and FSP participant was employed, lost or changed jobs, MHSOAC can validate and quantify what being in FSP means for employment and livable wages, Early said.

Last month, MHSOAC got death records from 2000 to 2019 and birth records from 2000 to 2018 to study suicide and maternal mental health, and at the end of June it will get data from the California Education Department from 2000 on.

“What we have are at the base are mental health consumers and then we go out linking to schools, going back so that you can follow an individual from school all the way to adulthood to see what works, what was a part of that success and how do we invest in what goes to those successes,” Early said. “Where could we have intervened earlier to see a successful outcome?”

Ultimately, the commission will be able to link that school data to birth, employment, criminal justice data and death records, providing a full view of someone’s life span to see what’s most impactful.

“We begin to have an accurate picture of what impact are the mental health services…having on reducing some of these negative impacts that are associated with being a mental health consumer,” Early said.

About the Author

Stephanie Kanowitz is a freelance writer based in northern Virginia.